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May 17, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the request for information entitled "Medicare Program; Request for Information on Medicare Advantage Data," 89 *Fed. Reg. 5907* (January 30, 2024), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The AAMC appreciates CMS' interest in strengthening the availability of Medicare Advantage (MA) data. We have a specific interest in several MA data elements to improve health care delivery and health services research. Improving the collection and scope of data related to MA plans and beneficiaries will allow policymakers, researchers, and stakeholders to better analyze how these plans are meeting Medicare program goals, including garnering a better understanding of the value and quality of care offered through MA plans as compared to under Medicare FFS. This information will allow Medicare beneficiaries to make more informed decisions and compare coverage options more accurately. Currently, MA data is not as accessible or transparent as FFS data. Better aligning MA data accessibility and transparency with FFS data accessibility and transparency will better enable comparison of these Medicare coverage options not only for program oversight and integrity purposes, but also for researchers and other stakeholder to evaluate access to and the quality and costs of care furnished through these options.

ACCESS TO DATA

MA data is made available through research identifiable files (RIF) for public purchase, while Medicare fee-for-service (FFS) data is available for purchase as both limited data sets (LDS) and RIF. While the data available in RIFs is generally more robust, accessing RIFs involves additional steps and greater costs, creating a barrier that is insurmountable for some and limiting access for researchers with fewer resources. This discrepancy further showcases a gap in data accessibility and transparency between Medicare Advantage and Medicare FFS. Limiting publicly available MA data solely to RIFs excludes a large portion of stakeholders and researchers from accessing MA data. This is especially true in light of recent proposed policy changes from CMS that eliminate the use of physical data access and require use of the Virtual Research Data Center (VRDC) for RIF data beginning in 2025 at the earliest.[1] This change significantly increases barriers to research that is critical to providing evidence and answering questions that enable progress on critical issues, such as health equity, health access, health care quality and safety, cost, drug pricing, and many other federal policy priorities. The AAMC further outlined our concerns with these changes in an April 2024 letter to CMS.[2] Specifically, the barriers created by the policy changes will dramatically affect researcher's efforts, especially for smaller or early career researchers with limited funding and resources. With this in mind, we urge CMS to provide LDS for MA data in addition to the currently available RIFs so that researchers of all sizes and budgets have the opportunity to access this critical data. This would provide similar data access to what is currently offered for Medicare FFS.

ENCOUNTER DATA

Compared to the data availability and transparency in Medicare FFS, Medicare Advantage falls behind. Medicare FFS data submitted to CMS has one hundred percent claim completeness and includes payment information. In contrast, MA data submitted to CMS includes possible upcoding issues and since 2017 has contained only forty-nine to eighty-nine percent claim completeness depending on the setting, while publicly available MA data excludes payment information.[3] In addition to incomplete encounter data in MA, there are also challenges around the ability to estimate the quality of care provided to beneficiaries in MA plans as compared to FFS. While the beneficiary population for FFS is included in most IQR/OQR quality measures, the same is not true for those enrolled in MA plans. CMS is also not required to calculate and publicly report Medicare quality data related to claims, encounter, or administrative data-based measures for MA plans. However, they are required to calculate and publicly report this quality data for Medicare FFS.

With these discrepancies in mind, we strongly urge CMS to explore options to enforce the reporting of complete, timely, and accurate encounter data for MA beneficiaries across health care settings in order to capture all levels of care. As the majority of eligible Medicare beneficiaries are now enrolled in Medicare Advantage,[4] having complete and validated encounter data would allow researchers and stakeholders to evaluate data points such as observable utilization, with which accurate data can then be linked to

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[1] https://www.cms.gov/data-research/files-order/data-disclosures-and-data-use-agreements-duas/important-research-data-request-access-policy-changes-0

[2] https://www.aamc.org/media/75791/download?utm_source=sfmc&utm_medium=email&utm_campaign=highlights&utm_content=newsletter

[3] MedPAC analysis of MA encounter data and MedPAR, risk-adjustments, MDS, and OASIS data, https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf

[4] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

observed patient outcomes to draw conclusions on access and patient benefit. Without the availability of complete and accurate data, it is difficult to draw reliable conclusions regarding patient outcomes. Additionally, encounter data is utilized to calculate risk adjustment factors among other factors that have the potential to impact payments to providers. Without complete and validated encounter data, these calculations may not be accurate, and without access to the data used to complete these calculations there is a lack of transparency for providers, researchers, and other relevant stakeholders. As noted above, encounter data that is collected by CMS should be made publicly available for research purposes in addition to oversight use.

