



Medicare Payment
Advisory Commission

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May 29, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-4207-NC

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) request for information (RFI) entitled: "Medicare Program; Request for Information on Medicare Advantage Data," published in the *Federal Register*, vol. 89, no. 20, pp. 5907–5909 (January 30, 2024). This request for information seeks comment "on all aspects of data related to the Medicare Advantage (MA) program" to inform the agency's efforts to improve and broaden its collection of various MA-related data. Given the continued growth of the MA program, the Commission strongly supports these efforts because improved data would help beneficiaries and policymakers to better evaluate how MA affects access to care, quality of care, service use, and program spending. We appreciate your staff's work on the request, particularly considering the competing demands on the agency.

Our comments focus on the following areas:

- Beneficiary access to care
- MA marketing and plan offerings
- Quality and outcomes
- Market dynamics
- Special populations
- Improvements to current data collection

Beneficiary access to care

The Commission commends CMS for its focus on beneficiaries' access to care in MA. As we outline in our forthcoming June 2024 report, provider networks and prior authorization are important tools that MA plans can use to influence the services and providers that

enrollees can access. On the one hand, these tools have the potential to promote more efficient and higher-quality care. On the other hand, misapplication of these tools could lead to delays or denials of needed care. Improved data regarding how MA plans use provider networks, prior authorization, and other utilization management tools is important for ensuring access to high-quality care in MA. That said, it is important that CMS balance the potential benefits with associated costs of gathering new data.

Provider networks and directories

Accurate information about the providers included in an MA plan's network is crucial for beneficiaries because it enables them to make informed decisions about, first, enrolling in a plan and, subsequently, seeking health care services. CMS requires MA organizations (MAOs) to disclose information to enrollees about a plan's service area and contracted providers in the form of a provider directory at the time of enrollment and at least annually thereafter. However, the current system for generating and maintaining provider directories is costly and inefficient. Plans maintain their own directories, and provider groups must submit their information to every plan they contract with.

To ensure beneficiaries have the necessary information to make decisions about their health care coverage, the Commission supports recent CMS efforts to facilitate the maintenance and dissemination of accurate MA provider network information. For instance, a 2020 Health Plan Management System (HPMS) memo encouraged MAOs to use the National Plan and Provider Enumeration System (NPPES) as a resource to validate the network data that providers submit, and highlighted the option to require that providers regularly attest to the accuracy of their data in NPPES.¹

A national provider directory, as CMS discussed in a 2022 RFI, would also facilitate beneficiaries' access to good information about the sources of care available in different MA plans.² In the Commission's annual focus groups with beneficiaries, MA enrollees report that a key factor when picking among plans is whether their doctor is "in-network".³ A single repository of plans' provider network data, which is complete, accurate, and regularly updated, would allow beneficiaries to make informed decisions about enrolling in MA plans that contract with their preferred providers, and to identify new in-network

¹ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. HPMS memo regarding "National Plan and Provider Enumeration System as a Resource to Improve Provider Directory Accuracy." January 3. <https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpms-hpms-memos-archive/hpms-memo-3>.

² Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. Request for information; National Directory of Healthcare Providers & Services. *Federal Register* 87, no. 194 (October 7): 61018. <https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services>

³ We annually conduct focus groups with beneficiaries and clinicians in different parts of the country to assess beneficiary and clinician experiences with the Medicare program from a qualitative perspective. Our most recent findings are reported in Campanella, S., R. Catterson, C. DeBroux, et al. 2023. *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2023 focus groups in select states*. Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Bethesda, MD: NORC. https://www.medpac.gov/wp-content/uploads/2024/02/Feb24_MedPAC_FocusGroupSiteVisitReport_CONTRACTOR_SEC-1.pdf

providers when needed. It would also reduce the administrative burden for both providers and MA plans.

NPPES could be the scaffolding upon which to build this database. The data would ideally include all information currently collected in NPPES and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), such as national provider identifiers (NPIs), specialty taxonomy information, organization affiliations, and contact information. For facilities, organizational NPIs, tax identification numbers, and CMS certification numbers (CCNs) should also be collected. These data would ensure that providers, including what and where they practice, could be correctly identified. Unfortunately, providers currently have little incentive to keep the information in NPPES up to date, and both the Office of Inspector General (OIG) and researchers have raised questions about the accuracy of NPPES data.⁴ However, using NPPES as the basis for a national provider directory could have the added benefit of improving the quality of this data source. Further, a central repository could improve efficiency and reduce administrative burden by reducing the number of times the same data are collected.

The key addition to this information would be the list of all MA plans for which each provider is in-network. MA organizations should be required to attest to the providers that are in-network with each of their plans, providing the contract start date and end date, as applicable. Ideally, providers would also be required to independently confirm their network status. Because MA plans and providers are permitted to initiate or terminate contracts throughout the year (whereas beneficiaries are generally prohibited from switching plans outside of defined enrollment periods), mid-year network changes can be consequential for beneficiaries. In order for plan-provider network data to be most useful in capturing these changes to networks, providers and plans should be required to attest to the accuracy of this information at least monthly. We recognize that such a process has the potential to be administratively burdensome, and we encourage CMS to implement this attestation through a simple process that would minimize reporting burden and maximize the likelihood of compliance.

