Center on Health Policy at BROOKINGS

May 29, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services

Secretary Xavier Becerra
Department of Health and Human Services

Re: Medicare Program; Request for Information on Medicare Advantage Data [CMS-4207-NC]

Dear Administrator Brooks-LaSure and Secretary Becerra:

Thank you for the opportunity to offer comments on ways that the Centers for Medicare and Medicaid Services (CMS) could improve data related to Medicare Advantage (MA).[1,2] MA now accounts for more than half of Medicare enrollment, so robust data on MA plans' interactions with beneficiaries, providers, CMS, and other entities is essential to understand how well the Medicare program is operating and how to make it work better. In this letter, we make several specific recommendations about how CMS can improve the data currently available on the MA program:

- Improve MA encounter data: Our most important recommendation is that CMS should take steps to improve MA encounter data. These data are the only source of comprehensive, granular information on the health care received by MA enrollees and, as such, are the linchpin of efforts to understand MA. To make them more useful, CMS should:
    - allow researchers to access data on provider payments that CMS already collects as part of encounter records and, if necessary, improve these data to ensure that they reliably measure both enrollee cost-sharing and plan payments;
    - allow researchers to access data on claim denials that CMS already collects as part of encounter records and, if necessary, improve these data to ensure that they can be used to reliably identify encounters that result in a denied claim;

[1] The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than ourselves.

[2] The recommendations in this letter are drawn in part from prior work. See Loren Adler, Matthew Fiedler, and Benedic Ippolito, "Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce," May 12, 2023, https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/; Loren Adler and Matthew Fiedler, "Comments on the Request for Information on Consolidation in Health Care Markets," May 8, 2024, https://www.brookings.edu/articles/comments-on-the-request-for-information-on-consolidation-in-health-care-markets/.

- proceed with plans to collect detailed data on utilization of supplemental benefits and make these data available to researchers once they become available; and
- consider collecting granular information on prior authorization requests.

CMS should also take steps improve data quality since there is evidence that the encounter data suffer from some data quality problems. More generally, CMS should recognize that while the encounter data began as a tool for administering risk adjustment, they now serve many other purposes, and its approach to these data should evolve accordingly.

- Collect data on MA plans' non-fee-for-service provider payments: MA plans often pay providers using non-fee-for-service methods, but, unlike fee-for-service payments, many such payments are not captured on encounter records. This gap impedes efforts to understand the overall level of MA provider payments, plans' utilization management and diagnosis coding efforts, and compliance with medical loss ratio (MLR) rules. CMS should collect plan- and provider-level data on the size and characteristics of these payments.
- Release ownership data for all provider types and improve ownership data quality: Data on provider ownership has many uses, but it can be particularly important to understanding MA since owning providers may help plans increase diagnosis coding intensity or circumvent MLR regulations, among other effects. CMS generally collects data on provider ownership as part of the Medicare enrollment process but has only released these data for certain provider types, notably excluding physician practices. CMS should release these data for all provider types. Additionally, since analyses of released data have identified data quality problems, CMS should take steps to improve data quality.
- Make available certain other data that CMS already holds: CMS can also improve understanding of MA by releasing (or more promptly releasing) certain other data that it already holds. Specifically, CMS should: (1) release data on plan bids promptly, rather than waiting five years to do so; and (2) make final MA risk score data available to researchers.

An overarching theme of our recommendations is that CMS should build data systems that capture comprehensive, granular data on MA plans' operations (where this can be accomplished without imposing undue administrative burden on plans or CMS). Relative to aggregated or summarized data, granular data are far more versatile and, as such, can continue to provide insight even as circumstances evolve and the questions before policymakers change. They may also often be less costly for MA plans to report since they may require less pre-submission processing. Thus, while it will often be appropriate for CMS to create and release statistical summaries based on these data, we believe that CMS' data collection efforts should focus on these types of granular data.

The remainder of this letter discusses these points in greater detail.