DATA RELATED TO PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

The AAMC appreciates the agencies recent policy changes to prior authorization reporting by requiring payers to publicly report metrics that include rates of denials, rates of denials that are reversed on appeal, and resolution timelines, for both standard and expedited requests. However, we urge CMS to work with plans to strengthen these requirements by also requiring additional reporting of more granular information on prior authorization requests to enable analysis of the types of services for which such requests are made. Additionally, with respect to which such requests are denied, we urge the agency to require additional reporting on the timeliness of determinations and reasons for denials, claims and payment requests denied after a service has been provided, beneficiary out-of-pocket spending, and disenrollment patterns stemming from these denials. These data points will allow policymakers and regulators to adequately oversee the program and create potential reforms as needed.

Data Related to Prior Authorization for Prescription Drugs

In addition, we urge CMS to expand its prior authorization data collection efforts to include prescription drugs. While CMS did take steps to expand publicly reported prior authorization metrics in its January 2024 Interoperability and Prior Authorization final rule, prescription drug information was excluded.[5] Excluding prescription drug information omits an important component of care, and a large segment of prior authorization that providers and patients experience. Prior authorization and step therapy requirements are routinely used by insurers to steer patients towards less expensive medications rather than the medications that the enrollee's provider has deemed clinically appropriate.[6] Research on the use of step therapy protocols among some of the largest U.S. commercial health plans showed that plans applied step therapy in 38.9 percent of drug coverage policies.[7] Without including prescription drugs in the data collection process, CMS will not be able to accurately capture how MA plans operate and the extent to which their polices impact patients or increase the administrative burden on providers.

Use of Algorithms and AI in Prior Authorization

As the use of algorithms and artificial intelligence (AI) continues to grow, the limited data about their inputs, performance, and usage becomes increasingly opaque. Recent media reports have highlighted the negative effects of unmonitored use of algorithms and AI in MA plans, specifically noting the harmful

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[5] 89 FR 8758

[6] See, for example, SP Pourali, et al., Out-of-pocket costs of specialty medications for psoriasis and psoriatic arthritis treatment in the Medicare population, JAMA Dermatol, 157:1239-1241 (2021), finding that 90 percent of Part D plans required prior authorization for the use of biologics in the management of psoriasis and psoriatic arthritis.

[7] 5 KL Lenahan et al., Variation in Use and Content of Prescription Drug Step Therapy Protocols, Within and Across Health Plans, Health Affairs, Vol. 40, No. 11 (Nov. 2021).

effects of these practices on patients.[8] As reported, AI-powered decision-making tools have been observed prompting providers to make more restrictive decisions regarding prior authorization and continuation of care than Medicare coverage guidelines. While CMS did address issues surrounding the use of algorithms and AI in a FAQ titled "*Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)*"[9], we remain concerned around the lack of transparency and data available regarding the use of algorithms and AI by MA organizations. Additionally, in April, the Office of Management and Budget (OMB) released a memo including government-wide policies related to AI to minimize potential risks, while still benefiting from its usage.[10]

