USC Schaeffer
Leonard D. Schaeffer Center
for Health Policy & Economics

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Administrator of the Centers for Medicare & Medicaid Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4207–NC
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RE: Solicitation of Comments on CMS-4027-NC; Response to Medicare Program; Request for Information on Medicare Advantage Data

The Centers for Medicare & Medicaid Service (CMS) has requested input from the public regarding the collection, administration, and dissemination of Medicare Advantage data.

We are public health researchers at the USC Schaeffer Center for Health Policy & Economics[1] with extensive work evaluating Medicare Advantage (MA), including more than 30 peer-reviewed publications covering a wide range of topics such as enrollment trends, prescription drug utilization management trends, comparisons of utilization in MA and traditional Medicare (TM), comparisons of provider payment in MA and TM, supplemental benefits and out-of-pocket cost reductions provided to beneficiaries by MA plans, favorable selection in MA, deficiencies in MA risk adjustment, fundamental problems in basing MA rates on county-level TM expenditures, and determinants of Alzheimer's diagnosis and treatment in MA. We have compiled suggestions related to (1) publicly available data and (2) administrative Encounter and Part D data, including additional data CMS should consider requiring plans to submit. We anticipate that our suggestions will improve MA transparency to better inform beneficiaries and taxpayers, be highly valuable for researchers, or both. While acknowledging that certain suggestions may entail administrative costs to CMS, insurers, or providers, we believe modest investments could facilitate critically important improvements to overall understanding of a program that enrolls 55% of Medicare Advantage eligible beneficiaries nationwide and accounts for $0.5 trillion in federal payments annually.

Improvements to Publicly Available Data

1. **Create MA-based Medicare Physician Utilization and Payment Data Public Use Files**
    a. CMS currently makes three datasets publicly available that contain the utilization of services and procedures provided to Medicare beneficiaries. The three datasets provide summary measures of total utilization and average payments at the provider level (e.g., the total number

[1] The views expressed in this letter are those of the authors and do not necessarily reflect the views of the USC Schaeffer Center or the University of Southern California (USC).

of TM beneficiaries seen by a provider), the procedure level (e.g., the total number of TM beneficiaries who receive a procedure), and the provider-procedure level (e.g., the total number of TM beneficiaries who receive a procedure from a provider). These files are currently based entirely on data from beneficiaries in TM.

b. Because adjudicated claims data (i.e., from TM) are inherently different than encounter records (i.e., from MA), we suggest that CMS continues to report these files based only on TM claims. In addition, we suggest creating a similar file based on MA Encounter data to characterize utilization rates among MA enrollees. Because the Encounter data do not contain payment fields, we understand that these MA files will only contain quantity-based variables, such as the total number of beneficiaries receiving care from a provider and the total number of services administered, and would not be able to contain measures related to average prices or charges.

c. We recognize that because the MA Encounter data is inherently different from and contains different fields than the TM claims data, variables created based on the Encounter data will have far greater measurement error than TM-based variables. However, the current dataset lacks information on half of Medicare enrollees. Reporting these TM-only and MA-only datasets separately, potentially with a caveat in the documentation, would allow the TM-based file to maintain the same level of integrity and comparability with past years while also allowing researchers to better understand provider case-mix and access among the MA population.

d. Even if CMS decides not to incorporate these suggestions regarding MA data, we recommend CMS include the socioeconomic or demographic composition of the patients seen by given providers in the existing Public Use File. Such information would enable researchers to better understand the demographic profile treated by different providers and assess research questions related to equity and access, which would contribute significantly to achieving the key CMS priority of improving health equity and addressing social determinants.

2. Require MA plans to maintain accurate, up-to-date provider directories, including key clinician information

a. CMS should require plans to upload lists of all in-network providers (identified by National Provider Identifier (NPI) or CMS hospital identifier (e.g., CMS certification number or CCN)) in a machine-readable format. Provider networks are an important dimension of plan quality but are difficult to observe, especially hospital networks.

   i. Maintaining accurate, up-to-date provider directories should generally parallel CMS requirements for reporting Part D pharmacy networks.

   ii. CMS should also require, as feasible, data on whether providers are accepting new patients and explore feasibility of reporting appointment availability and average appointment wait times.

b. Additionally, CMS should consider publicly listing the data that firms submit for their network adequacy evaluations.

3. **Report Part D premiums for MA plans (MA-PDs) both before and after "buy down" from MA supplemental rebates**
    a. Currently, CMS reports effective Part D premiums (i.e., those actually charged to beneficiaries) in the Plan and Premium Report data within the Part D Landscape Source files. For stand-alone prescription drug plans (PDPs), these data represent the actual plan premiums. However, for MA-PDs, these data represent the amount the beneficiary pays toward the Part D premium, which is generally not the same thing as the total plan premium, because many MA-PDs use a portion of their MA supplemental rebate dollars to "buy down" some or all of the Part D premium on behalf of beneficiaries. The difference is substantial; KFF reports that, in 2023, 73% of MA-PD enrollees paid nothing for their Part D premium (meaning the MA-PD "bought down" the Part D premium in full, which appears as a $0 premium in this file), and MedPAC reports that, in 2024, MA plans on average contribute $24 of supplemental MA rebates per member per month toward basic Part D premiums and an additional $34 per member per month toward supplemental Part D premiums.
    b. It is useful to researchers to know what beneficiaries are actually paying for Part D premiums, and we encourage CMS to continue to report these "post-buy down" Part D premium data. However, we encourage CMS to also report the "pre-buy down" Part D premiums (both basic and supplemental) for MA-PDs. These data would facilitate useful analyses of the Part D program, including comparisons across PDPs and MA-PDs, as well as enable analyses of an important component of MA supplemental rebate dollars, which are not currently feasible due to the lack of availability of these data.

