FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

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

As a leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to respond to the *Medicare Program; Request for Information on Medicare Advantage Data* (i.e., 2024 Medicare Advantage Data RFI). Central to Families USA's mission is a commitment to guaranteeing that families and individuals throughout the nation have access to high-quality, affordable, comprehensive health care and the health they deserve. This includes ensuring that our nation's seniors and all those who rely on Medicare for their health care have access to high-quality care and coverage options.

Medicare Advantage (MA) is a coverage option within the Medicare Program which allows Medicare beneficiaries to receive Part A and Part B coverage benefits from private plans rather than from Traditional fee-for-service (FFS) Medicare.[1] MA plans are required to cover all Traditional Medicare benefits at a level of cost-sharing that is no greater than what is provided through Traditional Medicare.[2] MA plans are also allowed to provide additional benefits not covered under Traditional Medicare, referred to as supplemental benefits.[3] The MA program has rapidly increased its enrollment over time and now provides coverage to more than half (51%) of all eligible Medicare beneficiaries as of 2023, compared to less than a quarter (19%) in 2007.[4] Notably, this significant growth in MA enrollment is expected to continue, with the Congressional Budget Office (CBO) projecting that 62% of all Medicare beneficiaries will be enrolled in a Medicare Advantage plan by 2033.[5]

As MA enrollment continues to climb, it is critical that policymakers ensure the MA program provides access to high-quality, affordable, and equitable care and coverage that Medicare beneficiaries deserve and can count on. Yet, a lack of meaningful transparency across the MA program poses a significant barrier to ensuring MA plans and organizations are fulfilling their obligations to beneficiaries and their families.[6]

Families USA applauds the steps the Centers for Medicare and Medicaid Services (CMS) has taken to date to promote transparency throughout the MA program, such as strengthening its regulatory authority to require additional data reporting from MA plans and organizations into

the future and requiring MA plans to report additional data on the utilization and out-of-pocket costs related to supplemental benefits.[7] We strongly support CMS's ultimate goal to collect and publicize MA data to the same extent as Traditional Medicare to achieve meaningful transparency across the entire Medicare Program, and to allow for adequate evaluations of health care quality, equity, and affordability within the MA program, and between MA and Traditional Medicare, as well as other federal health care programs such as Medicaid.[8]

To that end, Families USA urges the administration and CMS to exercise the limits of their existing regulatory authority to further promote meaningful and comprehensive transparency across the MA program to empower policymakers with the information needed to ensure the MA program is delivering affordable, high quality, and equitable care. In response to this RFI, we focus on three areas of MA data collection and reporting that we believe are particularly important to achieving transparency of the MA program. These include: MA encounter data, supplemental benefits, and ownership transparency.[9]

Medicare Program; Request for Information on Medicare Advantage Data

1. MA Encounter Data
2. Supplemental Benefits
3. Ownership Transparency

MA Encounter Data

To administer health care benefits through Medicare Advantage, CMS collects a large quantity of information from plans, providers and other sources.[10] MA plans are required to submit to CMS detailed bid information based on their own health care encounter and expenditure data; diagnostic information for risk adjustment based on encounter data; and quality data summarized from encounters, medical record reviews, and member surveys.[11] Current MA program policy relies on a set of limited information that is often summarized from plans' internal utilization data such as spending information for bids, diagnosis codes for risk adjustment and Healthcare Effectiveness Data and Information Set (HEDIS) data for quality measurement. These data are often summarized by MA plans in a way that that prevents CMS from linking the data sources to gain a complete understanding of how plans administer the Medicare benefit.[12] This is a major barrier to ensuring the MA program has rigorous oversight from policymakers and CMS. Ensuring that encounter data is both complete and accurate is a key tool that CMS could use to replace many of these existing data gaps and would allow for much stronger oversight over the MA program.[13] However, there are several challenges with MA encounter data that must be addressed to ensure the data is both complete and accurate.