Considering this increased interest and concern around the use of AI, the AAMC urges CMS to require public reporting of the use of algorithms and AI and by MA organizations for the purpose of prior authorization as well as any additional uses. Further, it would be beneficial to understand the categorization of these algorithms to gain insight into how these algorithms are being applied. For example, reporting if an organization is utilizing an algorithm or AI to assist in informing decisions related to the level of care or length of stay would give policymakers and providers a greater insight into how plans are using these programs to help navigate patient care. Lastly, understanding what types of data inputs are being analyzed by these algorithms allows for greater oversight on the use of algorithms and AI to further ensure equity in their use. The data inputs used in an algorithm or AI program work to train the program and plays a vital role in either creating or eliminating potential bias depending on the source and validity of the data used. Creating transparency around training these relatively new technologies builds trust and allows for greater oversight in order to ensure equity and fairness in the use of these programs. Within the April memo from OMB were several guidelines for how to manage risk from the use of AI including requiring all agencies to implement minimum practices around managing risks from safety-impacting AI and rights-impacting AI. Several of these policies highlight a first step in ensuring equity and safety in the use of AI, as well as preventing discrimination caused by AI algorithms. Many of these policies address our concerns related to AI as we have outlined above.

DATA RELATED TO BENEFICIARY ACCESS TO CARE

The AAMC is committed to supporting beneficiary access to care. Complete and sufficient data related to beneficiary access to care is needed, including complete and up-to-date data on provider directories and networks, to provide for greater oversight of plans, support beneficiaries' informed decision-making, and improve beneficiaries' ability to access care. Provider networks and directories are a list of doctors, other health care providers, and hospitals that an MA plan contracts with to provide medical care to its beneficiaries. Beneficiaries often use these directories to identify providers they can access that are 'in-network,' while CMS may utilize provider networks to oversee network adequacy standards. For example, between September 2016 and August 2017, CMS found that out of 6,841 providers reviewed at

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[8] STAT News, "How UnitedHealth's acquisition of a popular Medicare Advantage algorithm sparked internal dissent over denied care" (July 11, 2023) by Casey Ross and Bob Herman, available at: https://www.statnews.com/2023/07/11/medicareadvantage-algorithm-navihealth-unitedhealth-insurance-coverage/ ; STAT News, "Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need," (March 13, 2023) by Casey Ross and Bob Herman, available at: https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/
[9] https://www.aamc.org/media/74896/download?attachment
[10] Office of Management and Budget, (2024). *Advancing Governance, Innovation, and Risk Management for Agency Use of Artificial Intelligence* https://www.whitehouse.gov/wp-content/uploads/2024/03/M-24-10-Advancing-Governance-Innovation-and-Risk-Management-for-Agency-Use-of-Artificial-Intelligence.pdf

14,869 locations, 52.20 percent of provider directory locations listed by MA online provider directories had at least one inaccuracy.[11] Health plan directories are often the first source used by patients to identify health care providers and check whether a clinician is within their health plan's network and taking on new patients. Specific to Medicare Advantage, beneficiaries are more likely to utilize their plan's directories (compared to other sources) to find a new doctor in comparison to Medicare FFS beneficiaries, with one third of MA beneficiaries using their directory to find a new doctor in the past twelve months.[12] However, as highlighted by CMS' review, health plan directories often contain outdated or even erroneous information frustrating patients and providers alike. Having up-to-date provider directories can assist not only beneficiaries in identifying and accessing providers, but can also assist in facilitating care coordination, health information exchange, and advance public health data reporting and research.

Additionally, delineating between specialties and types of services within provider directories is especially meaningful for beneficiaries in need of specialized care. Certain MA plans use narrow networks that often exclude teaching health systems and hospitals and their associated providers who furnish primary, specialty and subspecialty care and behavioral health services. To ensure access and the availability of subspecialty care and behavioral health care, it is imperative that network adequacy standards be met and that beneficiaries have the proper information to be able to access and identify these providers that are in their network. Teaching health systems and hospitals and their associated physicians and other providers are an important part of ensuring access to high-quality, cutting-edge treatments. Ensuring providers are included in-network and that provider directories are up-to-date allows beneficiaries to identify these institutions and physicians within their network that are accessible to them in order to receive specialized and sub-specialized care and behavioral health services that often are only furnished at teaching hospitals and health-systems. Ensuring this allows beneficiaries to access a greater number and type of providers, in order to meet their health care needs and improve health outcomes.