4. **Report prior authorization denials at a more granular level**
    a. To understand MA utilization management prevalence and trends, it is important to understand the types of care that were sought out but initially or ultimately denied through the prior authorization process. To that end, clean claims are not sufficient, since they typically only present data on care that was ultimately received by the patient.
    b. In the past, CMS has provided data on the prevalence of denials at the contract level (2015-2021). CMS should consider continuing to report these data at the plan (not contract) level since plan-level data are relevant for beneficiaries choosing plans. It should also consider adding greater granularity to understand (1) the *types* of care that were initially denied, (2) the share of these instances that were appealed or ultimately denied, (3) the timeliness of this process, and (4) how these factors varied across plans (not just contracts).
    c. CMS should develop a standard template for plans to use to report their utilization management policies and requirements, with the results summarized in consumer-friendly formats included in Plan Finder.

5. **Report additional information on broker commissions**
    a. As documented by the CMS, there have been increasing complaints over broker behavior. Brokers can provide valuable information for enrollees making insurance decisions but can also face conflicts of interest, which have prompted recent rules capping compensation to brokers.
    b. Currently, publicly available data include only minimum and maximum broker commissions for each contract. This does not reasonably reflect actual commissions. CMS should consider

reporting average and median commission values to better capture the potential financial incentives for brokers.

6. **Improve documentation of plan payment dataset**
    a. While several datasets, such as the administrative TM claims datasets, include incredibly helpful and clear documentation on how variables were created and how they should be interpreted, some public datasets have less clear documentation. An example of this is the plan payment data, which provides very little information on how the data are generated or how to interpret the variables provided. For instance, from year to year, documentation is conflicting on whether plan payments and rebates are risk adjusted. Further, an unfamiliar user may mistakenly think that total average payments to plans for Parts A and B coverage include both bids and rebate payments. Improved documentation would clarify data elements and reduce the potential for misinterpretation by researchers.

7. **Require plans to report financial relationships/vertical integration with providers**
    a. As of 2015, researchers using hand-searching methods estimate that 22% of MA plans are vertically integrated with providers. Joint ownership with providers may generate greater efficiencies but could also produce conflicts of interest. However, currently there is no consistent reporting of these financial relationships.
    b. As discussed in Chapter 12 of the March 2024 MedPAC report, this lack of transparency is a major barrier to research. CMS should consider requiring plans to disclose any provider groups / entities (identified by NPI or CMS hospital identifier) with which they have joint ownership, a financial relationship, or an official joint branding.

8. **Require Employee Group Waiver Plans to report Part D plan data**
    a. Employee Group Waiver Plan (EGWP) enrollment is increasing and makes up nearly 20% of all MA enrollment. However, little is known about how these plans are designed, in part because data on EGWPs is less readily available.
    b. To better understand EGWPs, we suggest including their information in datasets, such as the Part D Formulary Extract, the Part D Tier Extract, and the Prescription Drug Plan Formulary and Pharmacy Network Public Use File.

Improvement of Administrative Encounter and Part D Data

Below are specific inadequacies in the administrative Encounter data that we have identified. By ensuring completeness of CMS Encounter data and rectifying the missing data fields documented below, more accurate and complete analysis of trends and differences between TM and MA could be developed by CMS and outside researchers. CMS should establish clear requirements for what needs to be reported (including the formats) and consider establishing incentives or penalties if there is continued failure to comply with the standards set. Note that we are unsure if some of the limitations we describe are due to lack of reporting from plans to CMS or lack of inclusion by CMS in the research dataset, but we highlight examples where better and more complete information would improve research and program evaluation.

1. **Ensure completeness of the MA Encounter data**
    a. A comprehensive MA Encounter dataset would be invaluable for comparisons between MA and TM. However, past work has documented high rates of incompleteness in the MA Encounter data in terms of total encounters captured by the dataset. Recent MedPAC analysis suggests that while data quality is improving, as of 2019, only 79% of inpatient stays have a corresponding encounter record, and this rate remains similar in 2021.
    b. In June 2019, MedPAC listed a number of recommendations to improve Encounter data, including providing greater feedback to plans on the accuracy of their submissions, incentivizing accurate reporting, and potentially collecting data through contractors. While we do not have insight into the relative costs of each of these approaches, we reiterate the substantial benefit of having accurate, complete Encounter data and encourage CMS to consider these MedPAC proposals.