Improve MA Encounter Data

We begin by discussing how CMS can improve the encounter data it receives from MA plans and makes available to researchers. These data are the only source of comprehensive, granular information on MA enrollees' receipt of health care services, which makes them the best available

tool for answering many questions about care delivery in MA, including the cost and quality of the care that enrollees receive. As such, these data are a linchpin of efforts to understand MA's performance. To fully realize the potential of these data, CMS should make several changes:

- Allow researchers to access existing data on provider payments and, if necessary, improve the data to ensure that they reliably measure both plan payments and enrollee cost-sharing: CMS currently collects some data on provider payments as part of each encounter record but does not include these data elements on the data extracts provided to researchers. It is also unclear exactly what elements CMS currently receives from MA plans (e.g., only plan payments or both cost-sharing and plan paid amounts) or how reliable these data are.[3]

  These limitations make it impossible to use the encounter data to study cost-sharing burdens borne by MA enrollees or how MA plans pay providers, both topics of first-order importance for understanding the MA program's performance. To facilitate research on these topics, CMS should include payment data elements on the research versions of the encounter data files, ensure that those data elements measure both enrollee cost-sharing and plan payments, and ensure that the payment amounts collected are reliable.

  CMS' regulations currently bar release of these data elements on the grounds that they are "commercially sensitive."[4] In establishing this restriction, CMS specifically cites concerns about disclosing payment rates negotiated between MA plans and providers.[5] But these concerns do not justify withholding these data. While it is sometimes argued that greater transparency about what health plans pay providers could raise negotiated prices, the balance of the evidence suggests that transparency reduces prices, on net, albeit only slightly.[6] Indeed, motivated by this hope, CMS has generally been moving toward increasing health care price transparency in recent years through the hospital and insurer price transparency rules. (Because of the hospital price transparency rule, some prices that MA plans negotiate with hospitals are also already publicly available.)

  MA plans may also express concerns that disclosing these data will weaken their competitive position vis-à-vis other MA plans (e.g., by making it easier for competitors to

[3] For discussion of the ambiguities regarding what CMS currently collects, see Jeannie Fuglesten Biniek, Meredith Freed, and Tricia Neuman, "Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency," *KFF* (blog), April 10, 2024, https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/.

[4] See 42 CFR 422.310(f)(2)(iv).

[5] Centers for Medicare and Medicaid Services (CMS), "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Hospitals and Certain Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program," August 22, 2014, https://www.federalregister.gov/documents/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

[6] Congressional Budget Office, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," September 29, 2022, https://www.cbo.gov/publication/58222.

enter). However, this strengthens the rationale for disclosure since weakening the market power of incumbent plans would likely benefit beneficiaries and reduce federal costs.

- Allow researchers to access existing data on claim denials and, if needed, collect additional data: Observing which encounters result in denied claims is important for understanding how MA plans manage utilization and how claim denials affect MA enrollees and health care providers. CMS currently collects claims adjustment reason codes on encounter records that can be helpful in identifying denied claims, but these codes are not included on the encounter data extracts provided to researchers. Making these codes available to researchers, particularly in combination with the information on payment amounts described above, would allow researchers to study these questions.

  Some observers have expressed concern that the data elements currently collected by CMS are not sufficient to reliably identify claim denials.[7] Without access to the data, it is difficult to assess whether the existing data are adequate for identifying claim denials for research purposes. If these data elements do turn out to be inadequate, however, CMS should collect any additional data elements necessary to reliably identify denied claims.

- Augment the encounter data with granular data on prior authorization requests: While encounters that result in denied claims are generally supposed to be included in the data that MA plans submit, CMS does not currently receive granular information on how MA plans use prior authorization. CMS could augment the encounter data by requiring MA plans to submit data on each prior authorization request they receive, including when it was submitted, what provider submitted it, what services were involved, and the request's outcome. MA plans must already track this data to administer their prior authorization processes, so submitting these data should impose a manageable reporting burden.

- Proceed with efforts to collect encounter (or similar) data on supplemental benefits and promptly share these data with researchers: Virtually all MA plans offer coverage for services not covered by traditional Medicare, and these benefits are likely a major tool that MA plans use to attract enrollees.[8] However, there is very little information available on how MA enrollees use these benefits, which makes it difficult to analyze the cost of delivering these benefits, their value to beneficiaries, and many related questions.

