



May 28, 2024

Secretary Xavier Becerra  
Department of Health and Human Services  
200 Independence Ave., SW  
Washington, D.C. 20201

**Re: Request for Information on Medicare Advantage Data**

Dear Secretary Becerra,

Thank you for the opportunity to provide comments and recommendations on strengthening the value of Medicare Advantage data for the Centers for Medicare and Medicaid Services. With over fifty percent of the Medicare eligible population in the MA program and looming estimates for the Medicare Trust Fund insolvency, the timing is ripe to take steps to strengthen and improve the program. As you know, the Alliance of Community Health Plans (ACHP) launched [MA for Tomorrow](#), an initiative to address concerning trends in the MA program and offer recommendations to ensure robust and high-quality coverage options for America's seniors. Data and transparency are key aspects of *MA for Tomorrow* and for creating a competitive landscape for beneficiaries' choice.

ACHP represents the nation's top-performing non-profit health plans improving affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that deliver high-quality coverage and care to tens of millions of Americans across nearly 40 states and D.C. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data driven systems improvement.

ACHP member companies leverage robust data sets to identify coverage, care and business trends to better serve patients and communities. The desire for more data is understandable but can be overwhelming. While data can offer valuable insight, it's imperative to consider the value of the information and how it can be used. In health care, access to more data almost always equates to increased administrative burden and therefore increased administrative costs. ACHP strongly requests that any new data collection and reporting requirements be designed to minimize the administrative burden for all stakeholders while also considering the implementation of other health IT and data requirements currently underway.

Given several new requirements on data reporting and transparency, ACHP is particularly interested in opportunities to improve how CMS leverages currently available data. ACHP encourages CMS to publish an inventory of MA plan data currently collected and made publicly available along with descriptors of how CMS uses it. These efforts will ensure that any additional data requirements are not redundant to existing requirements. CMS should also emphasize the proposed use of the data for any new requirements to prevent data collection for its own sake.



### **MA for Tomorrow Data Recommendations**

ACHP's *MA for Tomorrow* initiative consists of five pillars to strengthen and improve MA, including specific data improvement recommendations. These reforms prioritize greater choice and higher quality for seniors while ensuring long-term sustainability of the MA program.

#### ***Advancing Risk Adjustment for Care, Not Codes***

Risk adjustment, when done accurately and appropriately, provides health plans with the necessary resources to effectively manage beneficiaries' varying care needs. Unfortunately, risk adjustment can generate perverse incentives to aggressively code beneficiary risk to yield larger payments. Shifting from fee-for-service claims data to MA encounter data to calibrate the risk adjustment model would more accurately reflect care needs and diminish the opportunity to code inappropriately. MA encounter data captures relevant data elements needed to assess risk. CMS has been collecting this data for over 10 years and should take the necessary steps to re-calibrate the risk adjustment model.

#### ***Raising the Bar on Quality***

High quality coverage and care are defining features of the MA program. However, current quality data collection methods, electronic medical records and consumer surveys fail to fully capture demographic, access, outcome and experience data. These methods often exclude consumers with limited technology access, people of color and those with English as a second language. Given the importance of measuring the quality of coverage and care within the MA program, it is time to leverage new technologies to collect data. These improvements include expanding data collection modalities, simplifying survey length, reframing survey questions, integrating survey results and timelier survey release. Quality reporting is critical for evaluating the MA program and as a selection criterion for seniors. However, the information is only as good as the tools used to capture the data.

#### ***Transforming Benchmarks***

With increasing attention on the accuracy of MA payments, the use of the data is equally important as the type and quality of the data. MA benchmarks, the cornerstone of MA payments, are based on fee-for-service data. With more than half of eligible Medicare beneficiaries not in fee-for-service, the current MA benchmark does not appropriately reflect the MA population, particularly as benchmarks are based on a dwindling number of fee-for-service beneficiaries. To have the most accurate and comprehensive picture of the MA program, benchmarks need to be modified using the most appropriate data. ACHP's *MA for Tomorrow* proposal provides two recommendations to transform benchmarks.

First, MA benchmarks can no longer be based on consumers with *either* Medicare Part A of Part B. This skews the average cost of delivering care when comparing those costs to consumers enrolled



in *both* Medicare Part A and Part B. Basing benchmarks on both Medicare Part A and Part B beneficiaries reflects the changing demographics and characteristics of the MA and MA eligible populations. CMS has confirmed it has the authority to modify the MA benchmark methodology and ACHP believes CMS must do so in the CY 2026 Rate Announcement.

Second, as MA approaches or becomes the majority, of enrollment in a county, the reliance on county level fee-for-service data becomes a less appropriate comparator. A more accurate comparator for establishing benchmarks would be a 50/50 blend of national and local fee-for-service costs.

### **Additional MA Data Recommendations**

#### ***Provider Directories***

Improved data processes for provider directories can dramatically reduce burden for payers and providers and increase the value of these tools for patients. Specifically, a national provider directory with standardized data elements and reporting would streamline the current process. ACHP member companies dedicate significant financial and human resources to maintaining and verifying provider directories. Unfortunately that investment does not always equate to directory accuracy, due in large part to factors outside of payers' control. Health plans have highly individualized data collection processes. Completion of these processes depends on providers, who likely contract with several payers, often resulting in payers not receiving timely or accurate information and prompting additional outreach to providers. Meanwhile, providers are fielding multiple requests, dedicating valuable staff time and resources to submitting the data rather than using those staff resources for patient care.

A single source of truth would significantly improve this uncoordinated approach to collecting and sharing provider information. Providers would be required to update information directly in a single location, the national directory, as opposed to each plan individually at multiple times throughout the year. Plans could regularly retrieve that information for contracted providers. This would drastically reduce the information that providers need to submit and facilitate improved auditing activities to ensure accuracy. As an initial step in advance of a national provider directory, CMS could establish industry standards on provider information collection to improve directory accuracy.