MA plans and organizations are required to submit information to CMS on each medical item and service provided to MA enrollees.[14] These data are submitted as "encounter" records and use a standard claim format with similar information as is included in Traditional FFS Medicare claims with one key difference: MA encounter data often originate as claims that health care providers submit directly to MA plans for payment rather than submitting the data directly to CMS under Traditional Medicare.[15] Currently, CMS uses encounter records submitted by MA

plans to calculate their risk-adjusted payments. These data help CMS identify the health status (i.e. diagnoses) of each enrolled patient. This information is then used by CMS to adjust MA payments to account for the expected costs of each enrolled patient to ensure plans are equally incentivized to cover enrollees regardless of health status.[16]

Despite federal requirements for MA plans to submit encounter records to CMS for *each* medical item or service provided to enrollees, MA plans and organizations often submit incomplete and inaccurate encounter data.[17] In particular, there is strong evidence that MA plans and organizations *underreport* care that is used by MA beneficiaries when submitting encounter data.[18] According to the Medicare Payment Advisory Commission (MedPAC) not a single MA organization had 100% complete encounter data when comparing that data to other reference datasets.[19], Growing evidence indicates that MA plans across the program consistently fail to report a significant subset of health care visits that MA enrollees actually participate in.[20] As a result, CMS lacks adequate data on key programmatic information such as the types and quantity of care, and the cost of care being delivered to MA beneficiaries that is needed to provide robust oversight over the MA program. Without complete and accurate encounter data on each medical item and service used by an enrollee, CMS is limited in its ability to effectively hold MA plans accountable for delivering the high quality, equitable, and affordable care that MA plans purport to deliver to the patients they serve. [21]

There are three major drivers that contribute to the underreporting of MA enrollee utilization within MA encounter data:

- First, MA plans and organizations are not sufficiently incentivized to report complete encounter data.[22] As noted above, CMS currently uses encounter data to inform risk-adjusted payments to MA plans. For example, when an MA plan submits encounter data to CMS, the reporting of any new diagnosis for a patient actually results in a higher payment. Importantly, patient health records that do not include any new diagnoses do not impact the risk-adjusted payment. As a result, MA plans are financially incentivized not only to increase the number of new diagnoses in their patient population to generate higher payments but also are incentivized only to prioritize reporting encounter data that directly impacts their payment rates. The result is that MA plans are less likely to submit encounter data to CMS for patient visits that do not include a new diagnosis.[23]

- Second, CMS does not adequately verify the completeness of MA encounter data.[24] Currently, CMS uses a number of performance metrics to assess MA data completeness and accuracy. CMS then reports these metrics and their results to MA plans as a way to inform and educate plans on the extent to which they are complying with federal reporting requirements.[25] However, these metrics do not actually measure data *completeness*, and represent an insufficient level of data needed to meaningfully assess MA encounter data quality and accuracy.[26] For example, one such measure entitled: "Failure to submit *any* accepted records to the Encounter Data System" – only requires MA plans to submit one encounter record in a calendar year in order to achieve sufficient compliance.[27] When these baseline metrics are designed only to identify the absolute lowest performing MA plans and

organizations, the measures are insufficient to promote meaningful reporting of accurate and *complete* encounter data across *all* MA plans and organizations.[28]

- Third, CMS does not have in place comprehensive enforcement mechanisms that ensure MA plans and organizations meaningfully comply with federal reporting requirements. Currently, using the performance metrics described above, CMS identifies the lowest performing MA plans and organizations and targets them for further oversight, including: outreach, technical assistance, warning letters, and in limited circumstances, corrective action plans.[29] However, like the metrics themselves, these oversight efforts are only targeted to a subset of the worst performing plans and fail to provide needed oversight over all MA plans and organizations. The lack of enforcement mechanisms, coupled with the lack of complete and accurate encounter data, significantly weakens CMS's ability to conduct robust program oversight.[30]

With better metrics and more accurate and complete encounter data, CMS would have the needed tools to more effectively measure the utilization and quality of MA coverage, while at the same time enabling policymakers and researchers to make meaningful cost and quality comparisons across MA plans and between MA plans and Traditional Medicare.[31] Further, more reliable encounter data would allow CMS to assess how different MA plans and their particular plan design characteristics impact health care utilization, quality, health disparities, and patient outcomes disaggregated by beneficiary demographic characteristics. Ultimately, these types of analyses will help CMS hold the MA program accountable to delivering high value and equitable care to the benefit of the growing number of MA enrollees, while at the same time improving the health of the MA program by fostering and promoting healthy competition between MA plans and with Traditional Medicare.

