May 29, 2024

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The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-4207-NC, Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Medicare Program; Request for Information on Medicare Advantage Data [Docket No. RIN 0938-ZB84]

Dear Administrator Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' request for information regarding data collection practices for the Medicare Advantage (MA) program. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include nearly 100 hospitals and more than 600 other health care facilities across the nation.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole.

Daily, we observe the unique benefits that the Medicare and Medicaid programs offer to patients, their families and health care systems. AHPA seeks to provide an informed policy voice that reflects our experience delivering whole person care to these communities. Specifically, we offer comment to CMS on the following issue areas:

- Optimizing and Standardizing Data Collection
- Timeliness of Data Reporting
- MA Marketing and Consumer Decision-Making
- Beneficiary Access, Provider Directories and Network
- Implementation of V28 Risk Adjustment Model

Optimizing and Standardizing Data Collection

Encounter Data

In its RFI, CMS asks for recommendations to better improve data collection practices, particularly around MA encounters. We believe that encounter data is vital for making meaningful comparisons between MA and traditional Medicare. We also believe that MA encounter data collected by CMS should be aligned with the encounter data currently being reported for traditional Medicare. **We urge CMS to base any further MA data reporting timelines, formats, and data elements on traditional Medicare data collection.** We agree with our colleagues at the National Association of Accountable Care Organizations (NAACOS) that CMS should consider gathering the following encounter data elements to enhance comparability between MA and traditional Medicare:

- **National Provider Identifier-level data** to allow stakeholders to better gauge utilization and optimize networks.
- **In- and out-of-network data** to empower consumers to choose plans that best fit their health care needs.
- **Hierarchical Condition Category (HCC) Risk Score data** to provide insight into the plan offerings which beneficiaries look for to meet their unique health care needs. Historical HCC Risk Score data would also be beneficial to allow payors to more quickly close any gaps that may exist.
- **CMS Physician Supplier and Beneficiary Summary Public Use File that includes MA data,** which would capitalize on data from the private sector that is currently already being reported.
- **Medicare Part D data** to increase price transparency and standardization of pharmaceutical benefits.
- **Hospice care data** would empower beneficiaries to choose plans best suited for their end-of-life care planning.

Prior Authorization

AHPA believes that the lack of uniformity in utilization data reporting has become a significant source of provider burden, especially regarding prior authorization. Increasing transparency around prior authorization would promote better care coordination and continuity of care for beneficiaries. While beginning in 2026, MA plans will be required to publish certain prior authorization data on their websites, including requests, denials, and appeals, detailed data, including the type of services denied the most, the cost of those services, and the top reasons

given for denials. will not be reported. **We urge CMS to require that MA plans share their utilization management policies and procedures and to report all services – primary and supplemental benefits alike – that require prior authorization at the procedure code level** along with:

- Total number of denials by procedure code:
    - Total number of denials that were successfully overturned, along with payment information.
    - Total number of denials that remained denied with no payments made.
    - Breakdown of top services denied along with the reason for the denials.
- Length of the decision process from claim submission to final decision, including any appeals, as well as data on when payments are made to providers.
- Additional beneficiary demographics such as race, ethnicity, gender, age, Medicaid eligibility, etc.

Care coordination in the Post-Acute Care (PAC) setting would also be advanced by more comprehensive data reporting. We recommend that CMS require plans to report:

- **Post-Acute Care (PAC) reimbursement percent differences between MA and traditional Medicare.** Due to lower reimbursements, Skilled Nursing Facilities (SNF) and Home Health (HH) agencies often refuse or limit the number of MA beneficiaries they take on; this also negatively impacts lengths-of-stay for patients waiting to be discharged from acute care facilities.
- **Readmission rates.** Given the limited number of MA-approved days for PAC, beneficiaries are being discharged from PAC facilities prior to reaching the level of independence they need which leads to increased readmission rates to acute care.

<u>Supplemental Benefits</u>

More providers, including our AHPA member systems, are increasing efforts to help patients address Health Related Social Needs (HRSNs) identified through screening tools. Increased sharing of data and easy access to the supplemental benefits available to enrollees, would enable providers and health insurers to better coordinate care and reduce costs. For example, there have been instances in which hospitals have assumed the cost of transporting a patient to their home to later discover that the patient's plan covered transportation. This is particularly frustrating to providers engaged in Value-Based Care (VBC) arrangements, where the provider assumes the financial risk for patients' health care costs and outcomes. To avoid this issue and improve data sharing, we recommend that CMS:

- **Require MA plans to report utilization data of supplemental benefits publicly.** From a population management standpoint, it is critical for providers to know which are the

services most utilized by both their patients and communities. While we know what plans are offering the benefits, there is a lack of data on who is receiving these services and to what extent. In February 2024, CMS published a notice requiring MA plans to submit supplemental benefit utilization data to CMS but this data is not publicly available nor accessible by providers.[1]

- **Require the sharing of supplemental benefits information in real time and in a standardized manner.** Often, MA plans include information about their supplemental benefits in difficult-to-locate sections of their websites and every plan does it differently. This hinders providers' ability to easily access the information they need to coordinate resources and formulate plans of care for their patients in a timely manner. Standardizing the electronic format and location of the supplemental benefits information will enable providers to focus more on providing whole-person care to the patient.

