March 24, 2024

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Comments on the Request for Information (RFI) seeking input on Medicare Advantage Data (CMS-4207-NC)

Dear Administrator Brooks-LaSure:

The Brown University [Center for Advancing Health Policy through Research](#) (CAHPR) is a nonpartisan research and policy center that aims to make fundamental contributions toward understanding and developing policies that will lower spending growth, improve patient outcomes, and drive structural change in healthcare delivery in the US. Thank you for the opportunity to respond to your request for information (RFI) on opportunities to enhance and expand Medicare Advantage (MA) data capabilities and increase public transparency.

CAHPR's research focuses primarily on the impact of insurance design and its interaction with market structures. Our Center's investigators have been conducting extensive research on the MA program, including the effects of MA on beneficiary access, quality, and experience, as well as the value of the MA program.

Below are CAHPR's responses to the RFI on Medicare Advantage Data. The responses represent the views of faculty members affiliated with CAHPR at the Brown School of Public Health. We believe that the opportunity to enhance and expand MA data capabilities and transparency will help future research gain a better understanding and insights into the MA program at large.

Improving MA Encounter Data

Accurate and Complete MA Encounter Data: In 2012, CMS began collecting encounter data from Medicare Advantage plans. CMS required plans to submit encounter data detailing the health care services provided to an enrollee, the enrollee's health conditions, and payment information. Often, this encounter data is incomplete, making it difficult to track plan performance. According to an HHS OIG report, MA plans are not required to identify the services in the encounter data for which payment was denied.[1] Without this information, it is challenging for researchers and oversight entities to detect

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[1] U.S. Department of Health and Human Services Office of Inspector General. [The Inability To Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight](#) [Internet]. 2023 Feb.

inappropriate billing patterns and investigate fraud and abuse. To address this issue, CMS should consider requiring MA plans to submit a denied-claim indicator in encounter data to ensure that the investigative entity can accurately investigate the appropriateness of denied claims, track denial trends by series type, and assess whether claims from certain demographic groups are rejected more frequently than others.

Improve the Timeliness of Data: There is a three-year lag in the release of encounter data to researchers, which is a longer lag time than currently exists for Traditional Medicare data. This lag slows researchers' ability to evaluate the Medicare Advantage program, limiting the timeliness of our policy recommendations. CMS should consider releasing the encounter data to researchers at an earlier time. This may involve the release of preliminary claims files that are modified when finalized in subsequent data releases.

Improving the Accuracy of the Data: As reported by MedPAC[2] and other researchers,[3,4] there is currently significant concern about the quality of the Medicare Advantage Encounter Data. While the data quality appears to have improved for inpatient, outpatient, and carrier files over time, there is still plan-level variation in completeness, and the home health and nursing home encounter files appear to be very inaccurate. CMS should consider increasing the enforcement of its data reporting requirements for plans and conduct more audits to ensure that compliance with regulations on data reporting is occurring.

Reporting of the Organization and Physician Provider National Provider Identifiers (NPI): The current MA encounter data does not have a consistently populated provider identification field. This is different from Traditional Medicare data, which has high levels of completeness on the provider of a given service. CMS should consider including individual-level national provider identifiers (NPIs) for all individual provider services, and organization NPIs and CCN numbers for all facility providers to bring the encounter data quality more in line with the FFS claims.

Reporting of Spending and Cost Information: While the Transparency in Coverage (TiC) final rule requires the disclosure of all negotiated allowed amounts between plans and providers, it does not apply to MA.[5] There are currently no fields in the MA encounter data on the price that a plan paid a provider for a given service . TiC should be expanded to MA prices and disclosed publicly and in claims. CMS should consider requiring that plans report plan-allowable amounts for each service being provided, as well as out-of-pocket spending for the beneficiary.

Reporting of Denied Claims: MA encounter data does not currently include any records of denied claims This is different from the Traditional Medicare claims data, which includes denied claims and a denied

[2] MedPAC. Ensuring the accuracy and completeness of Medicare Advantage encounter data. In: Report to the Congress: Medicare and the Health Care Delivery System [Internet]. 2019.

[3] Jung J, Carlin C, Feldman R. Measuring resource use in Medicare Advantage using Encounter data. Health Services Research. 2021 Oct 6;57(1):172–81.

[4] Creighton S, Duddy-Tenbrunsel R, Michel J. The Promise And Pitfalls Of Medicare Advantage Encounter Data. Health Affairs Forefront [Internet]. 2019 Feb.

[5] U.S. Centers for Medicare & Medicaid Services (CMS). Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F) | CMS [Internet]. www.cms.gov. U.S. Centers for Medicare & Medicaid Services.; 2020.

claims indicator. CMS should consider requiring MA plans to report all denied claims to the encounter record and denote these claims using an indicator variable. CMS should also consider requiring the reporting of inpatient hospital claims that were downgraded to outpatient status for payment.

Reporting of Prior Authorization: It is well known that MA plans to engage in utilization control through prior authorization requirements. There is currently no required reporting of the extent to which these prior authorizations are used, which limits the ability of researchers to understand if care is being properly provided by plans. We suggest that CMS consider requiring plans to report a variable in the encounter data that indicates if there was a prior authorization requirement for a given service. We also suggest that CMS include an additional data variable that indicates when prior authorization was first requested and when it was granted or denied for a service to allow researchers to understand what delays in care may look like. We also suggest it report all preauthorization requests that were denied.

