



May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4207-NC; Medicare Program
Submitted electronically to: <http://www.regulations.gov/>

RE: Request For Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to request for information on Medicare Advantage (MA) Data Collection and Transparency. NAACOS is a member-led and member-owned nonprofit of more than 450 accountable care organizations (ACOs) and other value-based provider entities in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS represents over 9 million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). Additionally, our members engage in value-based care (VBC) arrangements across other payers, including Medicaid and Medicare Advantage. We appreciate the opportunity to highlight the urgent need for more complete and accurate MA data collection as MA enrollment has reached half of all enrolled in [Medicare](#). Our comments below reflect our shared goals of driving accountable care in both traditional Medicare and MA.

Specifically, our comments reflect the need for (1) providers and stakeholders to have access to comprehensive MA data sets to promote program and payment transparency and (2) providers to have data and aligned approaches to support provider-led transformation in MA through VBC arrangements. As noted above, our members regularly participate in risk arrangements across multiple payers. Encouraging value-based arrangements in MA drives provider payment that is based on outcomes and quality, rather than volume. MA should have explicit incentives that will encourage provider-led transformation. Additionally, as the VBC portfolio increases and expands across payers, there is greater need for comprehensive and more streamlined data collection and transparency to ease provider burden and gain insights necessary for creating and driving value. CMS can support this effort with increased data collection from MA plans and working with payers to improve and standardize data that is shared with providers.

DATA COLLECTION AND TRANSPARENCY

Medicare Advantage Encounter Data

MA encounter data reported to CMS is one of the most important data sets for insights into MA programs. However, MA encounter data is limited compared to the data available for traditional Medicare. This prohibits meaningful comparisons between traditional Medicare and MA and further disadvantages providers in payment and risk arrangement negotiations. Particularly for those providers who have committed to managing risk through advanced primary care and population health management, more transparent data can help design and implement innovative approaches for payment models. **CMS should replicate MA data sets like traditional Medicare, including releasing MA encounter data in the same timeline and format as traditional Medicare data.** Creating comparable files for MA would also improve accountability and transparency. Specific elements CMS should consider adding include:

- **National Provider Identifier (NPI)-level Data:** Encounter data needs to be at the NPI level. Having populated provider identification data (e.g., NPIs for provider-level services, Tax ID Numbers, CMS Certification Numbers (CCNs) for facility-level providers) enables more accurate analyses of which providers rendered what kinds of services, utilization patterns, provider coverage, network optimization, etc. These data elements would also allow stakeholders and VBC entities to produce more accurate calculations on performance for distribution purposes.
- **In/Out-of-Network Data:** CMS should require plans to report accurate and timely MA network data, indicating whether care was rendered in or out-of-network. This insight helps to elucidate any potential challenges with network adequacy and provides consumers more transparency about the possibility of out-of-network costs.
- **CMS Physician Supplier & Beneficiary Summary Public Use File (PUF):** CMS could leverage any existing private sector data by including MA data in the PUF with separate distinctions for traditional Medicare and MA data elements.
- **Hierarchical Condition Category (HCC) Risk Score Data:** CMS should make available beneficiary HCC risk scores for all Medicare beneficiaries in a format that can be linked to the MA encounter data. Specifically, each beneficiary's prospective risk score should be included in the Master Beneficiary Summary File (MBSF) that is part of the Research Identifiable Files (RIF) that are available to use with valid data use agreements with CMS. This will give users better information about the types of beneficiaries selecting MA plans and specific plan offerings. It will provide important context for comparing utilization rates across plans and allow greater insights into network adequacy for certain types of beneficiaries. It is important to make these HCC risk scores available not just for current and future years, but also historical years to support accurate analyses of MA utilization trends and track data on where patients have changed plans. Having this prior history would allow for more seamless transfer of real-time interventions and prevent delays in closing clinical gaps and care coordination.
- **Part D Drug Data:** CMS should integrate pharmacy data including claims, real-time pharmacy benefit data, and dispensing information. Transparency in this area will help to standardize benefits that are currently varied across plans, making this increasing cost element much more difficult to manage. As part of price transparency in Part D spend, CMS should also include rebate details that the current data sets do not include because this data helps providers understand actual cost information when rebates are applied.