The AAMC previously submitted comments to CMS in a response to a 2022 request for information (RFI) entitled, "Request for Information; National Directory of Healthcare Providers & Services," 87 FR 61018, in which we strongly supported efforts to build stakeholder consensus to inform the future development of a centralized solution to improving health plan directories to improve patient experience and reduce burden for providers.[13] We continue to support this effort, especially as it pertains to improving data collection for MA plans. As noted in our response to the 2022 RFI, there is often great cost for physician practices to maintain directory information, coupled with frustration due to "varying frequencies and levels of detail at which different directories require information."[14] Creating more standardization in the information collected and streamlining collection and reporting efforts in a way that alleviates burden and frustration from providers is imperative. As stated in our previous comments, we urge CMS to consider positive incentives to encourage updates and reporting on provider directories with the aim of improving the accuracy of information, reducing burden on providers, and improving the ability of patients to access meaningful information. Negative incentives will only frustrate and take away from the intent of improving systems for stakeholders.

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[11] https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/provider_directory_review_industry_report_round_2_updated_1-31-18.pdf

[12] Gretchen Jacobson et al., What Do Medicare Beneficiaries Value About Their Coverage? Findings from the Commonwealth Fund 2024 Value of Medicare Survey (Commonwealth Fund, Feb. 2024). https://doi.org/10.26099/gq43-qs40

[13] https://www.aamc.org/media/64121/download?attachment

[14] 87 FR 61018

Lastly, to the extent possible, CMS should expand data collection efforts related to provider networks and network adequacy at the plan level, rather than the organization level, to ensure beneficiary access and oversight of plans. MA organizations generally have multiple plans within the same service areas; however, these plans may not include all the same providers in a network. Tracking at the organization level would mask these differences in plans. Focusing on the plan level allows for greater detail in beneficiary access to care. Additional granularity in network adequacy data and tracking will allow beneficiaries and providers to better compare to other types of Medicare coverage options such as Medicare FFS, which becomes especially meaningful when considering quality. Access to accurate provider networks and network adequacy data at the plan level becomes especially important for beneficiaries in need of specialty care as MA plans are less likely than FFS plans to include an adequate number of providers such as cancer centers and geriatricians, endocrinologists, and psychiatrists.[15]

DATA RELATED TO CARE QUALITY AND OUTCOMES

Beneficiary Access to Care as a Measure of Quality

In addition to our comments regarding provider directories and network adequacy, the AAMC believes that there is a need for additional quality metrics for MA plans to report regarding their use of prior authorization. Specifically, the AAMC strongly supports the use of the "Level 1 Denials Upheld Rate Measure" for use in the Medicare Part C Star Ratings Program. This measure would assess MA plans on the rate at which Level 1 appeals of prior authorization request denials reviewed by health plans internally find the original determination to deny coverage to be reasonable. There is currently a measure that focuses on Level 2 appeals, which are reviewed by an external independent reviewer. By adding a complementary measure with focus on Level 1 appeals, which occur earlier in the process, plan enrollees (and potential future enrollees) can assess the rate at which plans uphold prior authorization denials and whether the plan is able to efficiently ensure that patients are able to get necessary care in a timely and appropriate manner. This is especially critical in consideration of the U.S. Department of Health and Human Services Office of Inspector General report finding improper denials by some plans raising concerns about patient access to medically necessary care in the MA program.[16] The measure is meaningful to patients and health care providers, and measure documentation demonstrates high reliability and usability in the MA Star Ratings Program.

Comparing Beneficiary Care Quality and Outcomes Across Medicare Program

The AAMC believes there is great need to better measure quality of care received by Medicare patients covered by MA plans, and to be able to compare quality of care between MA and FFS Medicare, but we are concerned that it will not be feasible to do so reliably due to incomplete data for the MA population. The Medicare Payment Advisory Commission (MedPAC) has noted impediments when assessing the completeness of MA encounter data – in September 2022 it found that 21 percent of MA inpatient stays

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[15] MedPAC, (March 2024). *Report to Congress: Medicare Payment Policy* https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