Moreover, more complete encounter data could also allow CMS to significantly improve the accuracy of CMS payments to MA plans and help rein in the systematic upcoding observed across the MA program.[32] Systematic upcoding by MA plans and organizations has been well-documented, and serves to undermine the integrity of the MA payment system and the accuracy of risk-adjusted payments.[33] These coding abuses make the MA enrollee population appear sicker and costlier despite the fact that MA enrollees tend to be healthier and less costly than those in Traditional Medicare (whose historical health care costs, importantly, are used to inform the MA risk adjustment model and MA payments).[34] MA plans have even gone so far as to upcode and assign erroneous patient diagnoses – through sham chart reviews and health risk assessments (HRAs) – that are not medically supported (i.e., not supported by the patient's medical record) or do not result in any additional medically necessary treatment or care.[35] This harmful practice contributes to billions of dollars in CMS overpayments annually, higher Part B premiums that are borne by Medicare beneficiaries across the Medicare Program, and undermines the extent to which the MA payment system can hold MA plans and organizations accountable to delivering high quality, equitable, and affordable care.[36]

Specifically, more complete and reliable MA encounter data could be used as the basis for calculating risk-adjusted plan payments and in particular, the expected health care costs associated with patient diagnoses that inform the risk adjustment – instead of using Medicare FFS data.[37] By using MA encounter data as the sole basis for calculating risk-adjusted payments (instead of Medicare FFS data), CMS would remove the ability for MA plans and organizations to upcode in order to secure higher plan payments by coding patient diagnoses at higher rates than those in Medicare FFS.[38] This would represent a critical step to reining in systematic upcoding which directly harms the financial sustainability of the Medicare program as well as the financial wellbeing and health of Medicare beneficiaries and taxpayers.[39]

Therefore, **we urge CMS to use its existing statutory and regulatory authority to take additional steps to improve the accuracy and completeness of MA encounter data.[40,41,42] Specifically, CMS should:**

- **Increase the extent to which it evaluates and audits the encounter data submitted by MA organizations;**
- **Establish more comprehensive performance metrics that specifically evaluate the *completeness* of MA encounter data; and**
- **Impose financial penalties, up to the withholding of a percentage of MA related payments, for all MA organizations that do not meet such metrics.**

These steps are critical to promoting meaningful transparency into the MA program and ensuring CMS has the comprehensive data it needs to actually hold the MA program accountable to its obligations to our nation's seniors and their families.

Moreover, to ensure CMS can assess the extent to which the MA program is delivering equitable care and coverage, **CMS should maintain accurate and complete information on beneficiary demographic characteristics across the Medicare program, including among MA enrollees**.[43] **This data should be self-reported and housed in the Medicare Enrollment Database, where it can be easily linked to reported MA encounter data, giving CMS a more accurate picture of how health care utilization and out-of-pocket spending in MA impacts health care quality and patient outcomes by enrollee demographic characteristics – including by race, ethnicity, gender, sexual orientation, language, geographic location, socioeconomic status, age, and ability status.** This is especially important as there is evidence of growing adverse selection in the MA program, where healthier beneficiaries are more likely to enroll into a MA plan compared to Traditional Medicare while sicker and more marginalized beneficiaries largely stay segregated to Traditional Medicare.[44] As well as evidence that Medicare beneficiaries who are chronically ill, costly, or nearing the end of life are more likely to leave MA after initially enrolling.[45] In addition to further driving overpayments to MA plans as compared to Traditional Medicare, this raises a particular concern about the extent to which the MA program can play a positive role in driving health equity and the ability of MA plans to adequality serve marginalized populations.

Supplemental Benefits

In addition to providing coverage for Traditional Medicare Part A and B benefits, MA plans can offer supplemental benefits.[46] These benefits are an important component of the coverage MA plans offer to Medicare beneficiaries, and most often include additional health related benefits such as dental, vision, or hearing coverage.[47] These benefits are funded by rebates which are paid by CMS on top of an MA plan's base payments when certain conditions are met, and represent a critical mechanism for MA plans to compete with each other and Traditional Medicare for prospective enrollees. [48] As a result, MA plans are increasingly offering supplemental benefits to enrollees, with 99 percent of MA plans now offering at least one supplemental benefit as of 2022.[49] This increase in supplemental benefit offerings has resulted in an increase in the associated Medicare payments for those benefits. For example, Medicare payments for supplement benefits more than doubled from $1,140 per enrollee in 2018 to $2,300 per enrollee in 2024.[50]

