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Dr. Mehmet Oz, Administrator
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244

June 16, 2025

Re: Request for Information: Health Technology Ecosystem

Administrator Oz:

On behalf of the Better Medicare Alliance and the more than 34 million beneficiaries enrolled in Medicare Advantage, we are pleased to submit the following comments on the Centers for Medicare & Medicaid Services (CMS) Request for Information on the Medicare Health Technology Ecosystem.

Better Medicare Alliance is a diverse coalition of over 200 Ally organizations and more than one million beneficiaries who value Medicare Advantage. Together, our Alliance of community organizations, providers, health plans, aging service organizations, and beneficiary advocates share a deep commitment to ensuring Medicare Advantage remains a high-quality, cost-effective option for current and future Medicare beneficiaries.

Better Medicare Alliance appreciates CMS' efforts to engage partners and solicit stakeholder input on ways to improve the health technology ecosystem in Medicare Advantage in order to best meet the needs of the millions of seniors and individuals with disabilities that choose Medicare Advantage. And we share CMS' goal of promoting transparency in order to best meet beneficiaries' holistic health care needs via a technology ecosystem that works for and serves beneficiaries, providers, and payers.

Thus, Better Medicare Alliance's response focuses on health technology ecosystem improvements related to the following in the attachment:

- Updating the CAHPS survey to best capture the beneficiary experience in Medicare Advantage
- Developing uniform provider directory data elements and processes for increased efficiency and accuracy, including development of a national provider directory
- Supporting continued development of broadband access and permanently extending Medicare telehealth flexibilities
- Aligning data elements and definitions across CMS programs
- Promoting sustainable value-based care arrangements, including enhancing data sharing capabilities with community-based organizations

Better Medicare Alliance thanks you again for your commitment to Medicare Advantage. We appreciate the opportunity to submit comments and look forward to continued engagement and

partnership with CMS on shared goals to ensure Medicare Advantage continues to offer high-quality, affordable care to meet beneficiary needs.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

ATTACHMENT

Patient Needs

- **Updating the CAHPS survey to best capture the beneficiary experience in Medicare Advantage**

Better Medicare Alliance shares this Administration's commitment to Medicare Advantage policies that ensure the program remains a critical part of promoting value-based, person-centered care for Medicare beneficiaries. We appreciate the focus on patients' needs in this request for information and remain focused on ensuring Medicare Advantage continues to offer high-quality and affordable care and extra benefits tailored to meet the needs of Medicare beneficiaries.

As we consider how to best meet patients' needs, we encourage CMS to further address limitations of CAHPS and modernize the survey, with input from stakeholders and beneficiaries. Better Medicare Alliance has previously made recommendations around the current limitations of measuring patient experience in the Medicare Advantage CAHPS survey.[1] Recommendations include modernizing measurement by updating the survey language to reflect the unique needs of today's beneficiaries, provide more granular survey results to health plans to empower better quality improvement, remove questions that health plans cannot directly impact, and explore ways to reduce burden on beneficiary survey respondents to improve response rates. CMS has taken steps to address these limitations, including piloting a web-based CAHPS survey method and we applaud CMS for their actions and look forward to further engagement on modernization efforts.

- **Developing uniform provider directory data elements and processes for increased efficiency and accuracy**

Beneficiaries rely on provider directories to find providers and equip them with the information necessary to make informed decisions on their choice of health plan and provider, based on information such as in-network status, location, language proficiency, and more. We appreciate the challenges beneficiaries face with accessing up-to-date and timely information and the complexities providers and health plans experience to update directory information.
Both short- and long-term opportunities remain to improve the utility and accuracy of provider directories that require standardizing and creating more uniform and regular data updates and promote transparency around provider networks for beneficiaries.

1. Require health plans to standardize their processes, including data collected, for requesting personnel changes from providers. Provider groups have reported that health plans have different processes for reporting personnel changes, which adds unnecessary administrative burden for providers. CMS could first develop a model form

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[1] Center for Innovation in Medicare Advantage, Measuring Patient Experience of Medicare Advantage Beneficiaries: Current Limitations of the Consumer Assessment Tool and Policy Recommendations, January 2021. Available here.

with standardized data for personnel changes, and second, require health plans to adopt the model form and follow a standardized process for personnel reporting.

2. Increase demographic and accessibility-related information included in provider directories. CMS could build on its recent efforts by including demographic and other accessibility-related information in provider directories. For example, provider directory information could include whether a provider has expertise in addressing specific health care needs or chronic illnesses.

Provider directory data would empower beneficiaries to choose providers that can understand and relate to their experiences and background. Multiple studies suggest that when providers share the same race or ethnicity as their patients, there are improvements to a variety of outcomes, including time physicians and patients spent together and medication adherence as well as patient perceptions of treatment decisions.[2] Beneficiaries should have the option to find a provider they can relate to, if they so choose, and more robust data in directories would enable beneficiaries to choose the best provider for them. This data could positively impact beneficiaries' health care experience, including their choice in finding a provider that best fits their needs and health outcomes.

