May 29, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

SUBJECT: CMS–4207–NC, Medicare Program; Request for Information on Medicare Advantage Data, Federal Register (Vol. 89, No. 20), January 30, 2024

Dear Administrator Brooks-LaSure:

On behalf of more than 400 hospitals, the California Hospital Association (CHA) is providing comments in response to the agency's request for information related to data collection for Medicare Advantage (MA) plans. Outreach by the Centers for Medicare & Medicaid Services (CMS) on this important topic is appreciated. As CMS contemplates additional data collection requirements, it should continue to engage MA plans, hospitals, and other providers in an iterative process. The agency is strongly encouraged to use the formal rulemaking process to implement additional data collection and reporting requirements.

Almost half of California's Medicare beneficiaries are enrolled in an MA plan. Many of these beneficiaries are enrolled in high quality Medicare Advantage Organizations (MAOs) that are part of tightly integrated delivery systems that are fulfilling the promise of MA plans to provide cost-effective care. Unfortunately, a large portion of California's Medicare beneficiaries are enrolled in plans that care more about their bottom lines than patients. These plans abuse prior authorization requirements, attempt to deny services that are covered by Medicare FFS, and reimburse less than Medicare's inadequate rates[1] among other strategies to pad their already significant bottom lines.

These tactics to maximize profit at the patient's expense threaten not just Medicare Advantage beneficiaries' access to care[2], but access for the entire community. It is becoming more common to see reports of providers no longer accepting Medicare Advantage plans[3] from organizations that place profits over patients due to these issues. Unless plans that care more about their bottom lines than patients change their behaviors, this is a trend that is anticipated to grow. Sixteen percent of hospitals nationally

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[1] Based on CHA analysis of 2022 California Office of Health Care Information and Access data, Medicare covered 73% of the cost to provide care to beneficiaries, resulting in hospitals losing $.27 per dollar of cost.
[2] https://www.modernhealthcare.com/providers/medicare-advantage-rural-hospital-emergency-program
[3] https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html

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report they will stop accepting one or more Medicare advantage plans in the next two years[4]. Another 45% are considering taking similar steps.

Beyond threatening beneficiary access, the bottom-line padding tactics used by some plans drive unnecessary costs which are ultimately borne by everyone. A recent survey of hospital CFOs highlights how this increases unnecessary administrative costs, as 87% reported onerous prior authorization requirements and 75% reported unnecessary denials related to medical records. Another survey finds that 15.7% of MA claims are initially denied. It costs hospitals an additional $47.77 to resolve payment delays and denials by MA plans resulting in unnecessary costs that do not improve patient outcomes or program integrity[5].

Further, delays in prior authorization (or outright denials) for post-acute care services or inadequate networks both increase operating costs and prevent MA beneficiaries from receiving care in the setting that is most appropriate for the patient. A survey of CHA members finds that patients with Medicare Advantage are nearly twice as likely to experience a discharge delay than those with traditional Medicare. Across all hospitals and payers, these discharge delays increase health care costs by $3.25 billion[6] annually in California.

Given these well documented behaviors by some plans that place profits over patients, it is important for CMS to take steps to ensure that:

- Beneficiaries enrolled in MA have access to the same services as those in Medicare fee-for-service (FFS).
- Beneficiaries can access those services in a timely manner.
- Providers who deliver these services are paid appropriately and promptly.
- Data related to value-based care models is standardized and consistently reported.
- Any new reporting requirements are promulgated through formal rulemaking, implemented in the least costly manner possible for all stakeholders, and undertaken in a manner to ensure comparability with Medicare Fee-For-Service as appropriate.

In the appendix below, please find responses to questions posed in the RFI. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president of federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy

[4] https://www.beckershospitalreview.com/finance/most-cfos-say-collecting-from-medicare-advantage-is-getting-harder.html?
[5] https://www.statnews.com/2024/05/01/insurance-claim-denials-compromise-patient-care-provider-bottom-lines/
[6] https://calhospital.org/wp-content/uploads/2024/01/Impact-of-Inadequate-Networks-CHA-Analysis-FINAL.pdf

Appendix – Responses to Select RFI Questions

Protect Beneficiary Access and Experience of Care:

- *Access to Care in Rural Communities*: Rural households report a lower median income than those in urban areas and have a greater proportion of the population reporting food insecurity[7]. Transportation issues are also a common challenge when trying to access care in rural areas. And among Medicare beneficiaries, rural residents were more likely than urban residents to be covered by both Medicare and Medicaid (dual eligible) (28.3% compared to 22.4%).