Yet, CMS and the public have limited information on the extent to which MA enrollees are actually using these supplemental benefits, the out-of-pocket costs and plan payments associated with such benefits (e.g., service level allowed amounts), the demographic characteristics of enrollees who are most likely to use them, and ultimately whether these benefits have a meaningful impact on health care quality and enrollee health outcomes.[51] At the same time, the limited summary data that is reported to CMS suggests "low utilization of these benefits by… enrollees [overall]."[52] For instance, despite dental coverage representing one of the most common supplemental benefits offered by MA plans, beneficiaries in these plans are equally likely to access these services compared to those in Traditional Medicare, who by default do not have dental coverage.[53] Combined with a lack of clarity as to whether MA plans are proactively encouraging the use of supplemental benefits, the lack of overall transparency regarding the use of these benefits raises questions as to whether they are truly providing value to beneficiaries and contributing positively to their health and health care coverage.[54,55]

This is particularly concerning given the growing body of evidence that MA plans often use aggressive marketing tactics about their supplemental benefits to incentivize seniors to select their plan, but those benefits often differ from what is actually available to seniors when they go to utilize their coverage down the line.[56] In some cases, MA plans are marketing completely false or misleading supplemental benefits altogether.[57] Importantly, there is a general lack of data reporting by MA plans to understand what supplemental benefits are being offered, their value to seniors and whether seniors are actually able to access those benefits after selecting a plan.[58]

We applaud CMS for taking meaningful steps in recent years to promote greater transparency around MA supplemental benefits, including requiring MA plans to report additional summary level data on the utilization and out-of-pocket costs of supplemental benefits at the plan level, clarifying that encounter data submissions should include supplemental benefits and providing additional guidance to MA plans to ensure appropriate submission, and strengthening certain medical-loss ratio (MLR) requirements (e.g., requiring MA organizations to report aggregate spending data at the contract level) related to supplemental benefits.[59] These are important

steps in giving CMS the data required to oversee the MA program and in particular ensure that rebate dollars funding supplemental benefits – and the supplemental benefits themselves – are truly benefiting the health and well-being of Medicare beneficiaries.

At the same time, we remain concerned that there are notable data gaps related to the use of supplemental benefits; most importantly, there is a persistent lack of public information on associated plan payments and the out-of-pocket costs that beneficiaries experience, at the encounter level.[60] Further, understanding the extent to which beneficiaries are financially liable for care associated with supplemental benefits is critical to determining the value of supplemental benefit coverage and the extent financial barriers may or may not be contributing to lower utilization of these benefits. Improving data collection and reporting on supplemental benefits is essential to ensure that the benefits that MA plans and organizations market to prospective enrollees are truly meaningful and beneficial to the health and well-being of Medicare beneficiaries. Therefore, **we urge CMS to take additional steps to require more comprehensive supplemental benefit data from MA plans and organizations and to make that data public**.[61] **Specifically, CMS should require that MA plans report beneficiaries' out of pocket liability as well as plan payments (i.e., allowed amounts) for each transaction (i.e., encounter) related to the use of supplemental benefits; this information should be included in the MA encounter data and be made publicly available.** [62]

Ownership Transparency

As observed across the health care system, there is growing consolidation among insurers that offer MA plans. There is growing horizontal consolidation between MA organizations, with only a handful of insurance companies projected to receive MA related dollars in 2023 – including UnitedHealthcare (26%), Humana (18%), Blue Cross Blue Shield (14%) and CVS Health (11%).[63] And there is growing vertical integration between MA organizations and health care providers; UnitedHealthcare for instance now employs almost 50,000 physicians as of 2021 and their reported share of medical expenses that flow to employed providers or other related businesses increased nearly 250% between 2016 and 2019.[64]

As consolidation among MA plans and organizations continues to increase, it is critical that CMS, policymakers, and researchers have the data needed to analyze the impact of consolidation on the care and coverage delivered by MA plans. This is especially important given the evidence suggesting that vertically integrated MA plans, in particular, are more likely to engage in systematic upcoding, which can be harmful to both Medicare beneficiaries and taxpayers alike.[65] In fact, vertically integrated plans have been found to generate 16% higher risk scores for the same patients compared to Medicare FFS, which is nearly three times the effect among non-vertically integrated plans.[66] These plans are putting in places financial incentives that act to pressure their employed providers to diagnose their enrollees with additional or even erroneous diagnoses to secure higher risk-adjusted payments from CMS.[67]