CMS' commitment to creating a national provider directory would improve accuracy, comparability, and beneficiary access. We recommend that the development of a directory be a private-public partnership. Such an approach is necessary to streamline collection of information, improve accuracy, and to allow connections with other data management systems/Electronic Health Records potentially including scheduling/practice management systems. The directory could be fully searchable, include an application program interface for easy access to third-party organizations that support beneficiary decision-making, and offer digital endpoints to support care coordination. The national provider directory should also remain flexible enough to accommodate additional data elements required by specific states or circumstances. The national provider directory should also include:

1. **The ability to update across public and private directories:** A national provider directory should be designed for interoperability, allowing seamless data exchange with existing provider directory solutions and databases. This includes linking with health insurer and group health plan directories, Medicare, Medicaid, state licensing databases, and health agencies, as well as reputable data sources such as the Council for Affordable Quality Healthcare (CAQH) and the National Plan and Provider Enumeration System (NPPES).

2. **Resources and incentives to providers:** Recognizing the administrative burden faced by providers in submitting timely and accurate information to directories, CMS could offer support to encourage provider adoption of a national health directory. To address this, CMS could allocate technical assistance and training. Leveraging best practices and incorporating lessons learned will help create a more efficient and optimized platform, minimizing the burden on providers.

3. **Standardized data elements:** CMS could collaborate with stakeholders to establish a standard set of core data elements and essential fields to populate a national provider

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[2] Michigan Medicine University of Michigan. Minority Patients Benefit From Having Minority Doctors, But That's a Hard Match to Make. March 31, 2020. Available here.

directory. The national provider directory should also remain flexible enough to accommodate additional data or elements required by specific states or circumstances. For example, it could include optional fields for provider race, ethnicity, gender, etc., and should be adaptable to future data requirements.

4. **Include a broad range of health care providers:** Health care providers extend beyond traditional physician practices and hospitals. As such, a national provider directory should encompass ancillary providers such as dental, vision, behavioral health, pharmacies, post-acute care facilities (i.e., skilled nursing and long-term acute care facilities), and social service programs. Including a broader set of health care and social service providers will ensure a national provider directory can address a person's social, emotional, and physical health and wellbeing.

5. **Trusted Governance:** The success of a national provider directory hinges on the establishment of trusted governance. Without a central, transparent authority to define standards, oversee data accuracy, and ensure accountability, provider information can quickly become outdated, fragmented, or inconsistent across systems. Trusted governance is essential to set clear expectations for data contributors, maintain data integrity, and align incentives across health plans, providers, and technology vendors.

Providers

- **Supporting continued development of broadband access and permanently extend Medicare telehealth flexibilities.**

The home has increasingly become a viable site for care delivery, with advancements in technology such as telehealth as a primary driver. Better Medicare Alliance believes delivering high-quality care in rural communities includes both in-person and telehealth/virtual care options. Rural communities have fewer health care workers, emergency facilities, critical care units, and specialists, and accessing in-person care can be a burden as there are fewer transportation options and people tend to live farther away from health care services.[3] Medicare Advantage can offer services such as expanded telehealth services and transportation for appointments, enabling beneficiaries to have stronger access to comprehensive health care despite the challenges posed to rural beneficiaries.

Telehealth is one tool to increase access to care for rural Americans and especially vital for improving access to specialists. Compared to urban areas, rural areas have a third as many specialists per capita.[4] Further enhancing and expanding telehealth means people living in rural areas have access to specialists and services more readily. Additionally, telehealth reduces the burden experienced by beneficiaries, including travel costs and travel time, while decreasing staffing costs for providers.[5]

Like other approaches, telehealth is not without its challenges. Underdeveloped technology and poor broadband access can make it difficult for those in rural areas to utilize telehealth to its full potential. Broadband access in rural areas lags behind coverage in urban areas; 22.3% of rural Americans lack access to broadband compared to 1.5% of Americans living in urban areas,

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[3] Centers for Disease Control and Prevention, Rural Health: Preventing Chronic Diseases and Promoting Health in Rural Communities, February 2023. Available here.
[4] Cyr ME, Etchin AG, Guthrie BJ & Benneyan JC. Access to specialty healthcare in urban versus rural US populations: a systematic literature review. BMC Health Serv Res. 2019;19(1):974. Available here.
[5] Butzner M & Cuffee Y, Telehealth interventions and outcomes across rural communities in the United States: Narrative review, J Med Internet Res. 2021; 23(8): e29575. Available here.

meaning one in five rural Americans are without high speed internet.[6] Significant progress and investment has been made in broadband infrastructure, however, opportunities remain.

