

August 31, 2022

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
Baltimore, Maryland 21244-8013

Submitted electronically to: <https://www.regulations.gov>

**Re: Medicare Program; Request for Information on Medicare
CMS-4203-NC (RIN 0938-AV01)**

I. Intro/Overview

The Center for Medicare Advocacy bases our policy work on our experience serving Medicare beneficiaries. While Medicare Advantage (MA) may work for many, we don't hear from these individuals. Instead, we hear from beneficiaries – commonly those who are sicker and have greater health needs – who have been poorly served by their MA plan. Certainly, beneficiaries in traditional Medicare face barriers to coverage and care, which we devote much of our time addressing. However, from our experience assisting Medicare beneficiaries, and borne out by independent research, many of these barriers are exacerbated for beneficiaries enrolled in Medicare Advantage. We are better able to speak to MA deficiencies, than successes, and therefore target our comments primarily on the former.

On a systemic level, there is a growing imbalance between MA and the traditional Medicare program, including in payment – leading to significant, wasteful overspending – along with expansions in coverage under MA without similar expansions in traditional Medicare, and far more favorable enrollment opportunities into MA than other types of coverage. It will take Congressional intervention to truly right this ship, but there is much that CMS can and should do in this regard.

The universal, traditional Medicare program, preferred by most beneficiaries, has been neglected for years, while the private Medicare Advantage (MA) system has been repeatedly bolstered and promoted. Over the last several years, a number of legislative, regulatory, and policy changes have combined to create an imbalance between traditional Medicare and Medicare Advantage (MA).¹ For example: coverage expansions such as the ability to provide new supplemental benefits were added for MA, but not for traditional Medicare; enrollment periods were changed to favor MA; and the scope of

¹ For a discussion of this growing imbalance, see, e.g.: Center for Medicare Advocacy Alert – “Tipping the Scales Toward Medicare Advantage” (March 2018) available at <https://medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage/>.

coverage by Medicare supplemental insurance policies (Medigaps) was restricted. Further, despite provisions of the Affordable Care Act that reined in excessive overpayments to MA plans, there is still evidence that MA is costing the Medicare program more than traditional Medicare spends per individual, with mixed health outcomes. We have offered policy recommendations to counter some of these issues over the years, and do so again here.²

In recent testimony before Congress, the General Accounting Office (GAO)³ stated that “[d]ue to our concerns about the program’s susceptibility to mismanagement and improper payments as well as its size and complexity, we have designated Medicare, including Medicare Advantage, as a high-risk program. We—along with [OIG] and others—have identified significant concerns with CMS’s oversight of the MA program [citations omitted].”

Over the last several years, a number of unimplemented recommendations concerning improving and enhancing various aspects of MA oversight have been issued by the Office of Inspector General, the General Accounting Office and the Medicare Payment Advisory Commission – as well as consumer advocacy organizations.⁴

As a growing number of Medicare beneficiaries enroll in MA plans, CMS must adjust its resources and staff accordingly, and enhance its oversight and enforcement of MA and MA plan sponsors.

II. Comments

A. Advance Health Equity

Ensuring that all MA Enrollees Receive the Care that they Need

- *Enrollees from racial and ethnic minority groups*

² See, e.g., Center for Medicare Advocacy “HHS Transition Memorandum for Biden Administration Department of Health & Human Services (HHS)” (December 2020) available at: <https://medicareadvocacy.org/transition-memo-2020/>.

³ General Accounting Office (GAO), “Medicare Advantage – Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf.

⁴ Office of Inspector General (OIG), “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Bliss_OI_2022.06.28_1.pdf; General Accounting Office (GAO), “Medicare Advantage – Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf; Medicare Payment Advisory Commission (MedPAC), “Improving the Medicare Advantage Program” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf; see, e.g., Center for Medicare Advocacy “HHS Transition Memorandum for Biden Administration Department of Health & Human Services (HHS)” (December 2020) available at: <https://medicareadvocacy.org/transition-memo-2020/>.