Further, there are concerns that vertically integrated MA plans may be more likely to game MLR requirements, which are critical safeguards that ensure the majority of premium dollars cover

health related expenses (as opposed to administrative costs or profits).[68] Medical loss ratio requirements were put in place under the Affordable Care Act and cap the extent to which insurance premiums can flow towards administrative costs and profits as a fixed percentage.[69] However, plans can potentially game this requirement by vertically integrating with physician and other provider groups. Specifically, once they own a provider group, plans can pay themselves by paying their vertically integrated providers above market rates for health-related services and reporting it as a medical cost even though it represents additional profit for the parent company. As a result, plans can steer a greater proportion of their premium dollars above and beyond the capped rate per the MLR requirement through their vertically integrated provider groups.[70]

Therefore, **CMS should take steps to promote greater transparency of ownership among MA plans and organizations as well as the health care providers and other related businesses that may be owned by MA organizations. Specifically, CMS should collect more comprehensive data from MA plans and their contracted providers that includes a practice's parent company as well as related information on the entities with the largest ownership interest.[71] Importantly, this data should be publicly available and linkable to Medicare claims data, including MA encounter data, so lawmakers can understand how various ownership arrangements between MA plans and organizations and health care providers may or may not impact the affordability and quality of the care and coverage being provided by those particular MA plans.[72]**

Conclusion

Families USA applauds CMS and the Biden administration for taking meaningful steps to promote transparency of the MA program. As the MA program continues to experience record enrollment, it is critical CMS continues to strengthen transparency of the program by collecting more comprehensive and higher quality data, and making it publicly available so consumers, researchers, policymakers, and other stakeholders can hold MA plans accountable to delivering high quality, affordable, and equitable care. Families USA stands ready to work with you to ensure our nation's seniors and all those who rely on Medicare for their health care have access to the high-quality care and coverage options they deserve.

Thank you again for the opportunity to provide comment. Please contact Aaron Plotke (APlotke@familiesusa.org), Senior Policy Analyst at Families USA, with any questions.

Sincerely,

Sophia Tripoli
Senior Director of Health Policy

[1] MedPAC, The Medicare Advantage program: Status Report, March 2023.
[2] Ibid.
[3] Ibid.
[4] KFF, *Medicare Advantage in 2023: Enrollment Update and Key Trends, August 9, 2023.* https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/
[5] Ibid.
[6] Jeannie Biniek, Meridith Freed, & Tricia Neuman, *Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency,* April 10, 2024. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/
[7] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE). Fed. Reg 30448, 30448-30848 (April 23, 2024)**;** Centers for Medicare and Medicaid Services, *Medicare Part C Technical Specifications Document, Contract Year 2024*, February 2024. https://www.cms.gov/files/document/cy2024-part-c-technical-specifications-02222024.pdf
[8] Centers for Medicare and Medicaid Services, *Medicare Program; Request for Information on Medicare Advantage Data*, January 30, 2024. https://www.federalregister.gov/documents/2024/01/30/2024-01832/medicare-program-request-for-information-on-medicare-advantage-data
[9] Ibid.
[10] See Chapter 7, MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Centers for Medicare and Medicaid Services, *ENCOUNTER DATA SUBMISSION AND PROCESSING GUIDE, Medicare Advantage Program,* November 2022, Version 5.0. https://csscoperations.com/internet/csscw3_files.nsf/F2/2022ED_Submission_Processing_Guide_20221130.pdf/$FILE/2022ED_Submission_Processing_Guide_20221130.pdf
[15] MedPAC, *Improving the Medicare Advantage Program,* June 28, 2022. https://www.medpac.gov/wp-content/uploads/2022/06/EC-Medicare-Advantage-testimony-FINAL-v2_SEC.pdf
[16] CMS previously used diagnostic data collected through the Risk Adjustment Processing System (RAPS) to calculate risk scores and used a blend of both data sources from 2016 through 2021; starting in 2022 encounter records became the sole data source used for diagnostic information among MA enrollees. MedPAC, *Improving the Medicare Advantage Program,* June 28, 2022. https://www.medpac.gov/wp-content/uploads/2022/06/EC-Medicare-Advantage-testimony-FINAL-v2_SEC.pdf. See also Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023.
[17] See Chapter 7, MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf
[18] Centers for Medicare and Medicaid Services, *ENCOUNTER DATA SUBMISSION AND PROCESSING GUIDE, Medicare Advantage Program,* November 2022, Version 5.0. https://csscoperations.com/internet/csscw3_files.nsf/F2/2022ED_Submission_Processing_Guide_20221130.pdf/$FILE/2022ED_Submission_Processing_Guide_20221130.pdf
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