This information could be the basis for improvements to the Medicare.gov website's Plan Finder, which would be more helpful for beneficiary decision making if it were searchable by both plan and provider, so that beneficiaries could determine whether a certain provider participated in a plan's network.

The accuracy of MA provider network information is important not just for beneficiary choice, access to care, and program monitoring; it has cost-sharing implications for beneficiaries. Currently, we do not have information about how often—and for which services—beneficiaries seek care out-of-network. Out-of-network service use by MA

⁴ Office of Inspector General, Department of Health and Human Services. 2013. *Improvements are needed to ensure provider enumeration and Medicare enrollment data are accurate, complete, and consistent*. OEI-07-09-00440. Washington, DC: OIG. Harrison, J. M., H. D. Germack, L. Poghosyan, et al. 2021. Surveying primary care nurse practitioners: An overview of national sampling frames. *Policy, Politics, & Nursing Practice* 22(1): 6-16. doi:10.1177/1527154420976081. O'Reilly-Jacob, M., J. Chapman, S. V. Subbiah, et al. 2023. Estimating the primary care workforce for Medicare beneficiaries using an activity-based approach. *Journal of General Internal Medicine* 38, 2898-2905. <https://doi.org/10.1007/s11606-023-08206-3>.

enrollees could be an indicator of inadequate in-network access. It would be useful to have an indicator in the MA encounter data for encounters that are out-of-network, alongside beneficiary cost-sharing liability and plan liability for such services. Possible approaches to adding this information to encounter data are described below, in the section on improvements to current data collection.

Prior authorization

Prior authorization, a process by which a provider requests approval from a payer before performing a service, providing a medical item, or prescribing a drug, is designed to help health plans contain costs and protect patients from receiving unnecessary care. This form of utilization management is rarely used in fee-for-service (FFS) Medicare, but nearly all MA enrollees are in plans that require prior authorization for some categories of services.

The data that MA plans are currently required to submit, however, are not sufficient to understand patterns in the use of prior authorization or the impact of those processes on beneficiaries. For instance, MAOs are required to submit counts of prior authorization requests and decisions aggregated to the contract level. While this gives some indication of the volume of prior authorization requests and their outcomes, it does not allow for comparisons of rates of prior authorization and outcomes by service type, specialty, or market area, or for certain plan types (e.g., HMO and HMO-POS, which can be governed under the same contract).

In 2021, MA plans fully approved the vast majority of prior authorization requests they reviewed. However, it is not possible to quantify delays in care associated with these review processes. This is an important aspect of performance in the MA program, and it is critical for beneficiaries' access to care. To the extent that some beneficiaries (e.g. those with a particular diagnosis, requiring a certain service or product, or living in a specific area) are disproportionately subject to prior authorizations, it is important to analyze the use of prior authorization to understand whether it contributes to disparities in access to care among Medicare beneficiaries.

Beneficiary and service/procedure level data are collected by CMS Medicare administrative contractors for the limited cases for which prior authorization is currently used in FFS (certain durable medical equipment and a limited set of services). Similar information, if it could be gathered efficiently, would be helpful in evaluating the more expansive use of prior authorization in MA. Data on the timeliness of prior authorization determinations and appeals would be valuable for ensuring that such processes do not impede access to needed care for beneficiaries. Collection of such data could be retrospective, such that it would not interfere with a plan's ability to adjudicate requests in a timely way. More granular data that would be useful for monitoring the use and timeliness of prior authorization would include beneficiary-service-level details of prior authorization requests and outcomes, such as:

- Beneficiary ID and characteristics, including qualifying diagnosis or justification for service;
- Details of each service request, including Healthcare Common Procedure Coding System (HCPCS)/procedure code(s), request date, requesting provider, and site of care;
- The MAO's initial determination, including decision date and justification;
- Details of any reconsideration requests, including request and decision dates, outcome, and justification; and
- An indicator of further appeal (and thus, transfer to the independent review entity).

MA marketing and plan offerings

Beneficiaries face a series of complex decisions when electing how to receive their Medicare benefits, including whether to enroll in an MA plan or remain in traditional Medicare with or without purchasing a supplemental Medigap policy. For beneficiaries considering MA plans, there are additional considerations such as whether plans offer supplemental benefits that are well suited to their health needs and whether enrollees of such plans have an easy time accessing those supplemental benefits. Beneficiaries often turn to insurance brokers and agents to help them navigate these decisions. For policymakers seeking to monitor, learn from, and improve MA, having good information about the beneficiary choice environment and its influence on beneficiaries and the program is important. Below, we make suggestions regarding information that we believe CMS could collect to facilitate greater transparency regarding these topics. In particular, we discuss the need for better information about plan payments to agents and brokers, enrollment in Medigap, and the cost and use of supplemental benefits.