  Owing in part to these factors, rural communities face elevated rates of morbidity and mortality and greater percentages of excess mortality from the five leading causes of death including cancer and cardiovascular disease. Further, rural older adults have a higher prevalence of several chronic diseases compared to urban older adults, including coronary heart disease and diabetes. Diabetes, one of the leading causes of death in the U.S., has been reported to be as much as 17% higher in rural areas than in urban areas[8].

  Even for beneficiaries covered under Medicare FFS access to care in rural areas can be challenging. This may be exacerbated for MA enrollees in plans that place profits over patients. Hospitals in rural areas – that are typically in these MA plans' networks – report that as enrollment increases in MA plans, MA beneficiaries are more likely to receive ambulatory and non-emergent services from providers outside of the local area. There is concern this is an explicit strategy to steer MA members in rural areas to providers outside of the local market that are preferred or affiliated providers due to lower negotiated payment rates or other financial incentives. Given the greater incidence of poverty, increased burden of disease, and lower levels of access to transportation, any efforts by MA plans that put profits ahead of patients to redirect care outside of the community negatively impacts access and outcomes for impacted Medicare beneficiaries.

  It is important for CMS to monitor this phenomenon and take corrective action on a plan-by-plan basis if necessary. Therefore, the agency should compare the distance rural FFS beneficiaries and each MA plan's enrollees travel to receive services. This analysis can be conducted at a contract level by using FFS claims and MA encounter data to calculate at the county level the average distances a FFS beneficiary and MA enrollee must travel from their home address to access care for each of the 29 provider specialty types and 13 facility specialty types used to assess the adequacy of the network for each service area[9]. This data should also be made public to help Medicare beneficiaries make well-informed coverage decisions. It will also shed light on plans that may have networks that meet the time and distance adequacy standards but are attempting to steer patients to other providers outside of the community to pad their margins.

- *Prompt Access to Post-Acute Care*: As noted above, a recent survey of California hospitals finds that patients with Medicare Advantage are nearly twice as likely to experience a discharge delay than those with traditional Medicare due to delays in receiving prior authorization for post-acute care. This finding is consistent with broader data analysis of claims data.

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[7] www.ruralhealthresearch.org/assets/2200-8536/rural-communities-age-income-health-status-recap.pdf
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043306/
[9] https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance12-12-2023.pdf

A review of claims data by the National Association of Long Term Hospitals found that in 2015, MA beneficiaries were approximately half as likely as Medicare FFS beneficiaries to receive services at a long-term acute care hospital (LTACH) (44%) or an IRF (53%), and 9% less likely to use SNFs relative to their Traditional Medicare counterparts[10]. These observed differences are largely the result of prohibitive authorization practices and the application of more restrictive medical necessity criteria by MAOs, which inappropriately limit patient access to covered PAC services[11].

This is further supported by an American Hospital Association (AHA) analysis of Medicare claims data between 2019 and 2020, which shows that MA beneficiaries who are discharged to PAC settings are generally sicker (measured by mean case-mix index), and experience longer stays in the referring hospital (measured by mean length of stay) compared to Traditional Medicare beneficiaries who are discharged to PAC settings. For example, MA beneficiaries who are discharged from a general acute care hospital to an LTACH had a 30% higher case-mix index (CMI) and a 35% longer length of stay (LOS) in the referring hospital compared to Medicare FFS beneficiaries discharged to an LTACH in the first three quarters of 2019[12]. This strongly suggests that those MA plans that place profits over patients are allowing only the sickest and most acute patients access to certain PAC settings. This limits access to other patients who would benefit from clinically appropriate, covered PAC services contrary to Medicare coverage requirements.