Reporting of In-Network or Out-of-Network Services: It is well known that MA plans to use network restrictions to control utilization and spending in the program. To better understand what care is delivered in and out-of-network, we suggest that CMS consider requiring plans to report in the encounter data an indicator of whether the care provided was in-network or out-of-network.

Reporting of Sub-Capitated Arrangements: Many MA plans don't pay providers on a fee-for-service basis but rather contract with providers through sub-capitated arrangements. These sub-capitated arrangements are not currently reported in the encounter data, limiting our ability to understand all of the care that beneficiaries might be receiving, as well as the flow of plan payments. We suggest that CMS consider requiring plans to report all services provided under these sub-capitated arrangements in the encounter data, with them identified as part of such an arrangement. A new file structure – outside of standard medical claims – would need to be developed to report these arrangements.

Other Opportunities to Improve Data Needs and Collection

Outside of the MA encounter data, there are other additional sources of data that CMS could collect from MA plans.

Data on Brokers: It is well known that many beneficiaries are guided to plans by brokers, but this information is not publicly available. We suggest that CMS consider reporting several files related to brokers, including an indicator in the Medicare Beneficiary Summary File for if a broker led to a beneficiary's enrollment in a plan along with a broker ID, and a public database of broker IDs linked to payments that they have received from different plans.

Collection of Better-Quality Race/Ethnicity Information: It has been well established that the current race/ethnicity variables collected by CMS are very inaccurate, even after using the RTI race/ethnicity

algorithm.[6, 7] We suggest that CMS collect self-report beneficiary race/ethnicity at the time of enrollment, which will drastically improve the quality of reporting. We also suggest that CMS consider the use of new race/ethnicity variables that are more similar to what is collected by the census, which allows for the selection of multiple races and ethnicities and separates race and ethnicity as separate variables.

Data on Plan Ownership: In recent years, there has been expansive growth in different ownership arrangements of MA plans. Many health systems are developing MA plans, and private equity firms are also moving into the space. It would be highly valuable to develop a database that includes information on the ownership status of different MA plans, linked to TINs, to allow researchers to understand what entities own plans in the MA space.

Data on Networks. There is currently no high-quality publicly available information on the networks of providers included in MA plans. As a result, researchers and beneficiaries don't necessarily have a good sense of which providers are included in which plans. We suggest that CMS consider requiring plans to report accurate and timely MA network data.

Data on Related Parties Contracts: Plan sponsors are increasingly owning provider entities and using incentive arrangements to encourage providers to submit more diagnosis codes. CMS should consider requiring reporting of such related party contracts, any incentives paid under such contracts, and the overall medical loss ratio for the provider group and the parent for the population covered when provider group profits become parent profits.

Recent CMS Data Request & Access Policy Changes

Ensuring that the new MA data collected by CMS is easily accessible to researchers will be essential. While this isn't specially related to MA data collection, the recent announcement CMS made changes to the policies for data request and access could severely impact researchers' access to data, including MA data. As you know, under the current policies, researchers have two options to access CMS Research Identifiable File (RIF) data. They can either request physical data extracts to be shipped to their institution or access the data needed in the Virtual Research Data Center (VRDC). However, the new proposal would require all researchers to request RIF data from within the VRDC environment, discontinuing the delivery of physical data extracts. Researchers are crucial in analyzing the Medicare and Medicaid program data, which covers many U.S. healthcare system patients. In 2022, taxpayers spent $1.8 trillion on these programs. Access to this data is essential for studying and improving patients' health nationwide. However, terminating existing institutional access to Medicare and Medicaid data will pose significant challenges for researchers, potentially leading to negative consequences.

[6] Huang AW, Meyers DJ. Assessing the validity of race and ethnicity coding in administrative Medicare data for reporting outcomes among Medicare advantage beneficiaries from 2015 to 2017. Health Services Research. 2023 Jun 25;58(5):1045–55. doi: 10.1111/1475-6773.14197.
[7] Grafova IB, Jarrín OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity. Medical Care Research and Review. 2020 Jul 7;78(5):616–26.doi: 10.1177/1077558720935733.

Some of the barriers and challenges researchers might face include an enormous *increase in costs* as the data access is per seat. CMS will be imposing new fees, a *decrease in monitoring and evaluation* of the Medicare and Medicaid program as fewer projects could be funded, a *decrease in research quality* due to smaller research teams which reduces the time available for rigorous coding checks and increases the likelihood of analytical errors, and *decreased opportunities for new researchers* since restrictions on data access could limit opportunities for PhD students and other trainees who rely on this data for dissertations and research projects.

To address these issues, CMS could take a more balanced approach between increasing data security and maintaining access. For example, CMS could consider postponing implementation by 3-4 years to provide researchers and institutions adequate time to transition to the new rules and address any challenges that may arise. CMS could also allow physical data users to enhance their institution-specific data security controls to align with what CMS requires of its contractors, allowing certain institutions to keep physical data access. CMS could also improve the accessibility of the VRDC by:
- Lowering fees
- Introducing a subscription-based fee model covering multiple projects and users
- Offering monetary credits towards VRDC access for institutions that have made significant investments in physical data infrastructure
- Implementing tiered fees for trainees and early-stage funded projects to ensure NIH-funded research dollars are not lost.

We appreciate the opportunity to provide feedback as you consider the next steps in improving MA data. Should you have any questions or would like to discuss our comments further, please contact me at david_meyers@brown.edu or Jared Perkins, Assistant Director of Health Policy Strategy, at jared_perkins@brown.edu.

Sincerely,

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