Plan payments to agents and brokers

MA organizations typically use agents and brokers to help market their plans and enroll new members. CMS has established limits on the compensation for agents and brokers to give them incentives to enroll beneficiaries in the MA plan that best meets their health care needs; the agency recently revised these limits in its April 2024 final rule for the MA and Part D programs. These limits apply on an annual, per enrollee basis.

However, there is currently no information about aggregate payments by MA organizations to agents and brokers. The agency may want to consider requiring MA organizations to report the following information, at the plan level and on an annual basis:

- Total payments to agents and brokers,
- Total number of enrollees for whom payments to agents and brokers were made;

- Total payments and associated enrollees, broken out based on the MA organization's relationship with the agent/broker (i.e., payments to independent agents and brokers (including entities such as field marketing organizations) vs. payments to agents and brokers who work directly for the MA organization); and
- Total payments and associated enrollees, broken out by new enrollees vs. continuing enrollees.

This information would help policymakers better understand overall spending by MA organizations on agent/broker payments and how those payments vary across plans. This information would also give beneficiaries a better understanding of the financial incentives that agents and brokers have to market certain plans over others.

Medigap coverage

One area that lacks transparency and deters comparisons between MA and FFS Medicare is Medigap coverage. When beneficiaries choose between FFS and MA, they often compare the combination of FFS and Medigap to MA. The availability of Medigap and the premiums that Medigap plans charge are thus important factors when deciding between enrollment in MA or FFS. Better information about which beneficiaries buy Medigap coverage, the extent of their Medigap coverage, and their Medigap premiums would give researchers and policymakers a better understanding of consumer decision-making when making coverage decisions. In addition, as beneficiaries with Medigap policies age, they are often restricted from switching to a different Medigap plan. There is currently no longitudinal data on Medigap premiums that would help policymakers understand how Medigap premiums change over time and how those changes affect beneficiaries' decision to remain in FFS or switch to an MA plan.

Two types of data that are currently not collected would improve policymakers' ability to understand the tradeoffs between FFS/Medigap and MA coverage:

- First, beneficiary-level data on each beneficiary with Medigap coverage, such as an encrypted beneficiary identifier, the name of the Medigap plan in which the beneficiary is enrolled (as well as a plan identifier that could be linked to the plan-level data described below), the start and end dates for the Medigap coverage, the plan's benefit package (e.g., F, G, N, Medigap select), and whether the plan is a high-deductible plan. These data should be available to researchers in the same manner as other beneficiary-level files, such as the Master Beneficiary Summary File.
- Second, plan-level data on premiums and supplemental benefits for each Medigap insurer, organized by state, insurer, benefit package, and enrollee age. These data would have plan identifiers that could be linked to the beneficiary-level data described above. These data would be comparable to CMS's landscape and plan benefit package files for MA plans and should be publicly available.

These files would also facilitate research on other MA-related issues besides beneficiary decision-making. For example, policymakers would be able to identify FFS beneficiaries with comprehensive supplemental coverage (Plans F and G). Since first-dollar or near first-dollar coverage is rare in MA plans, beneficiaries with these types of Medigap policies may be more likely to use Part B services and thus increase MA benchmarks. Policymakers are currently limited to self-reported information on a limited set of beneficiaries in survey data such as the Medicare Current Beneficiary Survey. Having more detailed information on beneficiaries' Medigap coverage would help policymakers begin to discern how much of the favorable selection that we have observed in MA can be attributed to comprehensive Medigap coverage among FFS beneficiaries. In addition, policymakers would have a more accurate picture of the overall cost liability (Part B premiums, Medigap premiums, and Part A and Part B cost sharing) for FFS beneficiaries. Coupled with more transparent data on beneficiary cost sharing in MA encounter data, policymakers could compare the overall cost liability of FFS beneficiaries and MA enrollees.

Cost and utilization of supplemental benefits

In addition to covering all Part A and Part B Medicare-covered services, MA plans may offer their enrollees additional benefits such as lower cost sharing; lower Part B or Part D premiums; or supplemental benefits such as vision, hearing, dental, and fitness benefits. Supplemental benefits are typically financed using rebates that plans receive from Medicare, though some are financed by charging enrollees an additional premium. Medicare's rebate payments to MA plans have more than doubled since 2018 and now account for a significant fraction of total Medicare spending on MA. Despite their importance, Medicare does not collect detailed information about MA enrollees' use of supplemental benefits, and little is known about their value. The bid data that plans submit annually to CMS include projections of how plans expect to allocate the rebates they receive from Medicare, but policymakers do not have reliable information about enrollees' actual use of the extra benefits. Using the bid data for 2023, we estimate that plans allocated approximately \$54 billion to the provision of supplemental benefits and the reduction of Part A and Part B cost sharing.

Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR § 422.310(b)), including items and services provided through supplemental benefits; however, CMS's Encounter Data Submission and Processing guidance limits the requirement to apply only to supplemental services for which the plan has sufficient data to populate an encounter record. Because there is no standard claim format for many supplemental benefits (e.g., fitness, meals, transportation, pest control), there is no standard way for plans to submit information about the use of such benefits. In addition, CMS systems accept "professional" and "institutional" claim formats, which allow for the collection of some supplemental services, but the Encounter Data System that CMS uses to collect encounter records from MA organizations has not historically been configured to accept dental claims.