These variations could be the result of extensive prior authorization requirements in MA that do not exist in Medicare fee-for-service, the use of more restrictive admissions criteria by MAOs, or other differences in how MAOs are applying Medicare criteria and rules related to coverage and payment in ways that limit access. At a minimum, this concerning variation warrants closer study to determine whether there is a correlation between higher CMI and longer LOS among MA enrollees and restrictive PAC admissions criteria — and whether this results in unequal access to PAC services between the two subgroups of Medicare beneficiaries. It will also ensure that plans are complying with the provisions of the 2024 final rule that clarifies MA plans must cover the basic Medicare benefit and use coverage and payment criteria that is no more restrictive than what is in FFS[13]. Greater transparency into MAO medical necessity and admissions criteria is necessary to conduct such an inquiry.

Given the need for this transparency, CMS should use claims data to calculate an average risk adjusted length of stay for each MA plan by contract, at the MS-DRG level by discharge disposition. This should be compared to FFS data for the same MS-DRGs to identify plans that are putting profits above patients by abusing prior authorization criteria, have inadequate post-acute care networks, or are otherwise impeding a seamless transition of care. This data should also be made public to help Medicare beneficiaries make well-informed coverage decisions.

- *Post-Acute Care Network Adequacy*: Onerous prior authorization criteria present only one barrier to ensuring MA enrollees can receive care in the appropriate setting. California's hospitals frequently report many post-acute providers that are contracted with MA plans that place profits over patients will not accept these enrollees. It is not uncommon for certain MA plans to deny

[10] National Association of Long Term Hospitals (NALTH), "Medicare Advantage Limits Use of Long-Term Care Hospitals; Users Have Significantly Higher Severity than in Traditional Medicare," Feb. 10, 2021.
[11] ibid
[12] https://www.aha.org/lettercomment/2022-08-31-aha-comments-cms-request-information-regarding-medicare-advantage-program
[13] https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f

payment to PAC providers after care has been authorized, reduce the number of covered days, or use other administrative gimmicks to underpay the PAC provider for medically necessary services provided to a MA plan member. Therefore, these PAC providers will only accept enrollees from these MA providers that place profits over patients in extremely limited circumstances.

Therefore, to protect access to PAC care for MA enrollees, CMS should take steps to ensure that MA plan networks – particularly for post-acute care providers – are truly adequate. To do this, the agency should conduct robust secret shopper surveys and make the results publicly available. It should also explore a mechanism to survey hospitals on a regular basis to identify MA plans whose PAC networks are either inadequate and/or use onerous administrative barriers to limit enrollee access to medically necessary PAC care.

- *MA Disenrollment in the Last Year of Life*: A 2021 Government Accountability Office (GAO) report discovered that patients with MA coverage in their final year of life are more than twice as likely to switch to Medicare FFS compared to those not in their final year of life. The report highlights that "beneficiaries in the last year of life generally have high levels of service utilization, and certain MAO practices, such as prior authorization, may present administrative burdens to accessing care[14]."

  CMS annually publishes MA plan disenrollment data for each plan at the contract level. In addition to providing it by race, sex, and Medicaid eligibility status, it should include rates of disenrollment by HCC score cohort available. Not only will this help beneficiaries make more informed enrollment decisions, but the agency should scrutinize plans that are more than one standard deviation above the mean for any category of enrollee to ensure that plans that place profits over patients are not using administrative barriers to "lemon drop" high-cost beneficiaries on Medicare FFS and pad their margins.

- *Provider Compliant Mechanism*: Hospital and health systems' experience with MAOs suggests those that place profits over patients are failing to adhere to CMS policies. These anecdotes were recently validated[15] in an HHS-OIG report. These violations (as an example, inappropriate use of proprietary clinical criteria to adjudicate coverage determinations) have negative implications for patients and providers. While CMS has recently clarified expectations that MAOs must follow the same coverage rules and criteria as Medicare FFS, hospitals remain concerned that plans that put profits above patients will continue to behave in ways that maximize their margins at the expense of beneficiary outcomes.