[23] See Chapter 7, MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf
[24] Government Accountability Office, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, September 2, 2014. GAO-14-571. https://www.gao.gov/products/gao-14-571; See Chapter 7, MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Urban Institute and American Action Forum, Using Encounter Data in Medicare Advantage Risk Adjustment, January 2019. Accessed at https://www.urban.org/sites/default/files/publication/99623/using_encounter_data_in_medicare_7.pdf on April 27, 2022.
[33] Ibid. See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023.
[34] Ibid; HHS OIG, *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments,* September 20, 2021. OEI-03-17-00474.
[35]Ibid.; See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023.
[36] Ibid; Families USA, *Re: CMS-2024-0006, Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, Regulatory Comment, March 1, 2024. https://familiesusa.org/wp-content/uploads/2024/03/Families-USA-MA-Rate-Rule-Comment-1.pdf
[37] Urban Institute and American Action Forum, Using Encounter Data in Medicare Advantage Risk Adjustment, January 2019. Accessed at https://www.urban.org/sites/default/files/publication/99623/using_encounter_data_in_medicare_7.pdf on April 27, 2022; See Chapter 7, MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf
[38] Ibid.
[39] Families USA, *Re: CMS-2024-0006, Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, Regulatory Comment, March 1, 2024. https://familiesusa.org/wp-content/uploads/2024/03/Families-USA-MA-Rate-Rule-Comment-1.pdf
[40] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE). Fed. Reg 30448, 30448-30848 (April 23, 2024); Centers for Medicare and Medicaid Services, *Medicare Part C Technical Specifications Document, Contract Year 2024*, February 2024. https://www.cms.gov/files/document/cy2024-part-c-technical-specifications-02222024.pdf
[41] See Chapter 7, MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf
[42] Government Accountability Office, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, September 2, 2014. GAO-14-571. https://www.gao.gov/products/gao-14-571
[43] HHS OIG, *Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability to Assess Health Disparities,* June 2022. OEI-02-21-00100. https://oig.hhs.gov/oei/reports/OEI-02-21-00100.pdf

[44] MedPAC, The Medicare Advantage program: Status Report, March 2023.
[45] Ibid.
[46] Government Accountability Office, *Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization,* January 2023. https://www.gao.gov/assets/gao-23-105527.pdf
[47] Ibid. Beginning in 2019 and 2020, MA plans could offer an expanded number of "primarily health-related supplemental benefits" such as support for caregivers of enrollees and in-home support services as well as "special supplemental benefits for the chronically ill" such as coverage of food and produce purchases and transportation for non-medical needs. For more information see, https://www.gao.gov/assets/d23105527.pdf; Also see, Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; MedPAC, Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023; https://www.gao.gov/assets/d23105527.pdf
[48] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023; MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf
[49] Jeannie Fuglesten Biniek, Meredith Freed, & Tricia Nueman, *Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries,* Kaiser Family Foundation, April 25, 2023. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/
[50] Ibid. MedPAC, *The Medicare Advantage program: Status Report,* March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf
[51] Ibid; Jeannie Fuglesten Biniek, Meredith Freed, & Tricia Nueman, *Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries,* Kaiser Family Foundation, April 25, 2023. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/
[52] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE). Fed. Reg 30448, 30448-30848 (April 23, 2024).
[53] CMS, *Dental Coverage Status and Utilization of Preventative Dental Services by Medicare Beneficiaries.* Medicare Current Beneficiary Survey. https://www.cms.gov/files/document/dental-coverage-status-and-utilization-preventive-dental-services-medicare-beneficiaries-poster.pdf
[54] Currently, there is no specific requirement for MA organizations, beyond more general care coordination requirements, to conduct outreach to enrollees to encourage utilization of supplemental benefits. For more information, see Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE). Fed. Reg 30448, 30448-30848 (April 23, 2024).
[55] Importantly, section 1854(b)(1)(C) of the Act requires that MA plans offer the value of MA rebates back to enrollees in the form of payment for supplemental benefits, cost sharing reductions, or payment of Part B or D premiums.
[56] US Senate Committee on Finance (Majority Staff), *Deceptive Marketing Practices Flourish in Medicare Advantage.*
https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf
[57] Ibid.