Even for supplemental benefits that are claims-based and can be included in encounter records, identifying which services were covered as supplemental benefits can prove

challenging. For example, many plans cover additional inpatient hospital days or inpatient psychiatric days as a supplemental benefit. However, encounter data do not include a mechanism for distinguishing such services from the core Medicare benefits that plans are required to cover. This makes it difficult to determine whether MA enrollees are receiving the Medicare benefit as entitled and whether enrollees are accessing the supplemental benefits that may have factored into their decision to enroll in a particular plan.

CMS has recently taken two notable steps to improve the collection of data regarding supplemental benefits. First, in a recent memorandum to MA plans, CMS clarified that encounter data records need to be submitted for all items and services, including supplemental benefits; explained that encounter records for supplemental dental benefits will be accepted beginning with plan-year 2024; described new default codes that are to be used to report supplemental benefits when a diagnosis code, procedure code, and/or revenue code is not typically collected; provided guiding principles for submitting non-claims-based supplemental benefit records; and announced that CMS has developed a Supplemental Benefits Indicator that will be used to identify encounter records for supplemental benefits that are submitted using the traditional claims format starting with plan-year 2024.⁵

Second, under new reporting requirements, plans will be required to submit significantly more detail about supplemental benefits, beginning with plan-year 2024.⁶ MA organizations will be required to submit plan-level information (not beneficiary-level encounter records) for a wide range of supplemental benefit categories, including the number of enrollees who are eligible for each supplemental benefit, the number of enrollees who utilized each benefit, total and median instances of utilizations among eligible enrollees, the net amount incurred by the plan to offer each benefit, the type of payment arrangement, how the plan accounts for the cost of the benefit including administrative expenses, and the total out-of-pocket cost per utilization for enrollees. Information about supplemental benefits that modify the cost sharing for basic services covered under Parts A and B will not be separately collected, however.

We recognize that there are significant technical challenges involved in the collection of data related to supplemental benefits, and we applaud CMS's recent efforts to improve the quality of data being collected regarding these services. We emphasize the value of improved visibility into the use of supplemental benefits and encourage CMS to continue its efforts to improve the data collection processes.

One area that CMS's actions to date do not address is the absence of reliable information about the amount that plans spend to lower cost sharing for their members. Non-special

⁵Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. HPMS memo regarding "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records." February 21. <https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-4-february-19-23>

⁶Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Medicare Part C reporting requirements. <https://www.cms.gov/files/document/cy2024-part-c-reporting-requirements.pdf>

needs plans (non-SNPs) consistently project in their bids that a large share of rebate dollars are used to buy down cost sharing for Part A and Part B services. In projecting this supplemental coverage, MA plans are expected to calculate the extent to which their cost sharing is actuarially equivalent to cost sharing in Medicare FFS. However, there is currently no requirement for MA plans to report their actual spending on supplemental coverage for cost sharing. Thus, the MA program lacks transparency on the extent to which MA plans reduce cost sharing for their enrollees, including coverage for when enrollees exceed their qualifying maximum out-of-pocket (MOOP) costs. Requiring this information to be reported in both base-period bid information and medical loss ratio (MLR) data would help policymakers and beneficiaries understand how rebate dollars are used. This information should be readily available by MA plans and could be reported by adding two rows in Worksheet 1 of the base period bid data and two additional columns in the MLR data. One data point would be the rebate dollars spent on reducing cost sharing for Part A and Part B services, and the other data point would be a subset of that total that was used to cover cost sharing beyond the MOOP amount. With this information, policymakers could have a better understanding of the amount of rebate dollars used to reduce cost sharing, the extent to which plans are liable for costs beyond the MOOP, and how plan projections for these supplemental benefits compare with actual plan spending.

Quality and outcomes

It is important for the Medicare program to monitor MA plan performance and quality to ensure that beneficiaries have access to high-quality health care and to promote improved quality of care in MA. Beneficiaries also need good information about the quality of care provided by MA plans in their local market to make informed choices about enrolling in an MA plan. Medicare currently collects close to 100 MA quality measures and uses many of them to determine a star rating from 1 to 5 for each MA contract. The Commission previously monitored a subset of the measures used in the MA 5-star rating program, but in recent years has determined that it cannot provide an accurate description of the quality of care across MA plans on this basis.⁷

The Commission reached this determination chiefly because quality is reported at the contract level, rather than the plan or market level. Contract-level measure results can include clinical data from a sample of enrollees as small as 411 across large, sometimes non-contiguous contracts, which are not reliably representative of care in a local health care market (for instance, the largest MA contract, with 2.6 million enrollees, has over 1,000 MA enrollees in each of 46 states and over 20,000 enrollees in each of 30 states). The Commission has made several recommendations to improve MA quality reporting and quality payment programs, including recommending in June 2020:

The Congress should replace the current MA quality bonus program with a new MA value incentive program that scores a small set of population-based measures, evaluates quality at

⁷ Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf

the local market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.