The House Energy & Commerce Committee, Oversight and Investigations Subcommittee recently held a rare oversight hearing analyzing Medicare Advantage plans.⁵ A memorandum⁶ to the Subcommittee prepared for the hearing by committee staff, under the heading “Disparities of Care” states:

A June 2021 JAMA Health Forum article found that MA contracts with higher star ratings had larger racial and ethnic disparities than did those with lower star ratings. Furthermore, MA contracts with lower concentrations of individuals of low socioeconomic status and Black or Hispanic individuals had larger disparities and worse quality for these individuals. An April 2021 CMS and Rand report also found that, with one exception, racial and ethnic minority MA beneficiaries reported experiences with care that were either worse than or similar to the experiences reported by White beneficiaries [citations omitted].

Some general trends in Medicare Advantage enrollment, and disenrollment, highlight disparities in care based on health, age, and race. Some of those trends are particularly concerning for older and sicker Medicare beneficiaries.⁷

Research suggests that healthier and younger enrollees tend to have more favorable views of their Medicare Advantage plans than sicker and older enrollees. Some research has pointed to the payment structure in Medicare Advantage as favoring healthier and younger beneficiaries.⁸ According to research compiled by the CMS, quality performance is lower for Black beneficiaries than for White beneficiaries in Medicare Advantage.⁹ Kaiser Family Foundation (KFF) data demonstrate that Black beneficiaries in Medicare Advantage reported cost-related problems at a higher rate than in traditional Medicare; Black beneficiaries in traditional Medicare who had supplemental insurance had even lower rates of cost-related problems.¹⁰ According to KFF, “[h]alf of Black Medicare Advantage enrollees in

⁵House Energy & Commerce Committee, Oversight and Investigations Subcommittee hearing titled, “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 28, 2022); video of hearing available here: <https://energycommerce.house.gov/committee-activity/hearings/hearing-on-protecting-americas-seniors-oversight-of-private-sector>.

⁶ Memorandum to Subcommittee on Oversight and Investigations Members and Staff from Committee on Energy & Commerce Staff Re: Hearing on “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 24, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Briefing_Memo_OI_Hearing_2022.06.28_0.pdf.

⁷ Note: some of the following text is adapted from the following article: Kata Kertesz, *Expansions of Medigap Consumer Protections are Necessary to Promote Health Equity in the Medicare Program*, 13 Stetson J. Aging L & Pol’y. 39 (2022).

⁸Momotazur Rahman, et al., High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare, Health Affairs (Oct. 2015) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676406/> (finding that [b]ecause Medicare Advantage plans receive prospective, capitated payments to finance and deliver services for their enrollees, they operate under strong incentives to manage their members’ health care costs. Policy makers have been concerned that capitated payments give Medicare Advantage plans an incentive to enroll healthier beneficiaries and to avoid enrolling those with chronic conditions. Indeed, a large body of literature based on data from the 1990s and early 2000s found that Medicare Advantage plans disproportionately enrolled healthier beneficiaries. This phenomenon, known as favorable risk selection, has historically yielded substantial overpayments to Medicare Advantage plans.)

⁹Ctr. for Medicare & Medicaid Serv., (CMS), “Racial, ethnic, and gender disparities in health care in Medicare Advantage,” (Apr. 2021), <https://www.cms.gov/files/document/racial-ethnic-gender-disparities-health-care-medicare-advantage.pdf>.

¹⁰ Jeannie Fuglesten Biniek et. al, *Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage*, Kaiser Family Foundation (June 25, 2021), https://www.kff.org/medicare/issue-brief/cost-related-problems-are-less-common-among-beneficiaries-in-traditional-medicare-than-in-medicare-advantage-mainly-due-to-supplemental-coverage/?utm_campaign=KFF-2021-Medicare&utm_medium=email&hsmi=136245934&hsenc=p2ANqtz--K3-McLM7FJKUQcUIMXntOZUgey_QlmT7VC2qrLku5wJbRUyadXPiZekbW7qx7uC_YojxQTWgFZ27P0skPLGxaekmkg&utm_content=136245934&utm_source=hs_email

fair or poor self-assessed health reported cost-related problems, compared to one-third of Black beneficiaries in traditional Medicare overall and just over one-fourth of Black beneficiaries in traditional Medicare with supplemental coverage.”¹¹

The differences were even more striking among Black Medicare beneficiaries who are under age 65 with disabilities. KFF found that about half (49%) of those enrolled in Medicare Advantage reported a cost-related problem, which is almost twice the rate reported among those with traditional Medicare overall (26%), and significantly higher than the rate of cost-related problems reported among beneficiaries in traditional Medicare who also had supplemental coverage (19%).¹²

