January 26, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: [CMS-4212-P] CMS Should Advance Insights by Optimizing the Use of Data in Medicare Advantage and Innovation Center Models to Enhance Health Access and Outcomes while Reining in Costs

Dear Administrator Oz,

On behalf of Applied Policy, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) Request for Information regarding modernization of the Medicare Advantage (MA) program. By responsibly combining and testing predictive methodologies that leverage CMS's unparalleled healthcare utilization, quality, and cost data with non-medical upstream drivers of health data, CMS is poised to dramatically advance and accelerate healthcare reform. CMS is uniquely positioned to strengthen payment accuracy, improve targeting of health benefits and upstream drivers of health services to optimize care access and outcomes, and reduce avoidable utilization by modernizing how Medicare Advantage Organizations (MAOs) and the CMS Innovation Center (CMMI) identify and support high-need beneficiaries.

Today, MA and CMMI models rely predominantly on retrospective clinical and claims data. While these data are essential, they capture risk only after disease progression or an acute medical event has occurred. At the same time, many of the most powerful predictors of utilization and care disruption, such as housing instability, income volatility, nutrition insecurity, lack of reliable transportation, and educational attainment, are already collected by other federal agencies. Leveraging these existing datasets under current statutory authorities would allow CMS to move from a reactive model of risk identification to a more proactive, predictive approach. Integration of this data with healthcare and claims data into predictive modeling could revolutionize the healthcare system's ability to identify and manage risk while preventing and slowing the progression of chronic disease through optimizing interventions and treatments at the patient-level.

The current Hierarchical Condition Categories (HCC) risk adjustment model effectively captures the costs associated with established disease based on healthcare utilization. However, it does not account for the upstream factors that influence whether beneficiaries can successfully manage those conditions. As a result, resource allocation remains largely reactive, and MAOs often deploy care management and supplemental benefits only after avoidable deterioration has already occurred.

We urge CMMI to develop and test alternate data integration and modeling approaches that incorporate upstream social and economic risk factors to identify risk earlier and more accurately. Doing so would spur innovation throughout healthcare system, and provide MAOs, ACOs, and providers with greater flexibility to address the holistic needs of beneficiaries with complex care needs.

Integrating selected federal datasets would allow CMS to develop a more complete, life-course view of beneficiary risk. Incorporating these signals would enable CMS to better understand variation in outcomes across similarly diagnosed populations and to calibrate payments and supplemental benefit targeting accordingly.

Datasets that could inform this work include:

- **Department of Education data** on educational attainment or district-level academic indicators, which may correlate with health literacy, preventive care uptake, and long-term disability risk;

- **Internal Revenue Service and Treasury data** on earned income patterns, income volatility, and participation in refundable tax credits (e.g., EITC, CTC), which are predictive of gaps in care and medication non-adherence;

- **Department of Housing and Urban Development data** on housing assistance participation, housing instability indicators, and local affordability metrics, which are strongly associated with avoidable utilization and poor chronic disease control.

To evaluate the impact of this approach, we recommend that CMMI consider launching a targeted model test: the Predictive Resource Alignment (PRA) Model. This model would assess whether incorporating cross-agency social risk indicators into benchmark calibration and care management targeting improves clinical outcomes and reduces total cost of care for MA or ACO populations.

Unlike prior approaches that rely heavily on self-reported social risk screenings, the PRA Model could utilize a secure, privacy-preserving data linkage architecture to generate de-identified, high-resolution geographic risk tiers. Participating MAOs or ACOs could receive a predictive risk feed, including a geographic heat map identifying beneficiaries at elevated risk of care disruption, without disclosing individual-level non-

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CMS data. This would allow plans to deploy limited resources, including social work support or medical nutrition therapy, where they are most likely to prevent avoidable deterioration.

Optional tracks within the model could allow MAOs or ACOs to incorporate other local or regional data sources, such as Duke University's Social, Environmental, and Equity Drivers (SEED) Health Atlas for North Carolina, to test whether their inclusion improves accuracy, leading to better health outcomes.

Crucially, such a model should be accompanied by the creation of model-specific research files accessible to external evaluators, consistent with CMMI's commitment to transparency and evidence generation. Current systems, such as the Virtual Research Data Center (ResDAC VRDC) and the use of qualified researcher agreements, could support exponential growth in information at no additional cost to CMS. By enabling independent, population-level research on the relationship between social risk factors and Medicare outcomes, CMS can strengthen the empirical foundation of future MA policy decisions and ensure that reforms are both effective and evidence-based.

The legal and technical foundations for this work already exist. The Evidence Act of 2018 encourages responsible data sharing and evaluation across federal agencies, and Section 1115A provides CMMI with broad authority to test innovative payment and service delivery models that improve quality and reduce costs. By thoughtfully bridging federal data silos, CMS can strengthen payment accuracy, improve targeting of benefits to improve health outcomes, and ensure Medicare Advantage dollars are aligned with the full range of factors that influence beneficiary outcomes.

Thank you for the opportunity to comment on this important effort to modernize Medicare Advantage for 2026 and beyond.

Sincerely,

James G. Scott

President & CEO

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