The Commission encourages CMS to consider requiring MAOs to report quality data at the local plan level, such that the performance of plans in the same market area can be compared.

Market dynamics

The structure and dynamics of health care markets are an important determinant of the availability, cost, and quality of the services available to Medicare beneficiaries. Given the potential impact of market dynamics on beneficiaries, it is important for policymakers to have good information about the structure and functioning of the MA market. We appreciate CMS's recognition of these issues and their inclusion in the RFI. Below, we make suggestions regarding how CMS could collect and make available information about the structure of the MA market, particularly the ownership of MA plans and the ownership arrangements between insurers and providers. Where possible, we suggest opportunities to leverage existing data sources to minimize the need to collect new information from plans and providers.

Mergers and acquisitions

Enrollment in MA is highly concentrated at the local level and increasingly concentrated at the national level. High enrollment concentration—particularly at the local level—can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits. Over the last decade, MA enrollment has become increasingly concentrated at the national level in plans owned by a small set of large insurers that serve a majority of markets in the country. Between 2008 and 2023, the share of total MA enrollment in the three largest firms rose from 32 percent to 58 percent. Much of the growth of these firms has been driven by their expansion into new markets.⁸ However, mergers and acquisitions (M&A) between insurers have also had a significant impact on the MA insurer landscape.⁹

Few data sources are available for examining the effects of M&A involving MA organizations. CMS's regularly published enrollment data and plan directories provide information about the parent organizations and legal entities that offer MA plans, but these sources are not well suited to systematic identification of M&A activity. For example, many organizations rebrand or slightly modify the company's name from year to year, making it

⁸Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf.

⁹McGuire, T. G., J. P. Newhouse, and A. D. Sinaiko. 2011. An economic history of Medicare Part C. *Milbank Quarterly* 89, no. 2 (June): 289–332.

difficult to create a longitudinal record of which MA contracts were owned by which companies.

To facilitate longitudinal analysis of MA plan ownership, CMS should prepare and publish three data files. The first should be a list of all parent organizations that have ever offered an MA plan, including any variations in the name used to report data to CMS over the years; in a separate field, the file should then provide a parent organization identification number that can be used to link the various names used by an organization over time. The second file should be a contract-level file that lists all of the parent organizations (using the parent organization identification number from the first file) ever associated with the contract, along with the dates associated with the start and end of the parent-contract affiliation. We believe that CMS already has the information needed to assemble these datasets and that making them available would be a straightforward way to aid policymakers interested in monitoring the effects of M&A on the MA program.

For the third file, CMS should develop a change of ownership (CHOW) file similar to those it has developed for hospitals and skilled nursing facilities.^{10,11} Those data include information about the legal business name of owners and sellers, the provider type, the change of ownership type (CHOW, acquisition/merger, or consolidation) and the effective date of the change. As it does for the facilities, CMS should also collect and publish an owner information dataset that provides information about individual and organizational ownership interest and managerial control associated with the buyer and seller organizations, the role of the owner, association date, address of the organizational owner and other ownership details.^{12,13} For facilities, these data are gathered from the Provider Enrollment, Chain, and Ownership System (PECOS). CMS would likely need to establish a new system through which to collect ownership information from MA organizations and establish rules to ensure that organizations report complete and accurate information. These data would allow a more comprehensive picture of the ownership landscape for MA plans because they would facilitate the inclusion of other investors and a more diverse set of ownership arrangements than would be visible in the parent organization and contract-level files we described above.

¹⁰Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Skilled Nursing Facility Change of Ownership—Owner Information. <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-change-of-ownership-owner-information>.

¹¹Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Hospital Change of Ownership. <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-change-of-ownership>.

¹²Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Skilled Nursing Facility Change of Ownership—Owner Information. <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-change-of-ownership-owner-information>.

¹³Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Hospital Change of Ownership—Owner Information. <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-change-of-ownership-owner-information>.

Vertical integration

MA organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially aligned arrangements).¹⁴ This vertical integration can affect how plans and providers serve MA enrollees, with implications for premiums, quality of care, access to care, and program spending. Proponents of integration argue that it can promote efficient care delivery, while others emphasize potential downsides such as the possibility of higher diagnostic coding and opportunities for insurers to avoid the constraints on profits posed by medical loss ratio requirements. These are important topics for policymakers to understand as the MA program grows and becomes more vertically integrated. Unfortunately, no public data provide a systematic accounting of the ownership relationships between MA plans and health care providers. This lack of transparency is a significant barrier to monitoring the effects of vertical integration on Medicare beneficiaries and the program.

To facilitate monitoring of the effects of vertical integration, CMS should collect from MA organizations the tax identification numbers of any health care providers for which the organization is an owner or has a controlling interest. To facilitate use of the data by the public while protecting the information of providers, CMS could publish the data using NPIs in place of tax information.