  Therefore, greater CMS oversight of MAO conduct is warranted. However, based on an examination of CMS' data collection on health plan performance, the agency may not have the information it needs to conduct thorough oversight of MAOs. Currently, there are limited provider reporting mechanisms available to provide CMS with important information about plan-level coverage denials, appeals, grievances, or delays in care resulting from prior authorization and other administrative processes. These are important indicators of beneficiary access and are essential to proper oversight of MAOs. CMS is strongly urged to evaluate its data collection and address gaps in these key areas.

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[14] https://www.gao.gov/assets/gao-21-482.pdf
[15] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Additionally, it is recommended CMS establish a complaint mechanism that allows providers to flag problematic plan behavior. Through the nature of their care relationships with patients, clinicians often have the most frequent interaction with plans, giving them unique insight into when plans have practices that inappropriately delay or deny patient access to care. To help ensure that patterns of inappropriate denials and delays are addressed as soon as possible, providers need a mechanism to flag problematic MAO activity. There is currently no streamlined way to do this. Therefore, CMS should create a mechanism for providers to raise issues to regulators. CMS should utilize this information to address and resolve problematic MAO actions.

Prior Authorization and Utilization Management:

- *Services Requiring Prior Authorization*: According to a 2021 American Medical Association survey of more than 1,000 physicians, 91% of respondents indicated that prior authorization "had a significant or somewhat negative clinical impact, with 34% reporting that prior authorization had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care."[16] In response to a recent AHA member survey, 95% of hospitals and health systems reported that the amount of staff time spent seeking prior authorization approval from health plans has increased in the last year. And the resource intensive staff time spent managing prior authorizations adds tremendous cost and burden to the health care system. For example, one 20-hospital system spends $17.5 million annually just complying with health plan prior authorization requirements. And a single 355-bed psychiatric facility needs 24 full-time staff to deal with authorizations[17].

  CMS has recently finalized several important rules[18,19] to limit health plans that put profits ahead of patient's ability to increase their margins by abusing prior authorization requirements. And to ensure that plans adhere to these changes, the agency also released a detailed FAQ[20] to facilitate plan compliance. Hospitals and providers greatly appreciate CMS' efforts in releasing this FAQ.

  Beginning in 2026, MAOs and other impacted payers will be required to publicly report the following metrics related to prior authorization (PA):

  - A list of all items and services that require PA
  - The percentage of standard PA requests that were approved, aggregated for all items and services
  - The percentage of standard PA requests that were denied, aggregated for all items and services
  - The percentage of standard PA requests that were approved after appeal, aggregated for all items and services
  - The percentage of PA requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services

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[16] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[17] https://www.aha.org/lettercomment/2022-08-31-aha-comments-cms-request-information-regarding-medicare-advantage-program
[18] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability
[19] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program
[20] www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf

- The percentage of expedited PA requests that were approved, aggregated for all items and services
- The percentage of expedited PA requests that were denied, aggregated for all items and services
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for standard PAs, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for expedited PAs, aggregated for all items and services

Hospitals support and appreciate these changes. However, more transparency[21] is necessary to help Medicare beneficiaries – particularly those with chronic conditions – make informed choices. First, there is concern that MAOs that put profits ahead of patients will bury these important statistics on their website, making them difficult for members (or potential members) to find when they need to make enrollment decisions. Therefore, CMS should create a single website and require MAOs to report these metrics to the agency so that the data can be posted in one easily available repository (in addition to on the plan's website).

Second, CMS is encouraged to create mechanisms whereby this data is used to guide oversight and enforcement activities. This would help ensure compliance with CMS rules, which have direct impacts on patient access to care and outcomes. Accordingly, it is recommended that CMS regularly audit a sample of plan denials and timeframes, as well as use the data to target potentially problematic plans. Without this level of detailed auditing, there will be ample opportunity for certain health plans to continue circumventing federal rules without detection, rendering the proposed patient transparency efforts and protections ineffective. This will enable meaningful change to take place where it is needed most.