  CMS recently announced that it would expand encounter data reporting to capture information on the utilization of supplemental benefits similar to the information that CMS currently captures on utilization of other services.[9] CMS should proceed with these plans

[7] Office of the Inspector General, United States Department of Health and Human Services, "The Inability to Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight," February 2023, https://www.oig.hhs.gov/oei/reports/OEI-03-21-00380.pdf.

[8] Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2024, https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/.

[9] Jennifer R Shapiro, "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records," February 21, 2024, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Submission_of_Supplemental_Benefits_Data_on_Medicare_Advantage_Encounter_Data_Records_508_G.pdf.

and, once data on utilization of supplemental benefits are obtained from plans, CMS should make them available to researchers alongside the existing encounter data.

- Take steps to improve data quality: Encounter data are useful only to the extent that they are accurate and complete. Some research suggests that they are still missing meaningful numbers of encounters, with some plans having more significant data completeness problems.[10] Our experience with the data also suggests that some relevant fields (e.g., national provider identifiers) are not always populated. To address these and other data quality problems, CMS should dedicate some internal analytic resources to identifying data quality problems (including implementing appropriate automated data completeness and quality checks), work with plans to resolve problems as they are identified, and impose appropriate penalties on plans when problems are not remedied.[11]

- Recognize that MA encounter data serve important functions beyond risk adjustment: CMS has sometimes stated that its decisions related to the encounter data "focus" on what is needed for risk adjustment purposes.[12] This approach is understandable since operating risk adjustment has been the main historical use of the encounter data. Going forward, however, CMS' decisions about what data elements to collect, what data to make available to researchers, and how to ensure data quality should recognize the broad role that the encounter data play (and could play) in overseeing MA.

Collect Data on MA Plans' Non-Fee-For-Service Provider Payments

In 2022, more than half of MA plans' health care spending was encompassed in some form of non-fee-for-service payment arrangement, such as a capitation or shared savings arrangement.[13] These arrangements often result in MA plans making payments to providers that are not associated with specific encounters and, thus, are not captured in the payment amounts reported on encounter records. In some cases (e.g., many capitation arrangements), the missing payments likely constitute the majority of a plan's payments to the relevant providers, and there are likely many other instances where the missing payments constitute a meaningful fraction of a plan's payments. Understanding these payments is important for many reasons, including measuring the overall level of provider payments in MA, understanding how MA plans manage utilization and encourage diagnosis coding, and monitoring compliance with MLR rules.

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[10] Jeah Jung et al., "Implementation of Resource Use Measures in Medicare Advantage," *Health Services Research* 57, no. 4 (August 2022): 957–62, https://doi.org/10.1111/1475-6773.13970; Philip G. Cotterill, "An Assessment of Completeness and Medical Coding of Medicare Advantage Hospitalizations in Two National Data Sets," *Health Services Research* 58, no. 6 (2023): 1303–13, https://doi.org/10.1111/1475-6773.14211.

[11] The Medicare Payment Advisory Commission has previously made recommendations in this vein. See Medicare Payment Advisory Commission (MedPAC), "Medicare and the Health Care Delivery System" (Medicare Payment Advisory Commission, June 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf.

[12] See, for example, CMS's response here: Office of the Inspector General, United States Department of Health and Human Services, "The Inability to Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight."

[13] Health Care Payment Learning and Action Network, "2023 APM Measurement Methodology and Results Report," October 30, 2023, http://hcp-lan.org/workproducts/apm-methodology-2023.pdf.

To provide insight into these payments, CMS should require MA plans to submit information on their non-fee-for-service payments. Concretely, we envision that insurers would, on an annual basis, report the total payment made to each provider under each of its non-fee-for-service payment arrangements for each of its MA plans (excluding amounts that are already captured in the payment amounts reported on encounter records). Insurers would also report basic information on the design of each non-fee-for-service payment arrangement (e.g., whether the arrangement is a capitation arrangement, a shared savings arrangement, an episode arrangement, etc.).

We recognize that many non-fee-for-service payment arrangements may span multiple MA plans (or even encompass both MA and non-MA plans) and involve payments that are not attributable to specific enrollees. In these cases, insurers could be directed to allocate payments across plans in proportion to enrollment (or using some other reasonable method). MA plans presumably already have and use similar allocation rules for MLR reporting.