[58] Ibid. Government Accountability Office, *Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization,* January 2023. https://www.gao.gov/assets/gao-23-105527.pdf
[59] CMS, *Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*, May 9, 2022. 87 FR 27704; Centers for Medicare and Medicaid Services, *Medicare Part C Technical Specifications Document, Contract Year 2024*, February 2024. https://www.cms.gov/files/document/cy2024-part-c-technical-specifications-02222024.pdf; See also, CMS, *Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records.* February 21, 2024. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Submission_of_Supplemental_Benefits_Data_on_Medicare_Advantage_Encounter_Data_Records_508_G.pdf; CMS, *Medicare Advantage General Supplemental Services Submission Guide,* February 2024. https://csscoperations.com/internet/csscw3_files.nsf/F2/Medicare%20Advantage%20General%20Supplemental%20Services%20Submission%20Guide_508.pdf/$FILE/Medicare%20Advantage%20General%20Supplemental%20Services%20Submission%20Guide_508.pdf
[60] Currently, publicly available MA encounter data does not include payment information such as gross charges, total plan payments (i.e., allowed amounts), nor enrollee out-of-pocket costs. For more information, see https://resdac.org/cms-data?tid%5B6056%5D=6056; CMS, *CMS Chronic Conditions Data Warehouse (CCW) Data Dictionary,* November 2020. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fresdac.org%2Fsites%2Fdatadocumentation.resdac.org%2Ffiles%2FCCW%2520Record%2520Layout%2520-%2520Medicare%2520Encounter%2520_Version%252006202_1.xlsx&wdOrigin=BROWSELINK; Further, experts have raised concerns that even internal MA encounter data that is submitted to CMS does not include enrollee out-of-pocket liability information. For more information, see Jeannie Biniek, Meridith Freed, & Tricia Neuman, *Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency,* April 10, 2024. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/
[61] Ibid.
[62] Implementation of this recommendation should build upon CMS' recent guidance sent to MA plans and organizations on February 21, 2024, that clarifies that MA plans are required to submit encounter level data to CMS on the use of supplemental benefits and provides guidance to help address any operational challenges. See, CMS, *Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records.* February 21, 2024. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Submission_of_Supplemental_Benefits_Data_on_Medicare_Advantage_Encounter_Data_Records_508_G.pdf
[63] Nancy Ochieng et al., "Medicare Advantage in 2023: Enrollment Update and Key Trends," Kaiser Family Foundation, August 9, 2023.
[64] Richard Frank & Conrad Milhaupt, *Medicare Advantage spending, medical loss ratios, and related businesses: An initial investigation*. March 24, 2023. The Brookings Institution. https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/
[65] Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment,* May 2015. National Bureau of Economic Research. https://www.nber.org/papers/w21222; Also see, Families USA, *Re: CMS-2024-0006, Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, Regulatory Comment, March 1, 2024. https://familiesusa.org/wp-content/uploads/2024/03/Families-USA-MA-Rate-Rule-Comment-1.pdf
[66] Ibid.
[67] Ibid.
[68] Richard Frank & Conrad Milhaupt, *Medicare Advantage spending, medical loss ratios, and related businesses: An initial investigation*. March 24, 2023. The Brookings Institution. https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/; Hayden Rooke-Ley,

Medicare Advantage and Vertical Consolidation in Health Care, April 2024. American Economic Liberties Project. https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf

[69] Hayden Rooke-Ley, *Medicare Advantage and Vertical Consolidation in Health Care*, April 2024. American Economic Liberties Project. https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf

[70] Ibid.

[71] Loren Adler, Matthew Fiedler, & Benedic Ippolito, *Assessing recent health care proposals from the House Committee on Energy and Commerce.* The Brookings Institution. https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/

[72] Ibid.