One step toward accomplishing this goal in a timely manner that would minimize burden for plans and CMS would be to publish a subset of the “related party” data currently collected as part of the annual MA bidding process. In their bid documentation, MAOs report their financial relationships with providers and other entities, but the data are not made public. Specifically, MA plans are required to “disclose and support each related-party arrangement at the time of the initial bid submission” and to project the amount per member per month that they expect to spend on services from related parties (defined as any entity that “has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any arrangement in which the MAO does business with a related party through one or more unrelated parties”).¹⁵ As a result, MAOs should typically have processes in place to facilitate the collection of ownership data for submission to CMS.

Ideally, the published data file would contain the bid identification number, the NPIs of providers that were reported to CMS in the bid documentation, and the dates during which the relationship was active. We encourage CMS to also begin collecting information about the amount of related-party spending reported in the bid that is attributable to each provider and suggest including those data as they become available. In addition, we

¹⁴Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf.

¹⁵Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. CY 2023 Bid Pricing Tools (BPT) and instructions. <https://www.cms.gov/medicarehealth-plansmedicareadvtspeccratestatsbid-forms-instructions/2023>.

encourage that CMS begin collecting base-period related-party spending information in Worksheet 1 of the Bid Pricing Tool (in addition to the projection that is required under current policy). Given the rapid pace of change in vertical integration for some organizations and the data lag required under 42 CFR 422.272(b), base-period information would be a useful complement to the plan-projected amounts.

Special populations

CMS has maintained a focus on certain populations, such as beneficiaries with end-stage renal disease (ESRD), through tailored policies for payment and quality measurement, and the maintenance of data necessary for their implementation. Due to differences in payment and quality measurement, these efforts have provided more insight about the service use and quality of care for beneficiaries with ESRD enrolled in FFS Medicare compared to those in MA. This section seeks to improve the accuracy and completeness of the data necessary to provide a similar understanding about service use and quality of care for MA enrollees with ESRD.

Beneficiaries with end-stage renal disease

Beneficiaries with ESRD have greater health care needs and use more services than most Medicare enrollees. Ensuring that this population has access to all the needed services and receives high-quality care is critically important. For many years, as part of our assessment of payment adequacy, the Commission has tracked access to care and use of services for beneficiaries with ESRD enrolled in FFS Medicare. In recent years, the share of beneficiaries with ESRD enrolled in an MA plan has grown substantially, from about 27 percent in December 2020 to 47 percent in December 2022. It is important to make the same assessments about access to care and use of services for beneficiaries with ESRD in MA.

For beneficiaries with ESRD in FFS Medicare, we analyze several data points that we would like to assess for MA enrollees. Some of the data elements below appear to be regularly reported on MA encounter records for dialysis services (Type of bill “072X”), but other data elements may not be consistently reported. CMS should provide guidance to plans to ensure that plans regularly report all the following items on encounter records for dialysis services:

- Type of dialysis provided (hemodialysis or peritoneal dialysis (identified by revenue center codes ‘08XX’), whether dialysis was performed at home (identified by condition codes ‘74’ and ‘80’), and whether dialysis training or retraining was provided (identified by condition codes ‘73’ and ‘78’).
- Whether dialysis was provided for the treatment of acute kidney injury (identified by condition code ‘84’).
- Patient height and weight (values provided for value codes ‘A8’ and ‘A9’) are required to apply ESRD prospective payment system case-mix adjusters related to patient body mass index and body surface area.

- Hemoglobin level, hematocrit level, and dialysis adequacy (values reported for value codes ‘48,’ ‘49,’ and ‘D5’) are necessary to evaluate dialysis treatment effectiveness.
- Vascular access site (identified by modifier codes ‘V5’ for catheter, ‘V6’ for arteriovenous graft, or ‘V7’ for arteriovenous fistula).
- Specific lab services and drugs/biologicals that are not related to the treatment for ESRD (identified by HCPCS modifier ‘AY’).

Improvements to current data collection

Encounter data

Since 2012, MA plans have been required to submit to Medicare a record of each encounter MA enrollees have with a health care provider. MedPAC has long been interested in using MA encounter data to better understand plan practices and assess beneficiaries’ access to care. Complete and accurate encounter data would be the best vehicle for learning about the care provided to MA enrollees. The information could also be used to provide more rigorous oversight of Medicare’s payments to MA plans—which reached \$455 billion in 2023—and to ensure that the Medicare beneficiaries enrolled in MA plans (now more than half of eligible beneficiaries) receive the full Medicare benefit. Lessons learned from MA encounter data could inform improvements of MA payment policy, facilitate comparison with traditional Medicare, and generate new policy ideas that could be applied across the entire Medicare program. Furthermore, improved encounter records would also enable Part D analyses such as the estimation of the effects of prescription drug use on medical utilization and comparison of MA-PDs and PDPs. Encounter data could feasibly be used to streamline administration of the program by replacing several of the data summarization and submission tasks that are currently conducted by MA plans.

However, in our annual reports to the Congress and presentations since 2019, the Commission has assessed the accuracy and completeness of MA encounter data and found that, though the data have improved since 2017, they do not include records of all items or services provided to MA enrollees.^{16,17,18} In our most recent analysis, we assessed data for inpatient hospital, home health, skilled nursing facility, and dialysis services and found evidence of missing encounter records for each type of service (Table 1).