- *Percentage of Claims Denied after Receiving Prior-Authorization*: There continue to be widely held concerns about the behavior of MAOs who approve prior authorization requests for PAC services, but later issue retrospective denials for the same services. This has been a long-standing and problematic issue for many PAC providers and results in hesitancy on their part to accept patients for whom coverage of their care will frequently be denied or underpaid. Such hesitancy further contributes to delays in patient transfers from general acute-care hospitals to PAC facilities. This fear was palpable among PAC providers during the COVID-19 pandemic when certain MA plans offered temporary waivers of prior authorization at CMS's urging but the plan had a history of retroactively denying payment for services after approving or waiving prior authorization. Therefore, in addition to the metrics listed above, MAOs should be required to report on the rate at which payment for PAC services (or any service) is denied (or the service is down coded or downgraded – e.g., number of covered days retroactively reduced) after the provider received prior authorization.

[21] The data collected and maintained by integrated delivery systems can be structured and/or interpreted differently from traditional health insurance carriers. Any new reporting requirements must accommodate these differences.

Inappropriate Claims Denials and Payment Related Issues:

- *Claims Denials Measurement*: A recent OIG report finds plans that place profits over patients have high rates of denials overturned on appeal and widespread and persistent CMS audit findings about inappropriate denials[22]. The report noted beneficiaries and providers successfully appealed 75% of denials from the claims sample selected. Most of these overturned denials (82%) were for payment to providers for services that the beneficiary already received. These findings are particularly concerning given beneficiaries and providers rarely used the appeals process designed to ensure access to care and payment. Only 1% of denials were appealed during the first year of the study.

  To protect beneficiaries, CMS should measure each MAO's level 1 upheld denial rate[23] at the contract level and make the information publicly available. This will help Medicare beneficiaries know the extent to which plans are denying or delaying care. It will also help expose patterns of inappropriate care denials by plans that are focused on profits, not on patients allowing CMS to improve MAO oversight and better protect Medicare Advantage enrollees.

- *MAO Denials for System vs. Independent Hospitals*: Based on anecdotes from hospitals in California and nationally, MA plans that place profits over patients are more aggressive in denying and downcoding claims for smaller, independent hospitals[24,25,26,27,28] than for hospitals affiliated with a health system. It is likely that these smaller, independent hospitals have less robust revenue cycle capabilities (both human and information technology resources) and are unable to effectively respond to denials. So predatory MAOs that place profits over patients take advantage of this capabilities imbalance to pad their profit margins at the expense of patients and access to care. CMS is encouraged to use claims data, data collected from MAOs, and data collected from hospitals to calculate denial and downcoding rates by type of facility. This will allow the agency to identify plans that are unnecessarily denying and downcoding claims from certain types of hospitals in an attempt to pad profit margins. Where the agency identifies patterns of this type of behavior, it should act to disincentivize it.

Supporting Value Based Payments

- *Defining Value Based Care/Payment*s: New data collection requirements related to value-based payment/value-based care should follow the four-category framework established by the Health Care Payment Learning and Action Network (LAN) as reported in its annual alternative payment models (APM) measurement report (see 2023 report here).

- *Ensuring Comparability of Health Equity Data Collection*: Race and ethnicity data should be defined using a single industry standard (e.g., OMB, HEDIS) to ensure alignment and comparability across metrics. CMS should work with MA plans, providers, and other stakeholders to identify the single industry standard and implement it through the notice and comment process as appropriate.

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[22] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf
[23] https://www.fah.org/blog/fah-quality-measure-recommended-to-cms-for-bringing-transparency-and-accountability-to-ma-plan-denials/
[24] https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012
[25] https://www.fiercehealthcare.com/providers/half-rural-hospitals-are-losing-money-rising-ma-enrollment-likely-wont-help-them-chartis
[26] https://www.axios.com/2023/08/21/rural-hospitals-medicare-advantage-financial
[27] https://www.npr.org/sections/health-shots/2023/10/17/1205941901/medicare-advantage-rural-hospitals
[28] https://finance.yahoo.com/news/denying-claims-medicare-advantage-plans-123041741.html?