[16] *See* U.S. Department of Health and Human Services Office of Inspector General, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (2022).

had no matching encounter record.[17, 18] Furthermore, MedPAC stated in its March 2022 Report to Congress that "[t]he current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA" due to the incomplete data.[19] In 2019, MedPAC recommended that Congress take action to ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with fee-for-service Medicare.[20] This recommendation is reiterated in the Commission's March 2024 Report to Congress, suggesting that the Commission has yet to observe improvement in the underlying quality of the data to facilitate comparisons with FFS Medicare.[21] We recommend that CMS consider policies to ensure that MA plans provide complete encounter data to the agency that can be relied on for quality measurement. This could be achieved by setting new data completeness requirements for plan payment and/or adopting sufficient penalties for plans that submit incomplete data.

Comparing Value-Based Care Arrangements in MA with Traditional Medicare

The AAMC shares the agency's commitment to value-based care in part through its goal of having all people with Traditional Medicare in an accountable care relationship with their health care provider by 2030. Considering the year-over-year growth in the number of patients enrolled in MA plans rather than Traditional Medicare, we urge the agency to consider collecting data from MAOs on the value-based insurance design(s) of its MA plan offerings, including whether the MAO enters value-based payment arrangements with contracted health care providers, including accountable care organizations (ACOs), episodic payments, total or partial capitation arrangements, and/or payments or bonuses tied to quality performance. We believe this could provide an opportunity to use that data to better compare value-based care arrangements across the Medicare program. Such information could also help better inform patients on how their health care provider is engaged with their MA plan to deliver high-quality, high-value care, as well as help inform Innovation Center model development and design.

DATA RELATED TO SUPPLEMENTAL BENEFITS

As of 2023, more than 9 in 10 MA enrollees are in plans that provide additional supplemental benefits, such as eye exams, dental, and fitness benefits.[22] Additionally, plans may offer Special Supplemental Benefits for the Chronically Ill (SSBCI) which are offered in the form of reduced costs sharing for Medicare covered benefits, reduced cost sharing for primarily health related supplemental benefits, additional primarily health related supplemental benefits, and/or non-primarily health related supplemental benefits. These benefits support a wide range of needs including food insecurity, transportation, social needs, in-home support, and many other needs. Often these supplemental benefits are marketed heavily to beneficiaries and in turn play a significant role in their enrollment decisions based

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[17] L Serna and A Johnson, Medicare Advantage encounter data, slide 8, Medicare Payment Advisory Commission (September 2022).
[18] S Hammon, A Johnson, and L Serna, Assessing consistency between plan-submitted data sources for Medicare Advantage enrollees, slide 8, Medicare Payment Advisory Commission (April 2024), finding that updated assessments of MA encounter data are consistent with findings in September 2022.
[19] MedPAC March 2022 Report to Congress, Chapter 12: The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans (March 2022).
[20] MedPAC June 2019 Report to Congress, Chapter 7: Ensuring the accuracy and completeness of Medicare Advantage encounter data (June 2019).
[21] MedPAC March 2024 Report to Congress, Chapter 12: The Medicare Advantage program: Status report, page 398 (March 2024)
[22] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

on the supplemental benefits advertised to them. While the availability of these benefits is widely reported, currently, there is limited information available to analyze the utilization and out-of-pocket spending associated with these additional benefits.

In response to the increased interest in MA supplemental benefits, CMS released additional guidance requiring the reporting of encounter data for the use of MA supplemental benefits beginning with contract year 2024.[23] The AAMC thanks CMS for providing this guidance and clarification; however, we urge CMS to continue to monitor reporting efforts and work swiftly to allow public access to this data as well as address any additional challenges that may arise and hinder the ability to collect this information. The availability of supplemental benefit utilization data will allow CMS and relevant stakeholders to have a greater understanding and oversight of how these benefits are used as well as allows for the analysis of the effects these benefits have on improving beneficiary health. In turn this deeper understanding can assist in tailoring supplemental benefits offered to improve health outcomes and the overall well-being of beneficiaries. In addition to utilization data, having data on the out-of-pocket spending associated with these additional benefits is also valuable. Beneficiaries enrolled in special needs plans (SNPs) are more likely to be in plans that offer SSBCI when compared to other MA enrollees.[24] Additionally, beneficiaries enrolled in SNPs tend to have significantly lower incomes and a greater likelihood of receiving Medicaid benefits or LIS than other Medicare beneficiaries.[25] Knowing this, it is imperative to understand the affordability, including out-of-pocket costs, of these additional benefits for beneficiaries in order to ensure continued access to these additional benefits. Therefore, we urge CMS to improve the data collection and transparency around the out-of-pocket spending associated with these additional benefits to improve oversight and ensure access to these services.