- **End-of-Life Care:** CMS should require reporting of hospice data elements as some MA plans choose to carve-in hospice benefits. Data elements should include the type, volume, timing, and cost. Hospice services are an essential aspect of delivering care to Medicare beneficiaries. Including this data will help evaluate quality of hospice services and whether they are meeting the needs of patients at the end of life.

Additionally, **CMS should improve the accuracy and timeliness of the encounter data.** The accuracy of data is a concern as plans do not have consistency in reporting requirements, which can lead to variations in data set completeness. While data completeness is improving over time, it has not caught up to the increasing demand for real-time analytics. For example, skilled nursing and home health information are incomplete in the overall types of encounter data, leaving out important components of care and compounding inaccuracies in data analysis. CMS should aim to release MA encounter files simultaneously with traditional Medicare claims to allow timely analyses to be performed across programs. Currently, there is a 2-year lag that prevents timeliness of data analytics to conduct any predictive analytics and inform program performance.

Finally, **CMS should provide information on costs in the encounter data.** Cost data is essential for analyzing the relative performance of MA plans compared with traditional Medicare. As a first step, CMS should add standardized prices based on traditional Medicare fee schedules. Eventually, it would be beneficial to include actual rates paid by MA plans. CMS should leverage the existing requirements outlined in the Transparency in Coverage final rule which requires connecting costs for items and services to encounter data. Meanwhile, the addition of standardized prices would go a long way to help providers and other stakeholders accurately analyze MA plan spending, as well as leveraging MA data for predictive modeling. CMS could leverage the plan price transparency requirements to support more comprehensive and standardized information about costs in MA.

Expanded MA Data Collection

Beyond improvements to the encounter data, CMS has an opportunity to provide additional insights into MA through collection of aggregate data related to MA plan practices. Over time some elements could be captured within encounter data.

Value-Based Care Arrangements

Despite the expansion of provider-led transformation within MA, little is known about the most promising aspects of these arrangements. The Institute for Accountable Care¹ found that 75 percent of organizations participating in traditional Medicare ACO programs also had VBC payment arrangements with MA or commercial plans. Similarly, the Health Care Payment Learning & Action Network (LAN) [reports](#) that as of 2022, 24.5 percent of all payment for medical care is now in two-sided financial risk arrangements. This information is summarized at the national level with no information about the use of VBC arrangements by geography, type of plans, or types of providers. While NAACOS has partnered with AHIP and the American Medical Association (AMA) to identify best practices of [value arrangements across payers](#), CMS can support adoption by collecting more information about VBC arrangements in MA. Specifically, CMS should collect and report:

¹ Robert Mechanic. All-Payer Value-Based Contracting in Medicare Accountable Care Organizations. American Journal of Managed Care. Am J Manag Care. 2023;29(11):601-604.

- **Information on VBC contracts that each MA plan offers and implements.** While voluntary reporting to the LAN has provided some insight into the adoption of VBC, CMS could help standardize this information and fill gaps. **CMS should collect and report on the percentage of patients, payments, or providers in value-based arrangements** and make these data sets publicly available. This data would also provide valuable feedback to CMS on how MA plans are engaging in VBC and general tolerance of provider groups taking on more risk-based contracts. In the future, CMS should consider adopting these metrics into Star Ratings, to help promote greater adoption of VBC arrangements. Over time, CMS could integrate some information on VBC arrangements within the encounter data. For example, CMS could require plans to report sub-capitated arrangements in the encounter data. After an initial period of collecting standardized data on payment arrangements in MA, we believe that CMS should construct a measure of VBC adoption in MA.
- **Information on how quality reporting impacts provider payment.** MA plans trying to improve their Star Ratings often design financial incentives for providers tied to quality measures in Star Ratings. The proliferation of quality measure sets across various payers, contracts, and models continues to be a challenge, as each provider contract varies in the measures and data collection timelines. We appreciate the efforts of the Core Quality Measures Collaborative (CQMC) in designing the ideal measure sets for different purposes; however, adoption of the core sets is slower than what we once anticipated. **Collection of quality measures and requirements MA plans place on providers would help provide more transparency that can further inform CMS of any future measure development needs and accelerate alignment across the board.**

Prior Authorization

A major source of provider burden can be attributed to highly variable utilization management practices across payers. Transparency in this process and creating standards for reporting will contribute to better care coordination, scheduling care, managing expectations, and understanding network access patterns.