Evaluating the progress made on broadband expansion, assessing and identifying any outstanding gaps, and continued investment into expanding broadband internet access in rural areas is vital to shrink this stark gap and necessary next steps. Leading organizations such as the National Rural Health Association also recommend that Congress continue to invest in rural broadband and update reimbursement methodology in order to extend access for rural patients.[7]

Medicare Advantage is especially able to deliver and enhance care with telehealth as the program faces fewer restrictions on offering telehealth than Fee-for-Service (FFS) Medicare. For example, Medicare Advantage has fewer restrictions and more flexibility on telehealth reimbursement. Additionally, Medicare Advantage plans offer telehealth benefits beyond those covered by FFS Medicare and have the flexibility to modify cost-sharing requirements.[8] These differences uniquely position Medicare Advantage to provide telehealth services and deliver health care to those living in remote areas without access to nearby physicians or specialists.

Prior to the COVID-19 pandemic, telehealth in Medicare was limited. Many of the restrictions that limited beneficiaries from utilizing telehealth services were waived and subsequently extended through the Consolidated Appropriations Act of 2023. However, opportunities remain to remove legislative barriers and restrictions, including changing geographic and originating site restrictions, qualifying providers, Federally Qualified Health Center and Rural Health Centers expansion, audio-only communication, face-to-face requirement for hospice care, and in-person requirement for mental telehealth services. While these barriers apply more broadly to Medicare and are not specific to Medicare Advantage, action would substantially improve beneficiary access to care with fewer disruptions and offer certainty and clarity for the many providers that utilize telehealth in their care plans and management.

- **Creating data alignment standards**

CMS should align data elements and definitions when developing data collection standards and guidelines for assessment tools and payer software (e.g., electronic health records). Having standard definitions and guidelines would reduce the administrative burden on providers and allow data to be carried over rather than reentered once provided. Alignment of data elements related to demographics could help cultivate accurate data to aid CMS in analyzing and evaluating community needs. As an example, a recent CMS white paper highlights that Medicare and Medicaid use different categories when collecting enrollment data on race and ethnicity; Medicaid includes a category for 'multiracial' that does not exist in Medicare.[9] This misalignment of categories can limit the ability to evaluate the impact on health outcomes and target interventions.

[6] Ibid.
[7] National Rural Health Association, Telehealth in Rural America, January 2022. Available here.
[8] KFF, FAQs on Medicare Coverage of Telehealth, May 2022. Available here.
[9] CMS. Assessing Equity to Drive Health Care Improvements: Learnings from the CMS Innovation Center. Available here.

Payers

- **Promoting sustainable value-based care arrangements**

Value-based payment arrangements are a critical way to reduce health care costs and promote high-quality, person-centered care. In recent years, value-based arrangements have been growing in Medicare Advantage.[10] However, with the recent termination of the Value-Based Insurance Design (VBID) demonstration, it is imperative that CMS continue to support value-based care arrangements within Medicare. The focus on person-centered care and the growing transition to value-based care arrangements facilitate the identification of high-risk, high-need beneficiaries to offer the right care with the right provider to improve outcomes. In value-based arrangements, health plans are rewarded for meeting goals, such as improving quality or lowering cost of care, and they may not receive bonuses or a portion of payment if those goals are not met.[11] This encourages plans to provide higher value care and decrease wasteful spending while ensuring beneficiaries receive the care they need.

In value-based arrangements, health plans regularly exchange a wide range of data with CMS. Even with the significant data exchange, there are some downstream providers that assume the risk of their patients' health care costs and outcomes that do not have full insight into the data exchanged or are unable to use the data in an actionable and meaningful way in their practice and patient population. Value-based arrangements provide tangible outcomes and savings to the Medicare Advantage program and further promote the delivery of person-centered care.

Better Medicare Alliance appreciates the differences in health plan and provider sophistication to digest, analyze, and act on data as well as respecting the collaborative partnership health plans and providers develop to deliver value-based care to beneficiaries. Yet, identifying improved data exchange opportunities between health plans and at-risk providers with actionable data will promote better health care delivery, accurate assessment of risks and prediction of health care costs attributed to the patients, and sustainable value-based arrangements. As such, we suggest CMS, with further stakeholder engagement, consider whether there are opportunities to improve the exchange of data among all relevant downstream providers and stakeholders in a more timely manner while preserving the contracting process of health plans and providers in order to best meet the unique needs of the populations and communities served.

- **Enhancing data sharing capabilities with community-based organizations**

Community-based organizations and the services they deliver are vital to delivering local, tailored care to beneficiaries. The partnerships fostered by community-based organizations, health plans, and others are a critical component to Medicare Advantage and something Better Medicare Alliance seeks to encourage in our work and with our Allies. Through these partnerships, local, innovative interventions occur that further address and meet the need of beneficiaries.

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[10] 4Health Affairs. The Medicare Value-Based Care Strategy: Alignment, Growth, and Equity. July 21, 2022. Available here.
[11] The Commonwealth Fund. Value-Based Care: What It Is, and Why It's Needed, February 7, 2023. Available here.

CMS should work to elevate community-based organizations' data-collecting capabilities and improve data-sharing capabilities between health plans, community-based and aging service organizations and providers. Research shows that community-based organizations, especially those focused on specific diseases or sub-populations, are well-situated to reach beneficiaries and provide culturally competent care.