DATA RELATED TO SPECIAL NEEDS PLANS FOR BENEFICIARIES DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

As noted above, MA Organizations also offer special needs plans, which are specifically designed to provide targeted care and limit enrollment to special needs individuals. A subset of these plans includes special needs plans focused on beneficiaries dually eligible for Medicare and Medicaid (D-SNPs). The number of individuals enrolled in MA D-SNPs continues to increase, accounting for half of all MA enrollment growth between 2022 and 2023, resulting in a higher MA enrollment share among dually-eligible individuals (56 percent) compared to non-dual eligible (47 percent). Of those who are dually-eligible, 62 percent were enrolled in a D–SNP.[26] Similar to other MA plans, there is a lack of data transparency as it relates to several factors of these plans including prior authorization and supplemental benefits. The KFF reports[27] that contracts containing exclusively D-SNPs (but no other plans) deny prior authorization requests at a much higher rate than MA plans overall, even though organizations with contracts containing only D-SNPs received few authorization requests per enrollee. However, as prior

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[23] Centers for Medicare and Medicaid. (2024). *Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records* https://leadingage.org/wp-content/uploads/2024/02/Submission-of-Supplemental-Benefits-Data-on-Medicare-Advantage-Encounter-Data-Records_508.pdf

[24] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

[25] https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ

[26] MedPAC, (March 2024). *Report to Congress: Medicare Payment Policy* https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

[27] https://www.kff.org/medicare/issue-brief/10-things-to-know-about-medicare-advantage-dual-eligible-special-needs-plans-d-snps/

authorization requests and denials are currently reported, evaluating the impact for D-SNPs overall or per person in not possible.[28] As noted above, D-SNP enrollees are more likely to be enrolled in a plan that offers SSBCI compared to other MA enrollees, which highlights a need for greater insight into the utilization of supplemental benefits for this specific population as use of these benefits could impact health outcomes. As the number of individuals in these types of plans continues to increase, so does the need for accurate data, which will allow for a greater understanding of how these plans address the needs and improve health outcomes for some of Medicare Advantage's most vulnerable enrollees. With this in mind, we urge CMS to explore additional policies for data transparency related to D-SNPs in order to ensure and maintain equitable access for this population of MA enrollees.

DATA RELATED TO PAYMENTS

Lastly, as we ask the agency to focus on the completeness, accuracy, and accessibility of encounter data, we also urge CMS to consider expanding what is included in the encounter data collected and made public. Specifically, we urge CMS to include standardized costs in the MA encounter data that the agency provides, and if needed, explore additional pathways to collect such data if such pathways do not currently exist. Further, it would be beneficial for researchers to understand the types of provider payments utilized by MA plans at the beneficiary level. Specifically, being able to identify if the plan provides payments to providers through fee-for-service payments, capitated payments, bundled payments, or some other combination or methodology. Lastly, providing data around MA plans payment timelines would also be beneficial for providers. Medicare FFS payment timelines have historically been quick and if paid after 30 days includes interest, whereas MA payment timelines often can be drawn out due to prior authorization and claims denials creating uncertainty for providers. Understanding these provider payments and timelines will allow stakeholders and researchers to better compare and evaluate MA plans as they relate to Medicare FFS, including evaluating for the allocation of resources and savings in providing care.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Katie Gaynor at kgaynor@aamc.org.

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer

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[28] Ibid.