2. **Provide an indicator for contract completeness**
    a. As long as the Encounter data remains incomplete, CMS should consider providing a dataset that identifies how each MA contract compares with external sources so researchers can judge the completeness of the data in a standardized fashion.
    b. Our group uses a measure developed by Jung et al that compares 2015 MA Encounter data with the Medicare Provider Analysis and Review (MedPar) and the Healthcare Effectiveness Data and Information Set (HEDIS) data to identify complete contracts.
    c. Our group has also assessed completeness of the Encounter data using a private data source with MA enrollees. We compared sample characteristics and rates of chronic conditions between the beneficiaries in the private data source and the same subset covered by the private company in the MA data. CMS could leverage private data in a similar fashion to assess the completeness of the data.

3. **Ensure performing physician field is populated**
    a. A much larger share of Encounter data compared to TM claims do not have a performing physician listed. This makes it difficult to identify provider participation and performance in MA.

4. **Report the CCN of institutional providers**
    a. While TM claims provide both NPI and CCN, MA Encounter data only provide NPI. This makes it much more difficult to identify hospitals and make comparable analyses across MA and TM.

5. **Provide an indicator for care that was received in-network or out-of-network**
    a. To better understand how networks shape patient access and cost-sharing, consider adding line-level indicators for care that was received in or out of network.

6. **Provide an indicator for use of prior authorization/denial**
    a. Adding an indicator for prior authorization or claim denial would help us better understand how utilization management impacts the cost burden for enrollees. While the Encounter data do not include cost variables, inclusion of denial indicators would help us better characterize

the share of services enrollees receive that insurance refuses to cover and for which beneficiaries may have to pay full cost.

7. **Use Encounter data to create analogous measures of chronic condition incidence in the Master Beneficiary Summary Chronic Conditions File (MBSF-CC) for MA enrollees**
    a. Subject to improvement of the quality of Encounter data, CMS should consider using the Encounter data to populate the MBSF-CC for MA enrollees as well (rather than only for TM enrollees, as is currently done). This would lower the barrier to research and would also facilitate analysis of the composition of the MA population.

8. **Develop a Limited Dataset (LDS) based on Encounter records**
    a. For research on TM, many researchers use the LDS, which includes beneficiary-level data with many variable fields removed or ranged that are present in the Research Identifiable Files (RIF). Because there are fewer privacy concerns with the LDS, the barriers to use for the data are generally lower than the RIF files since CMS does not require review by CMS's Privacy Board for use of LDS files and LDS files cost considerably less than RIF files.
    b. Creating an LDS dataset based on Encounter data that researchers could access at a lower cost would greatly help facilitate research on the MA program.

9. **Synchronize the release of MA Data with TM**
    a. Currently the Encounter Data is released 1-2 years behind the TM data, and closer to 3 years when considering the quarterly release of the TM data. Releasing quarterly updates of the MA Encounter data and annual updates aligned with the release schedule of TM would facilitate timely research comparing the two.

10. **Provide adjudicated diagnoses**
    a. The Encounter documentation provides information on how to adjudicate diagnoses. There are many nuances in approaching this programmatically that could impact the results. Providing adjudicated datasets in addition to the unadjudicated ones, or releasing official code for adjudicating the data, would ensure that all researchers using the Encounter data are starting from the same base of diagnoses.

11. **Address inconsistencies in the chart review data**
    a. The documentation notes that chart reviews would be identified with both the chart review switch and an original claim control number to link the chart review to an original encounter. In the data, we find records with an original claim control number and a null value in the chart review switch – about 6% of all Encounter records in the 2015-2016 Encounter data. We also find about 5% of all Encounter records are identified as a chart review with the chart review switch variable, but do not have a corresponding original claim control number. Providing clarity on this inconsistency would help ensure that chart reviews are correctly identified and analyzed.

12. **Provide information on type of payment structure**
    a. While cost information for MA plans is understandably difficult to provide, CMS should consider providing a useful categorical variable or dataset that identifies the type of payment structure (e.g. FFS, fixed fees, bonus plan, etc.) that plans employ to pay physicians and hospitals.

13. **Provide an indicator for whether care was received in or out of an integrated network**
    a. Research on quality of care would be facilitated by a variable that identifies whether an encounter or service was provided within or outside of an integrated network in which health care records are shared and care coordinated between providers.

14. **Separate MA Part D and medical premiums in the Part D Premium Extract**
    a. In MA plans with Part D coverage, the premiums reported in the Part D Premium Extract include both the cost of Parts A and B benefits as well as Part D drug coverage. These data would be much more informative for researchers if the Part D premiums were separated from the rest of the premiums.

The collection, administration and dissemination of MA and TM data by CMS is an invaluable resource for researchers to analyze and report on trends in the programs. We appreciate the opportunity to provide recommendations on ways in which the MA data could be improved and are available to discuss these recommendations in more detail. Please reach out to Stephanie Hedt (hedt@usc.edu) with any questions or to set up a meeting with the authors of this letter.

We look forward to hearing from you and further working together to improve MA data reporting.

Sincerely,

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