Quality Measures

AHPA recommends that CMS consider aligning the quality and performance measures and methodologies between Accountable Care Organizations (ACOs) and MA plans. **CMS should collaborate with MA plans and providers in VBC arrangements to determine the best methods for gathering and reporting data so that quality and performance data being collected by providers can be used across multiple efforts,** thereby reducing administrative burden.

Health Equity

Our AHPA member systems are committed to providing whole-person care to all patients and therefore support the efforts to collect and share Health Related Social Needs (HRSN) data used for the delivery of health care. Currently, the HRSN information collected by some MA payors is different than the one collected by providers for compliance with the Inpatient Quality Reporting (IQR) program. **We urge CMS to review existing HRSN datasets being collected by MA payors and seek to align that data with traditional Medicare.** This would help reduce administrative burden for providers and ensure that efforts related to health equity are consistent across Medicare.

Timeliness of Data Reporting

We urge CMS to publish MA data files, including quality performance data, simultaneously with traditional Medicare data. AHPA is concerned about a lack of consistency in data reporting intervals. Currently, there is a three-year lag in MA data becoming publicly accessible. Combined

[1] Centers for Medicare and Medicaid Services. Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records, February 2024.

with the need for standardization in reporting requirements, we believe that this misalignment leads to a lack of usable data in an age where real-time data analytics is critical for providing adequate patient care. This lack of consistency can have negative impacts on beneficiaries. While we applaud CMS' efforts to reconcile data inconsistencies, we believe that closing the current three-year lag would allow for better improve data analytics and program performance.

MA Marketing and Consumer Decision-Making

While MA plans provide many valuable benefits to beneficiaries, they also have certain restrictions or limitations that beneficiaries should be made aware of when enrolling in a plan. To increase transparency and prevent beneficiary confusion, we recommend requiring plans to disclose to beneficiaries:

- The types of supplemental benefits available by the plan.
- Clarity on the utilization management practices used, including the use of prior authorization for accessing services. Medicare beneficiaries should know that MA is different than traditional Medicare, which offers coverage without the arduous process of prior authorization and continued stay reviews.
- Information on out-of-network coverage and any existing barriers. Often, patients will travel and have limited benefits in other regions of the country.
  Information on the pharmaceutical benefits and formularies available. MA plans should also be required to notify patients and providers of any changes to their covered formularies.

Beneficiary Access, Provider Directories and Networks

At AHPA, a key area of focus in our efforts to address social determinants of health is to increase access to care. This area of need has frequently been identified through our Community Health Needs Assessment processes in several markets. As health systems, we strive to increase access to care and offer those services most needed by a community, however, in order to adequately address access-to-care issues, we need to work collaboratively with payors. Beneficiaries should be aware of the care options available to them and providers should be able to more easily communicate with MA plans when they are at capacity so plans can work to expand access in that market. To facilitate beneficiary access to care, we recommend that CMS:

- **Require MA payers to provide summary documents as well as detailed patient level content regarding empanelment per Tax Identification Number (TIN).** The empanelment could then list the providers per TIN with specific access. Quarterly

reconciliation efforts on the data regarding empanelment is critical to understand the true access for patients.

- **Make it easier for providers to notify MA plans when new providers with the capacity to take patients are added and limit future empanelment for providers with full patient panels.**

Implementation of V28 Risk Adjustment Model

CMS introduced a new Part C risk adjustment model in 2024. The new model updated the data years used to calculate Part C risk factors, transitioned to the use of ICD-10 diagnosis codes for identifying hierarchical condition categories (HCCs), and made numerous changes to the diagnoses and HCCs included in the payment model. According to CMS estimates, the impact of the risk adjustment changes would result in a 3.12% payment reduction to MA plans in 2024. In the final rate notice, CMS decided to phase in the model over a period of three years rather than implement it entirely in 2024 as originally proposed. In 2024, CMS blended Part C risk scores using 33% of the risk score based on the new model and 67% of the risk score as calculated under the old model. For 2025, CMS proposes to continue phasing in the new model with a blend risk score based on 67% of the new model and 33% of the old model.

AHPA recommends that CMS halt implementation of the V28 risk adjustment model until a comprehensive analysis of the impact thus far is conducted. According to an analysis by Milliman, the average value-add for general enrollment in MA plans stopped growing in 2024 for the first time historically.[2] From 2021 to 2023, the total value added of general enrollment MA plans grew by about 10% to 12% per year, due to enhancements in Part C and Part D benefits, coupled with reductions in member premiums. From 2023 to 2024, however, average growth in total value added was about 1%, significantly less than previous years.

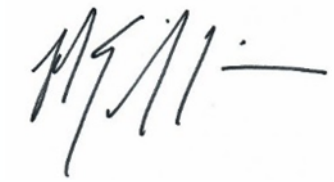
While AHPA supports efforts to strengthen data sharing and transparency, we are concerned that any additional payment reductions to MA plans will threaten beneficiary access to care, as MA payers limit their benefit offerings and reduce payments to providers engaged in value-based arrangements to make up for their payment losses.

Conclusion

[2] Milliman. State of the 2024 Medicare Advantage Industry: General enrollment plan valuation and benefit offerings. January 2024

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me or Susana Molina Ramos, Director of Public Policy at Susana.MolinaRamos@AdventHealth.com.

Sincerely,



Michael E. Griffin
President
Adventist Health Policy Association