



May 29, 2024

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS-4207-NC: Medicare Program; Request for Information on Medicare Advantage Data

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Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Request for Information on Medicare Advantage (MA) Data ("RFI").

The Task Force is a collaborative that supports accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

**I. Consistent Definitions in Any New MA Data Collection Efforts**

Task Force members believe that any new MA data collection efforts need to center on consistent definitions and interpretations of specific terms. Our experience is that a specific word or phrase can be subject to different definitions or interpretations across Medicare policies. Given the time and effort that any new data collection will require, being as clear as possible about the definition of the data elements and scope of collection is of paramount importance.

## **A. Value-Based Care/Value-Based Payment**

The concepts of value-based care and value-based payment are generally understood yet can be subject to different specific definitions in practice. Any new MA data reporting requirements should be offered in the context of proposed definitions of these terms to which the public can respond to. For purposes of value-based payment, the Task Force strongly urges CMS to use the [Health Care Payment Learning and Action Network's \(LAN\) Alternate Payment Model \(APM\) Framework](#). The APM Framework defines four APM categories, and the LAN already collects data from commercial payers regarding their value-based payment models in Medicare Advantage, state-based, and commercial lines of business. Similarly, providers, physicians, and other clinicians also recognize this centralized framework. While supportive of using the LAN APM Framework, our members note that some definitions in the Framework may be ambiguous, especially in the context of how certain CMS Innovation Center model are characterized, which impact whether these models qualify as Advanced APMs.

A specific definition of value-based care has a less common understanding, with proponents discussing a range of possibilities, including the Triple Aim, the Quintuple Aim, promoting health equity, and driving person-centered care. A desirable path forward would be for CMS to propose a definition of this term in the context of any specific reporting obligation and provide an opportunity for public comment before finalizing. Task Force members realize that CMS may want to consider different definitions for different audiences or contexts. The Task Force believes any definition should be sure to drive accountable care and not dilute the concept as originally contemplated.

## **B. Health Equity**

As health equity policies continue to evolve, the collection of demographic and health-related social need (HRSN) data should be defined using accepted industry standards. For demographic data, Task Force members believe the Health Care Effectiveness Data Set (HEDIS) is an effective measure set, with the United States Core Data for Interoperability (USCDI) Version 3 (defined by the Office of Management and Budget) as another accepted standard. For HRSN data, Task Force members largely have adopted the Gravity Project's standards. The Task Force urges CMS to propose and seek public input on what health equity standards should apply to different data collection efforts. If CMS mandates the use of any one standard for a particular activity, MA plans should be given sufficient time to implement changes to their data infrastructure before reporting obligations begin.

## **II. New Data Collection and Reporting Requirements Should Be Reasonable to Achieve a Stated Purpose Not Currently Being Met**

Any new MA plan data collection and reporting requirements should be reasonable and for a stated purpose that is not served by current data collection and reporting requirements. Prior to any proposed expansions of MA plan data requirements, the Task Force urges CMS to publish an inventory of the MA plan data that is currently collected and publicly reported, as well as information on how CMS uses each of these existing data sources.

New reporting requirements should not be redundant of existing requirements and should be proposed with a specific use case(s) for the targeted data. CMS should consider current health information technology and other data systems and infrastructure limitations, such as the structure of the data, the mechanisms through which data can be transmitted, and a realistic timeline over which any new systems or architecture will need to be developed and operationalized to support new data requirements. A good example of where these considerations are critical is if new reporting requirements were to link administrative data with data collected and housed in electronic health records. These systems should be sufficiently flexible to accommodate variation in current MA plan benefit design and not restrict future innovation in plan benefit design for areas like supplemental benefits.

MA supplemental benefits are another example of an area for further exploration. With recently adopted policies, CMS will now be receiving supplemental benefit information in different ways – both in the aggregate and individual level reporting. Similarly, there are specific supplemental benefit reporting obligations in the CMS Innovation Center’s Value-Based Insurance Design model. The Task Force urges CMS to allow these new data reporting policies regarding supplemental benefits to be implemented and take hold for a meaningful period before additional supplemental benefits reporting obligations are considered.

## **III. New MA Data Requirements Should Focus on Improved Comparisons to Traditional Medicare**

Any new data collection and reporting requirements for MA plans should be aligned with CMS alternate payment models (APMs) requirements, and possibly to Traditional Medicare requirements as well. As CMS develops its perspectives about what success in value-based care means, it is a worthy policy objective to compare success metrics between MA plans, APMs and Traditional Medicare more broadly. Therefore, there should be parallelism between Traditional Medicare and MA data collection and reporting requirement to the extent possible.

One area where this parallelism could take hold is quality measurement. CMS’s Universal Foundation for Quality Measurement provides a good foundation for alignment to ensure that

quality of care can be measured similarly in both Traditional Medicare and MA, although equally important is that measure burden across programs be reasonable and that CMS should seek to reduce measures whenever possible.

#### **IV. New MA Plan Data Requirement Should Include Public Disclosure Safeguards**

CMS should ensure that any new data collected from MA plans and made publicly available is reported at an appropriate level of aggregation, to protect proprietary or otherwise commercially sensitive information as well as individual enrollee data from being publicly disclosed and improperly used by third parties. All public disclosures of aggregated data should be accompanied with appropriate safeguards to be sure the data is only used for the intended purpose.

#### **V. New MA Plan Data Requirements Should Be Promulgated Through Rulemaking to Ensure Necessary Public Input**

The process by which CMS develops new MA plan data requirements should be iterative and give all stakeholders – not just MA plans but also their provider networks and representatives of their enrollees – an opportunity to provide input and respond to proposals. By actively seeking public input, CMS may find ways that are more effective and efficient to achieve their stated goals and learn why certain approaches may not be tenable. Notice and comment rulemaking is the way to achieve this objective, like how CMS handles annual updates to other MA policy requirements.

#### **VI. New MA Plan Data Requirements Could Inform National Standards for Denial Codes**

There is concern among Task Force members that no national standards currently exist regarding health plan codes for denials of both medical claims and prior authorization requests. CMS could collect information from MA plans regarding current usage of such denial codes to help inform a uniform set of denial codes. Regarding prior authorization, the recently finalized rules on interoperability and electronic and MA prior authorization policies will drive the system in the direction of uniformity, which could also be a meaningful direction for medical claims denial coding as well.

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The Task Force appreciates the opportunity to respond to the Request for Information on Medicare Advantage data. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to these comments.

Sincerely,

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