A recent study is illustrative of the racial inequities in quality of care that can result from Medicare Advantage payment incentives. The research published in September 2021 in Health Affairs, “Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements,” found that double bonuses.¹³ for Medicare Advantage plans are “not an efficient. . . mechanism for improving the MA program. . . nor are they equitable in allocation of those dollars, disproportionately benefiting White beneficiaries relative to Black beneficiaries,” without improving quality or enrollment in the MA program.¹⁴

The study found that “Black beneficiaries were substantially less likely to reside in counties offered double bonuses than White beneficiaries, thus contributing to racial disparities in the allocation of double bonus dollars,” disfavoring Black beneficiaries.¹⁵ CMS structures the system with the expectation that quality bonus payments will partially be passed on to beneficiaries through assistance with Medicare premiums or additional benefits like dental benefits for example. Therefore, differences in the allocation of Medicare Advantage bonus payments to counties that are eligible and not eligible for double bonuses could result in racial and geographic disparities. These could include differences in availability of enhanced benefits, or “translate to higher premiums for the same benefits when offered to primarily Black versus primarily White populations, which could harm the financial well-being of Black beneficiaries.”¹⁶ These findings, taken together with the Kaiser Family Foundation report revealing that Black beneficiaries had more cost-related problems in Medicare Advantage is concerning. According to Kaiser Family Foundation, “enrollees in Medicare Advantage do not

(finding that a smaller share of Black beneficiaries in traditional Medicare (24%) than in Medicare Advantage (32%) reported cost-related problems. Rates of cost-related problems were lower among Black beneficiaries in traditional Medicare with Medicaid and other forms of supplemental insurance (20%)).

¹¹ *Id.*

¹² *Id.*

¹³ Adam A. Markovitz et al., *Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements*, Health Affairs (Sept. 2021),

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00349> (showing that the Health Affairs study describes double bonuses as follows: An unusual feature of the MA bonus program is the delineation of “double-bonus” counties. In these counties higher-quality plans receive certain MA bonuses at double the dollar level paid to comparably performing plans in counties that are ineligible for double bonuses. Through the ACA, Congress created three criteria that a county must meet to be eligible for double bonuses: historically high MA enrollment (at least 25 percent in 2009); low Medicare fee-for-service spending (below the national average in a given year); and a 2004 “urban floor” designation, given to Metropolitan Statistical Areas (MSAs) with at least 250,000 residents that qualify for the minimum MA benchmark rate and granted to areas with low fee-for-service spending. Although the proportion of counties qualifying for double-bonus status is small, at around 7 percent of counties nationally, the impact of their double bonus status is large because 27 percent of MA beneficiaries live in them, based on our analysis of Medicare data.).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

generally receive greater protection against cost-related problems than beneficiaries in traditional Medicare with supplemental coverage, particularly for some enrollees, such as Black beneficiaries in relatively poor health, despite having an out-of-pocket cap and additional benefits.”¹⁷ These disparities are particularly significant given that half of all Black and Hispanic beneficiaries were enrolled in a Medicare Advantage plan, compared to 36% of White beneficiaries in 2018.¹⁸

• *Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life*

Research – and the Center for Medicare Advocacy’s experience serving Medicare beneficiaries – also indicates that sicker beneficiaries are not as well served by Medicare Advantage. A 2021 Government Accountability Office (GAO) report, “Beneficiary Disenrollments to Fee for Service in Last Year of Life Increase Medicare Spending,” looked for increases in spending in the traditional Medicare program due to beneficiaries disenrolling from Medicare Advantage in the last year of life.¹⁹ The report found that beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate of all other Medicare Advantage beneficiaries, with certain Medicare Advantage Organizations (MAOs), which may offer several plans, experiencing disenrollment at the rate of nearly 10 times higher for beneficiaries in the last year of life than all other beneficiaries.^{20 21} As beneficiaries in the last year of life are generally recognized to be high-cost and disproportionately requiring specialized care, the findings underscore that the cost containment measures employed by Medicare Advantage plans appear to limit access to necessary care for sick beneficiaries. GAO states:

While disenrollment among some beneficiaries is expected, high levels of disenrollment, or disparities in disenrollment among beneficiaries in poorer health, may indicate potential issues with beneficiary access to care or with the quality of care provided.²²

The GAO report also cited that a “number of other studies have found that beneficiaries in poorer health may be more likely to disenroll from MA to join FFS [Fee-for-Service, i.e., traditional Medicare].”²³ The underlying data from the report supports our experience that there are equity concerns regarding the care that Medicare Advantage plans provide to sicker and older beneficiaries.