¹⁶Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁷Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹⁸Medicare Payment Advisory Commission. 2022. Medicare Advantage encounter data. <https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf>.

Table 1 | Encounter data and independent sources are missing information for some MA enrollees, 2017–2021

Independent source	Independent source only	Encounter data only	Both sources
MedPAR			
2017	5%	9%	86%
2021	4	8	88
MDS*			
2017	6	6	88
2021	6	5	89
OASIS			
2017	11	40	49
2021	8	8	84

Note: MA (Medicare Advantage), MedPAR (Medicare Provider Analysis and Review), MDS (Minimum Data Set), OASIS (Outcome and Assessment Information Set). Includes only data for health maintenance organization (HMO)/HMO point of service, local preferred provider organization (PPO), and regional PPO contracts. Outpatient encounter data for 2021 were not available at the time of analysis.

*Excludes MA enrollees who were also eligible for full Medicaid benefits during the calendar year.

Source: MedPAC analysis of MA encounter data and MedPAR, risk-adjustment, MDS, and OASIS data.

To improve the completeness and accuracy of MA encounter data, the Commission recommended in 2019 that the Congress direct the Secretary to (1) establish thresholds for the completeness and accuracy of MA encounter data; (2) evaluate MA plans’ submitted data and provide feedback to organizations, including comparisons to external data sources; and (3) apply a withhold to plan payments (which would be refunded to MA organizations that meet those thresholds). The Commission also recommended instituting a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option for all MA organizations that prefer this method, for MA organizations that fail to meet completeness thresholds, or for all MA organizations if program-wide thresholds are not achieved. These recommendations have not been adopted, and our analysis shows the continued need for policies to address incomplete records.

Other researchers have also used comparisons of encounter data and other sources to identify contracts with comparatively lower rates of missing data and have suggested that limiting analysis to these contracts is one way to reduce the potential problems caused by incomplete data.¹⁹ Such comparisons provide policymakers with useful information about the reliability of the encounter data. Given CMS’s access to the relevant data and unique expertise in working with the relevant data files, the agency is well-positioned to conduct such comparisons, disseminate the findings, and regularly update the results. We encourage CMS to assess the match rates between encounter data and other sources and publish the results at the contract and provider level (to facilitate the identification of

¹⁹Jung, J., C. Carlin, R. Feldman, et al. 2022b. Implementation of resource use measures in Medicare Advantage. *Health Services Research* 57, no. 4 (August): 957–962.

patterns of missingness in the data). The datasets best used for this purpose are the Medicare Provider Analysis and Review (MedPAR, for inpatient hospital services); the Minimum Data Set (MDS, for skilled nursing stays); and the Outcome and Assessment Information Set (OASIS, for home health services). The results of these comparisons would be useful to policymakers seeking to better understand the encounter data and to plans and providers seeking to improve their data submission processes.

In addition to facilitating a regular and rigorous assessment of the data's completeness and accuracy, there are fields in the encounter data that could be added to the data, or collected more systematically, that would significantly increase the utility of the data:

- **Beneficiary cost-sharing liability:** CMS should establish a mechanism for collecting, on each encounter record, information about the amount of cost sharing the beneficiary paid for the service. This is important for monitoring whether plans are providing benefits appropriately, examining the out-of-pocket costs faced by MA enrollees, and learning from the innovative benefit designs that MA plans can develop.
- **Plan and other payer liability:** In addition to collecting the beneficiary's cost sharing liability, CMS should improve the accuracy of the payment fields plans use to report their payment to providers for each encounter. This field is frequently populated with zeros, even for encounter records that are not indicated as being covered under capitated payment arrangements. While some zeros may represent instances in which the plan denied payment to the provider, the frequency of encounters listing zero payment is higher than can be reasonably expected to be attributed to claims denials. We encourage CMS to monitor the frequency of such records in the data and to begin outreach to plans to better understand why the data are not being submitted and to develop guidance to address the issues.
- **Contract type code:** The "contract type code" field in the encounter data can be used to identify whether a service was delivered under a capitated payment arrangement between the plan and the provider.²⁰ Currently, CMS only provides guidance regarding use of the '05' value to indicate capitation. However, other values are sometimes submitted to indicate other payment arrangements (e.g., DRG, per diem, flat rate, etc.), though use of these codes is not consistent across organizations. MA organizations' ability to develop alternative payment arrangements with providers is one of the defining features of MA and is a potential source of innovation in the program. However, relatively little is known about the payment arrangements plans use. We encourage CMS to expand the guidance regarding the use of the claim contract field of the encounter data, encouraging

²⁰Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022a. *Encounter data submission and processing guide: Medicare Advantage program*. Baltimore, MD: CMS.

wider use of the field and guiding principles for which code should be used to characterize the payment arrangement the plan used to pay for the service.