#### ***Supplemental Benefits***

ACHP agrees with CMS, MedPAC and other stakeholders that additional transparency around supplemental benefits is valuable. New requirements on supplemental benefit utilization will go into effect next year [CMS 2025 MA and Part D final rule (CMS-4205-F)]. This will offer early insight into the anticipated challenges and realities of collecting and reporting supplemental benefit data. Currently, ACHP member companies relying on vendors for supplemental benefit offerings are not always guaranteed standardized, streamlined or consistent data and reporting. The quality of the



data largely depends on vendor companies and the specific benefit. If CMS requires additional supplemental benefit data collection and reporting, then it should consider a robust standards development process supported and vetted by the payer and vendor community. This would ensure thoughtful development of supplemental benefit reporting metrics and reduce unnecessary or excessive reporting.

MA plans' ability to offer innovative and flexible supplemental benefits is a key differentiator and valuable for seniors' plan choice. As CMS evaluates supplemental benefits, ACHP stresses that utilization of benefits among all members is not indicative of its value to a subset of beneficiaries. Some benefits may be highly valuable to some individuals and not others.

### ***MA Marketing and Consumer Navigation***

ACHP congratulates CMS for reforming agent and broker compensation to improve consumer navigation during the MA enrollment process. These reforms remove incentives to enroll seniors in certain plan products based on broker enrollment bonuses. Improvements to the Medicare Plan Finder that prioritize high quality rated plans would complement these new reforms. Currently, the Medicare Plan Finder lists plans alphabetically rather than by star rating unless a consumer opts to filter by star rating.

Defaulting to star rating over alphabetical order, rather than leaving it as optional criteria, encourages consumers to shop with quality in mind. It is imperative that quality and cost information are readily available to consumers to select the coverage option that best meets individual needs.

### ***Social Drivers of Health and Health Equity***

Rooted in its communities for decades, ACHP member companies have long been committed to addressing health disparities through culturally informed and population specific interventions. While health equity is a core priority for the Administration – and the member companies of ACHP – the framework of the Medicare Advantage Health Equity Index (HEI) falls short of achieving its intended aim. As currently constructed, the index takes a narrow view of what qualifies a beneficiary as having social risk factors, creating a prisoner's dilemma for health plans most invested in its success. Technical shortcomings in the design of the program and conflicting state contracting requirements will result in millions of Americans – and the health plans that serve them – being left out of this important new initiative. We call on CMS to revise the calculation eligibility threshold in the CY 2026 MA and Part D rule to allow all health plans the opportunity to earn the HEI reward.

Improved data collection and standards for social drivers of health data and health equity metrics will help MA organizations manage the ongoing influx of the Baby Boomer population into the MA program. Improved data for social determinants of health and health equity enables plans to develop robust, targeted coverage options and care management to address rising care demands



and costs of this population. Data reforms must encompass program specific adjustments and increased emphasis on public-private partnerships.

Enhanced quality and risk adjustment data is essential to allow MA organizations to better address social drivers of health and health inequities. Because the MA program lacks data standards and sufficient data collection methods for social drivers of health, this vital information is not appropriately captured in risk adjustment models. Incorporating social drivers of health in community-reviewed and endorsed risk-adjustment models will ensure MA organizations are adequately prepared to meet beneficiary needs. In addition, CMS should improve quality measurement surveys to assess health literacy and cultural competency to better serve diverse populations.

CMS can partner with the industry on proven successes in collecting, standardizing and integrating data to improve outcomes in the private sector. Those advancements could be scaled with assistance from the federal government and modeled after existing public-private partnerships, such as the federally-recognized coordinating entity for the Trusted Exchange Framework and Common Agreement. A separate entity for social drivers of health data could establish and improve health equity data standards and data collection methods, with an emphasis on disaggregated race, ethnicity, age and disability data. Absent a recognized coordinating entity, federal and stakeholder partnerships should be supported with resources to develop standards and guidance for capturing, documenting and using data related to individual social needs. Community based organizations are essential entities in addressing social drivers of health and closing health equity gaps. Advanced opportunities to create and strengthen data exchanges between these organizations, regional payers and providers would ensure continuity of care and promote trusted pathways to services.

### ***Utilization Management Data***

ACHP appreciates the recent reforms to utilization management data collection and reporting within the CMS 2025 MA and Part D final rule (CMS-4205-F) and the CMS Interoperability and ePrior Authorization final rule (CMS-0057-F). ACHP supports the new requirements to increase transparency into prospective coverage determinations. The requirement for a health equity analysis may deliver valuable insights. However, comparing prior authorization approvals/denials among 10 different groups of enrollees with social risk factors may not yield meaningful insights based on the assumption that discrepancies indicate discriminatory utilization management policies. CMS should consider a more meaningful analysis of health equity for prior authorizations that would consider a wider breadth of information related to members with specific social risk factors, such as claim types that are more commonly submitted for those with social risk factors.

While ACHP supports increased transparency and modernizing data standards, we remind HHS that regional, non-profit health plans have operating margins of less than two percent. The IT departments within our member companies often balance several competing priorities. We caution against significant additional data and reporting requirements until health plans can address those



on deck, and the industry better understands the use and value of the newly available transparency data.

We appreciate this opportunity to provide comments and recommendations to improve MA data collection, use and transparency. We encourage CMS to closely engage with ACHP and its member companies to consider new data collection and reporting requirements, captured through the rulemaking process. Please contact Dan Jones, Senior Vice President, Federal Affairs at [djones@achp.org](mailto:djones@achp.org) with any questions or if we can provide further information.

Sincerely,

Ceci Connolly  
President and CEO