¹⁷ [Nancy Ochieng et al., *Racial and Ethnic Health Inequities and Medicare*, KFF \(Feb. 16, 2021\)](https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/)

<https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/>.

¹⁸ *Id.*

¹⁹ Beneficiary Disenrollments to Fee- for Service in Last Year of Life Increase Medicare Spending, 21 GAO 482 (2021) available at <https://www.gao.gov/products/gao-21-482>.

²⁰ *Id.* at 12. Report finding that “Certain MAOs—which may offer multiple MA plans—had substantially higher relative increases in disenrollments to join FFS by beneficiaries in the last year of life compared to other MAOs. For example, in 2017, the MAO with the highest relative increase in disenrollments to join FFS saw beneficiaries in the last year of life disenroll at nearly 10 times the rate of all other beneficiaries. . . . In both 2016 and 2017, the same two MAOs had the highest relative increase in disenrollments by beneficiaries in the last year of life.

²¹ Note that in June 2022, GAO stated that CMS confirmed their findings: “In 2022, CMS analyzed disenrollments by MA beneficiaries for 2019 through 2021 and similarly found higher disenrollment rates by MA beneficiaries in the last year of life under certain MA organization contracts.” General Accounting Office (GAO) “Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight” (June 2022) GAO-22-106026, available at:

https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf.

²² Beneficiary Disenrollments to Fee- for Service in Last Year of Life Increase Medicare Spending, 21 GAO 482 (2021) available at <https://www.gao.gov/products/gao-21-482>.

²³ *Id.*

There has been much research highlighting the fact that Medicare Advantage enrollees who experience adverse health events or who have greater health needs switch from Medicare Advantage into traditional Medicare at higher rates.²⁴

A 2015 study in Health Affairs, “High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare,” found increased rates of switching out of Medicare Advantage into traditional Medicare among people who used home health and nursing home services, when compared to beneficiaries who did not use home health and nursing home care. Conversely, the study found lower rates of switching out of traditional Medicare into Medicare Advantage among people who used nursing home, home health, or acute inpatient care, when compared to beneficiaries who did not use these services.²⁵ “We found that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (17 percent versus three percent), short-term nursing home care (nine percent versus four percent), and home health care (eight percent versus three percent). These results were magnified among people who were enrolled in both Medicare and Medicaid.”²⁶

The report concluded that:

substantial switching from Medicare Advantage to traditional Medicare by beneficiaries who used nursing home and home health care, particularly those who were also eligible for Medicaid, and virtually no entry into Medicare Advantage plans by traditional Medicare