CMS should require MA plans to report all services (at the procedure code level) that require prior authorization along with indicating rates of denial. This would highlight any patterns regarding claims denial for certain services or enrollees and inform the effectiveness of prior authorization as a tool for utilization management. Specifically, **CMS should collect the following data points:**

- Total number of denials, successful overturn of denials to approvals, and any payment information,
- Total number of denials that stayed denied and received no payments for rendered services, and
- Timing of decision process from denials and approvals, appeals and overturn, and decisions leading to payment.

This data should be made publicly available to promote accountability regarding access to care. CMS could also use this information to create measures that can be incorporated into the Star Ratings, rewarding plans on metrics related to prior authorization (e.g., denials, appeals processes that lead to service delays, overturn rates for payment denials). With standardized data collection, **CMS could then work with MA plans to adopt more standardized prior authorization requirements and processes.**

Supplemental Benefits

CMS should require MA plans to report utilization of supplemental benefits. MA plans may offer supplemental benefits to beneficiaries, but currently, there is no information on the use by or value to beneficiaries. With supplemental benefits being such a critical component of the MA bid approach, it's

crucial to understand if these benefits are bringing value to beneficiaries and the overall Medicare program.

SUPPORTING PROVIDERS IN MA

Many providers do not have sufficient information about their MA-enrolled patients. For those that have taken the leap of managing risk in MA this is particularly challenging, as predictability and transparency is key to transforming care delivery and implementing meaningful and actionable interventions. CMS should use its position and authority to help drive alignment and standardization across payers. NAACOS, in partnership with AHIP and AMA, developed best practices for [sharing data](#) for the purposes of value-based care arrangements. NAACOS believes CMS should work with payers and providers to accelerate adoption of these best practices. Below we outline initial areas where CMS should focus.

Value-Based Care Arrangements

A key challenge for many providers bearing financial risk in MA contracts is the level of effort it requires for providers to ingest multiple data formats from various health plan portals. The FTE required to develop data formatting and analytic capabilities is often prohibitive for many provider groups and VBC entities. Conversely, traditional Medicare APMs provide regular standardized data feeds that can be easily used by providers with limited capabilities. **CMS should work with MA plans to create standardized data sets that MA plans share with providers in value-based arrangements.** Information should include, but not be limited to, full claims information for beneficiaries in the risk arrangement, summaries of patient care, histories of hospitalizations, utilization data, clinical and demographic information at both individual and population levels, and prescription drug information.

Additionally, NAACOS encourages CMS to work with plans to **encourage transparency in risk scoring.** As we note above, risk scores should be incorporated into encounter data; however, it is also important that risk scores and known chronic conditions are shared with providers in VBC arrangements. VBC models rely on Risk Adjustment Factor (RAF) scores to establish budgets against which savings can be achieved – a system that imposes significant administrative burden on providers. RAF scoring accuracy is of utmost importance to providers and entities in VBC arrangements that have taken on increasingly higher risk. Building confidence in RAF accuracy encourages predictability and transparency.

We believe working to standardize data elements and formats as well as align across payers will encourage adoption of VBC contracts in MA plans as it will improve provider experience and inform VBC infrastructure and design.

Quality Measures

We encourage **CMS to align quality measures and methodologies between ACOs and MA plans**, where appropriate. This will alleviate the administrative burden on providers in VBC arrangements across payers. Specifically, **CMS should collaborate with payers and providers in VBC arrangements to determine the best ways to structure measurement and data gathering** so that the quality data collected could be used across multiple efforts and is timelier to inform real-time interventions.

Supplemental Benefits

Beyond aggregate data on supplemental benefits, providers need more information on the availability of supplemental benefits for their patients. Clarity around how available services are being communicated to members will guide providers to understand how to serve their patients better and allow enrollees to be more informed when making decisions. This is particularly important in VBC arrangements when providers are at risk for cost and outcomes, supplemental benefit information is needed to manage costs and add value to the patient's overall care journey.

CMS should work with MA plans to share more information to providers about supplemental benefits that are available to the beneficiary in real time, at the point of care, and in a standardized manner.

The time spent for providers to manage to the various programs rather than managing patient care for beneficiaries across the board is compounding. For example, if only certain patients are eligible for telehealth visits, then Medicare patients' eligibility must be checked when scheduling visits and determining options for visits, which can delay access, burden systems, add costs, and hinder overall care management. Providers will gain much more understanding about which benefits their members are able to access and where providers can help connect patients to these benefits directly, which supports the whole-person care model.