- *Support Standardized Dashboards*: MA plans frequently offer hospitals and other providers participating in value-based arrangements access to online dashboards to support performance tracking. This is helpful, but because of the lack of inconsistently defined data fields, formatting differences, and calculations for similar metrics that vary across MA, hospitals and other participants are not able to determine "all-payer" performance across contracts. As hospitals and providers move into more value-based/total cost of care contracts, the lack of standardization makes it challenging to evaluate performance and align with what each MA plan shows in its dashboard. Having consistent data definitions, standardized calculations of common metrics, and formatting for data sharing with hospitals and other providers would facilitate improvement in patient outcomes and experience of care across the populations attributed to providers participating in these models. Moreover, as CMS shifts into quality reporting based on all payer populations, improving data transparency requirements, and requiring specific fields, metrics, and data formats to be shared regularly with providers from payers is essential. CMS should establish a learning collaborative to develop best practices and standardize across the industry, like the AHIP/CMS Core Quality Measures Collaborative.

- *Encourage Ongoing Performance Tracking*: Value-based contracts typically include quality measures related to screening certain populations for the onset of conditions that afflict a given group. Providers are typically required to meet certain percentages of a patient population screened for the measure (or provided with appropriate preventative care). For example, a participating practice will be required to meet a certain percentage of patients getting breast cancer screening (in addition to other metrics) to meet or exceed quality gates. This is challenging when the data from the payer on the number of patients or those that specifically qualify comes late and/or does not reconcile with the practice's list of attributed patients.

  This is particularly challenging at the end of the year when the provider's data shows the practice has surpassed the quality gate, but the plan data is not aligned. Due to these data discrepancies, in some instances, providers do not receive shared savings because the payer's calculations show the practice did not surpass the quality gate - often by a handful of patients. This despite internal practice data showing the practice did meet and/or exceed the quality gate. CMS is encouraged to work with MA plans and providers to improve data transparency and minimize patient attribution discrepancies.

- *Improve Provider Roster Discrepancy Resolution:* At the start of each performance year, it can take several weeks (and in some instances months) to reconcile differences in the provider roster submitted by a Clinical Integrated Network (CIN) versus what the plan shared back with participants. Frequently, there are inconsistencies in 1) how MA plans identify providers for attribution (inconsistent methodologies), 2) how MA plans maintain NPI level information within each TIN, and 3) how MA plans identify which TINs are participating in the contract when some participating providers have overlapping contracts. For instance, specifically relating to that last example, if the provider has a contract with the payer but is also participating in a CIN that simultaneously is contracted with the payer, it is frequently unclear how to determine which contract will be applied to that practice. CMS is asked to work with MA plans and providers to develop a framework to resolve provider roster discrepancies.

- *Improve Availability of Timely, Actionable Data*: APM participants strive to help their providers understand how cost and quality performance align with benchmarks and performance targets. However, APM participants frequently do not receive sufficient and timely data that allows for

NPI-level drill down. Having this data would enable APM participants to make more accurate and actionable calculations of performance. This is a significant issue hindering APM participants' ability to reduce cost and improve patient outcomes. Further, this level of data is necessary if providers are going to take greater population-based performance risk.

General Policy Principles Related to Data Collection:

- *Minimize Unnecessary Costs:* Any new data collection and reporting requirements should be designed to minimize unnecessary costs for MA plans, providers, vendors, and other stakeholders.

  Prior to proposing new data collection requirements, CMS should determine if the metric(s) of interest is (are) currently in its existing inventory or how existing data could be better used to achieve goals of potentially proposed data collection requirements. Additionally, new reporting requirements should:

  - Not be redundant of existing requirements
  - Be proposed with a specific plan for how the data will be used (to prevent data collection for its own sake)
  - Consider current health information technology (HIT) and other data systems/ infrastructure limitations in the data structure, the mechanism for transmitting the data, and the timeline over which any new systems or architecture will need implemented to support the new reporting requirements (e.g., linking administrative data with EHR data)
  - Account for variation in current MA plan benefit design.

- *Provide Comparisons with FFS Data as Appropriate*: New data collection and reporting requirements for MA plans should also be compared to FFS metrics from existing CMS data where appropriate.

- *Integrated Delivery Systems:* The data collected and maintained by integrated delivery systems and other integrated payer-provider organizations can be structured and/or interpreted differently from traditional health insurance carriers. Any new reporting requirements must accommodate these differences (e.g., reporting on use of prior authorization).