Release Ownership Data for All Provider Types and Improve Ownership Data Quality

Knowing who owns health care providers is valuable for many purposes, including estimating market concentration and the share of providers owned by specific types of entities, as well as estimating the consequences of changes in ownership patterns. But having good data on provider ownership is particularly important to understanding MA since owning providers may help plans increase diagnosis coding intensity or circumvent MLR regulations.[14] Owning providers may also help plans more efficiently manage care or allow them to disadvantage rivals.

Unfortunately, the available data on provider ownership has serious limitations.[15] While CMS generally collects data on provider ownership as part of the Medicare enrollment process, it has only released those data for certain provider types, notably excluding physician practices. Additionally, researchers examining the ownership data that CMS does release have identified important data quality problems.[16] The limitations of the publicly available data force researchers to rely other—often costly and time-intensive—approaches to trace provider ownership.

To remedy these problems, CMS should begin releasing the data it collects on provider ownership for all provider types, including physician practices. CMS should also take steps to improve the quality of the ownership data it collects for all provider types, including by conducting data quality reviews and strengthening penalties for inaccurate reporting.

If CMS cannot collect comprehensive high-quality data on provider ownership, CMS could consider requiring MA plans to submit an indicator on each encounter record for whether the provider involved is owned by the plan or part of the same broader corporate entity. While less

[14] Michael Geruso and Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," *Journal of Political Economy* 128, no. 3 (March 2020): 984–1026, https://doi.org/10.1086/704756; Richard G. Frank and Conrad Milhaupt, "Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation" (Brookings Institution, March 24, 2023), https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/.

[15] For additional discussion of the limitations of the existing data, see Adler and Fiedler, "Comments on the Request for Information on Consolidation in Health Care Markets."

[16] Amanda C. Chen et al., "New CMS Nursing Home Ownership Data: Major Gaps And Discrepancies," *Health Affairs* 43, no. 3 (March 2024): 318–26, https://doi.org/10.1377/hlthaff.2023.01110.

useful than comprehensive ownership data, these could still allow researchers and CMS to better understand how MA plan ownership of providers affects some outcomes of interest.

Make Available Certain Data CMS Already Holds

CMS could also improve understanding of the MA program by releasing (or more promptly releasing) data that it already holds. We highlight two specific opportunities:

- Promptly release MA plan bid pricing data: Data on MA plan bids are useful for assessing performance of the MA payment system and the nature of competition among MA plans. Unfortunately, CMS only releases bid data with a five-year lag. Considering how quickly market conditions change, this lag makes these data much less useful than they could be. CMS should move toward releasing these data shortly after bidding concludes.

  In establishing the current five-year lag, CMS justified the lag as necessary to avoid competitive harm to MA plans.[17] We do not view this as a compelling reason to delay release of these data. In our view, the most plausible way that faster release of these data could create competitive harm is by making it easier for insurers to enter new markets. While this would indeed harm incumbents, it would likely *benefit* beneficiaries and the federal government by making these markets more competitive. CMS' decisions should be guided by the needs of beneficiaries and taxpayers, not incumbent plans.

- Make final MA risk scores available to researchers: CMS has generally not allowed researchers to access the final risk scores used to pay MA plans. While these data were released for 2014, they have not been released for any prior or subsequent year. These data are useful for many purposes, most notably studying MA plans' diagnosis coding behavior. CMS should make these data available for years other than 2014.

  While these data will become less important going forward because risk scores are now generally calculated from the encounter data (rather than being partially or fully calculated from information submitted through the Risk Adjustment Processing System), access to these data for earlier years would facilitate useful research on this earlier period. Even going forward, these data would make some research projects easier to conduct (and potentially more accurate) by allowing researchers to rely on CMS' calculation of risk scores rather than generating risk scores themselves from the encounter data.

Thank you for the opportunity to comment on these issues. We hope that this information is helpful to you. If we can provide any additional information, we would be happy to do so.

[17] Centers for Medicare and Medicaid Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements" (Federal Register, November 15, 2016), https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.

Sincerely,

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