Increased transparency on the availability of supplemental benefits will also help advance VBC arrangements in MA. Currently, providers and entities in VBC arrangements invest in their own infrastructure in services that may be supplemental benefits, resulting in duplicative services that add costs and can cause confusion for beneficiaries. For example, complex care management may be a supplemental benefit offered by the MA plan and may be a service offered by the VBC entity as a method for managing cost and outcomes. Sharing more information with providers will help prompt discussions between payers and providers about the provision of certain benefits and how they are included in a VBC arrangement as well as minimize beneficiary confusion.

Finally, as part of transparency on prior authorization and supplemental benefits, **CMS should encourage MA plans to share their utilization management policies and procedures for supplemental benefits** so that there can be clarity around which supplemental benefit services or items require prior authorization and the overall use and availability (i.e., approvals/denials stratified by beneficiary characteristics).

HEALTH EQUITY

Meaningfully addressing health equity requires tailored approaches based on the unique needs of the patient and their overall community. Addressing patients' social needs is highly integrated with care delivery. Accordingly, the most effective approaches will result from strong coordination among payers and providers. Providers in VBC arrangements are uniquely suited to address patients' social needs as providers in VBC leverage health IT and care management infrastructure to provide coordinated, whole-person care. Reliable data is critical to achieving these goals, as health disparities cannot be addressed if they are not adequately measured, tracked, and reported. NAACOS is encouraged that the CMS Framework for Health Equity calls for, as its first priority, expanding the collection, reporting, and analysis of standardized data.

As CMS pursues health equity initiatives across programs, it is critical that the agency define clear standards for collecting sociodemographic and social drivers of health (SDOH)-related social needs data. These SDOH data sets will be essential in developing targeted interventions that close health equity gaps. Within MA, CMS should strongly consider how health equity information is collected and shared across the continuum of care. **CMS should review existing data sets collected on Medicare beneficiaries (e.g., race, ethnicity, and low-income status), streamlining both the data collection and data sharing to reduce administrative burden.** Currently, MA plans may collect data on beneficiaries' sociodemographic characteristics and health-related social needs, but too often these data are not shared with the providers caring for patients.

Similarly, CMS has required several types of providers to collect information on health-related social needs. We are concerned that we will quickly reach a point where the information is collected numerous times from many entities.

CMS' review and evaluation of what is already collected is necessary to ensure that the data is collected only when necessary but shared among plans, providers, and community partners as appropriate. Additionally, CMS must standardize SDOH information and collaborate with other payers to ensure comparability across programs and payment mechanisms. Standardization is essential to avoiding an untenable situation where payers and providers have too much information that is neither aligned nor structured and may provide conflicting information. **CMS can support expanding data integration processes to develop whole person profiles that integrate community and population level data.** Improving data sharing and transparency for health equity will also build trust and patient autonomy over data. When effectively shared this will ensure that patients and caregivers navigating clinical, social, and community services and networks are informed about standards of cultural competencies and confidentiality. Appropriate data sharing will also help ensure that beneficiaries are not inundated with the same, or very similar questions by their health plans and various health care providers; rather, that the data they do provide is appropriately shared across their providers.

Beginning in CY 2025, CMS will require MA plans to annually conduct health equity analysis of prior authorization policies and procedures and to make the results of that analysis publicly available. We are encouraged by this approach. As noted above we believe plans should be required to report more information on prior authorization. The reported information should be stratified by additional beneficiary characteristics that provide insights into health equity such as, race, ethnicity, gender, age, Medicaid eligibility, etc.

We are also pleased that CMS has implemented the Health Equity Index (HEI) in the Star Ratings for 2027 and beyond. We ask that CMS work with MA plans to provide transparent information to providers who are working to close any gaps in care. As we note above, more transparency with regard to the downstream quality approaches will help create more seamless collection and sharing of data used for quality. As CMS requires plans to stratify measures based on beneficiary characteristics, that information must also be communicated with providers.

CONCLUSION

Thank you for the opportunity to provide feedback on MA Data Collection and Transparency. NAACOS and its members are committed to providing the highest quality care for patients while advancing

May 29, 2024

Page 8 of 8

population health goals for the communities they serve. We look forward to our continued engagement on our shared goals across MA programmatic improvements. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@NAACOS.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Clif Gaus', with a long horizontal flourish extending to the right.

Clif Gaus, Sc.D.
President and CEO
NAACOS