- **NPI and CCN:** One of the foremost challenges in the use of the encounter data is the unreliability of the national provider identifier (NPI) fields. These fields have several issues:
 - For some encounters, the billing NPI field should be populated with the NPI for an organization but is instead populated with either an individual’s NPI or an invalid NPI.²¹ We encourage CMS to adopt a stricter front-end check to reduce the frequency of these occurrences.
 - For organizations with more than one NPI listed in the insurers’ system, CMS allows MA organizations to submit any NPI affiliated with that facility. Because multiple NPIs can be associated with a single facility, using these NPIs may not be a reliable way to determine the unit or type of facility in which a service was provided. One way to assess the reliability of the reported NPIs would be to assess whether the revenue and procedure codes reported on the encounter record are aligned with the provider type indicated by the NPI—particularly for facilities that operate distinct units billing under separate NPIs. Information about the prevalence of discordant codes could be incorporated into the feedback CMS gives plans about their data.
 - The encounter records do not contain a field for the CMS certification number (CCN), which is an important tool for the analysis of facility-based services. As a result, policymakers using the data to monitor the program must develop their own algorithms for assigning CCN (necessarily relying on the problematic NPI data described above). This could lead to misclassification of claims and will be a potential source of inconsistency. CMS should develop a protocol for assigning CCN to the encounter records and work with plans to ensure that encounter records contain the information needed to implement the algorithm.
- **Denied claims:** We encourage CMS to develop guidance for plans regarding how to populate encounter records for which the plan denied payment to the provider. Plans are required to submit encounter records for such claims, but the encounter data do not include a mechanism for identification of the denials.²² The Department of Health and Human Services OIG has recommended that CMS “require MAOs to definitively indicate on MA encounter data records when they have denied payment for a service on a claim” and stated that “knowing whether MAOs paid or

²¹Centers for Medicare and Medicaid Services Office of Enterprise Data and Analytics. 2023. Medicare Advantage Encounter Data Institutional Providers Analytic Approach. https://download.cms.gov/encounter_data/medicare%20advantage%20encounter%20data%20analytical%20methods_508.pdf.

²²Office of Inspector General, Department of Health and Human Services. 2023. *The inability to identify denied claims in Medicare Advantage hinders fraud oversight*. OEI-03-21-00380. Washington, DC: OIG.

denied claims is critical for oversight entities that use the MA encounter data to detect inappropriate billing patterns and investigate fraud, waste, and abuse effectively and efficiently.” We recognize that the standardized claims forms that are used to submit encounter data do not include a field intended specifically for denied claims. However, CMS recently announced that it has developed a Supplemental Benefit Indicator for the encounter data using the “paperwork” field in the claims forms.²³ It strikes us that this innovative approach, in combination with Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), and payment fields, could be used to develop an indicator for denied claims.

- **Out-of-network indicator:** As discussed above in the section about monitoring beneficiaries’ access to care, the lack of standardized information about plan provider networks makes it difficult for policymakers to discern how networks affect beneficiaries’ access to care. To facilitate an improved understanding of access, it would be useful to policymakers to have an indicator in the MA encounter data that could be used to identify services that are delivered out-of-network. We recognize that, in certain instances, MA organizations might not receive a claim for services rendered out-of-network, and so may not submit encounters for those services. However, policymakers are currently limited in their ability to determine the extent to which those services are being reported in the data, making it difficult to monitor the effects of networks on beneficiaries’ access to care. We encourage CMS to consider options for how this information could be added to encounter data: One option would be to require MA organizations to indicate out-of-network care on the encounter records they submit (using existing fields in the claims forms). Alternatively, CMS could use a national provider directory (like the one described above) to add the indicator to the data or confirm its veracity. A combination of the two approaches may be necessary to ensure that the indicator is reliable.

Altogether, these improvements would significantly improve policymakers’ ability to use the encounter data to assess MA enrollees’ access to care. The encounter data could be a valuable tool for policymakers seeking to monitor, learn from, and improve the MA program. However, incomplete reporting of the data, and several critical shortcomings, currently limit the value of the data. The Commission is eager for MA encounter data to achieve sufficient completeness to evaluate MA care delivery and service use.

Cost reports

MedPAC reports to the Congress each March on the Medicare FFS payment systems, the MA program, and the Medicare prescription drug program (Medicare Part D). Each year,

²³ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. HPMS memo regarding “Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records.” February 21. <https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-4-february-19-23>.

we evaluate the adequacy of Medicare's FFS payments to providers and make recommendations for how FFS payments should be updated. As more Medicare beneficiaries have enrolled in MA, it is increasingly important that we understand the effect MA has on providers' revenues and costs.

With this context, it is increasingly important that policymakers have insight into provider's margins on services provided to MA enrollees. The most straightforward way to get this information would be to update provider cost reports. For hospitals, this would require (at a minimum) creating new versions of the Worksheet D series (with MA days and charges, used to allocated costs) and E series (with payments received from MA plans). We encourage CMS to expand the cost reports to accommodate the collection of this additional detail.

Conclusion

MedPAC appreciates your consideration of opportunities to expand data collection to enable better monitoring of the MA program. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Michael E. Chernew, Ph.D.
Chair

MC/krs/sh/aj/er/ls