²⁴ See David J. Meyers, et al., *Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries*, JAMA Intern Med (Feb. 25, 2019), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2725083> (finding “[r]esults of this study suggest that substantially higher disenrollment from MA plans occurs among high-need and Medicare-Medicaid eligible enrollees. This study’s findings suggest that star ratings have the strongest association with disenrollment trends, whereas increases in monthly premiums are associated with greater likelihood of switching plans.”); See also Qijuan Li, et al., *Medicare Advantage Ratings And Voluntary Disenrollment Among Patients With End-Stage Renal Disease*, Health Affairs (January 2018), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0974> (finding that there is “a strong association between MA plans’ star ratings and incident ESRD patients’ voluntary disenrollment from MA plans to traditional Medicare in the year following the initiation of dialysis. These patients’ disenrollment rates, especially rates of switching from MA to traditional Medicare, were significantly higher than disenrollment rates among all MA beneficiaries. These findings suggest that the rate of voluntary disenrollment among high-cost, high-need patients may be an important measure of MA plan quality, that CMS and other policy stakeholders may want to monitor such disenrollment rates, and that low plan quality may lead to increased spending in traditional Medicare by shifting the costs of the ESRD population from some MA plans to traditional Medicare. Further research is needed to understand whether these findings extend to other chronically ill populations.”); Sungchul Park, David J. Meyers & Brent A. Langelier, *Rural Enrollees In Medicare Advantage Have Substantial Rates Of Switching To Traditional Medicare*, Health Affairs (March 2021) <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01435> (even greater among rural enrollees who were high cost or high need); Claire K. Ankuda, Katherine A. Ornstein, Kenneth E. Covinsky, et al., *Switching Between Medicare Advantage And Traditional Medicare Before And After The Onset Of Functional Disability*, Health Affairs (May 2020) <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01070> (while the rate of switches from Medicare Advantage to traditional Medicare increased slightly after disability onset, people with greater levels of disability were more likely to switch to traditional Medicare, compared to those with lower levels); See also, Patricia Neuman & Gretchen Jacobson, *Medicare Advantage Checkup*, New England Journal of Medicine (Nov. 29, 2018) <https://www.nejm.org/doi/full/10.1056/nejmhpr1804089> (finding evidence that quality of care is mixed with generally higher rates of preventive care and screenings among MA recipients, but “[s]omewhat counterintuitively, there seems to be no difference between Medicare and [MA] plans with respect to care coordination” and “[s]everal studies have flagged concerns about the quality of care received by high-need, high-cost enrollees, on the basis of disenrollment rates and other measures.”).

²⁵ Rahman, et al., *supra* note 8.

²⁶ *Id.*

beneficiaries who used these services or acquired dual eligibility. We found that a high proportion of beneficiaries with nursing home or home health care use choose to exit the Medicare Advantage program by the start of the next plan year. Thus, our study raises questions about the role of Medicare Advantage plans in serving high-cost patients with complex health care needs that span acute, postacute, and long-term care settings.²⁷

The above data highlight health equity concerns with Medicare Advantage. The increased enrollment in Medicare Advantage (Medicare Advantage enrollees now account for nearly half or 48% of the eligible Medicare population)²⁸ not only raises access issues for beneficiaries enrolled in the plans, but also undermines the social insurance structure of the Medicare program. “With legislative and administrative action over many years, the steady increase in measures that disproportionately favor the private Medicare Advantage program over traditional Medicare has led to increased enrollment in the plans and concerns about the traditional Medicare program being chipped away and slowly becoming privatized.²⁹ It is vital to the very existence of the Medicare program that it maintain a social insurance structure, providing reliable, consistent access to care on which all beneficiaries can rely, with a defined benefit and guaranteed coverage regardless of health status, age or income.”³⁰

The clear health equity concerns in Medicare Advantage call out for many policy changes, including improving Medicare Advantage oversight, payment reform or legislation to achieve parity between Medicare Advantage and traditional Medicare.³¹ Addressing the equity concerns in Medicare Advantage would help to address the underlying disparities central to the decision to switch from Medicare Advantage to traditional Medicare. While CMS would need the assistance of Congress to

²⁷ *Id.*

²⁸ Freed, Biniek, Damico & Neuman, “Medicare Advantage in 2022: Enrollment Update and Key Trends” (Aug. 25, 2022), available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/?utm_campaign=KFF-2022-Medicare&utm_medium=email&_hsmt=223948822&_hsenc=p2ANqtz-W3TYDMGI5Os9Tz858DUfYBZ6OyuoAEYNYOGj5AV7LmD4rpmj0zS1YM4helehdqgwZmp6unwcLEWQFhFVhTQFTDm5H0qcKAshQEOnyOwrTzPMjdE&utm_content=223948822&utm_source=hs_email.

²⁹ See, Center for Medicare Advocacy, *Tipping the Scales Toward Medicare Advantage*, (Mar. 21, 2018), <https://medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage/>; See also, David A Lipschutz, *Commentary: Don't Further Privatize Medicare*, *Inquiry* (Aug 5, 2019), See also, Emily Gee, Maura Calsyn & Nicole Rapfogel, *Trump's Plan To Privatize Medicare*, Center for American Progress (CAP), (Oct. 11, 2019) <https://www.americanprogress.org/issues/healthcare/news/2019/10/11/475646/trumps-plan-privatize-medicare/>; See also The New York Times, *Medicare's Private Option Is Gaining Popularity, and Critics*, (Feb. 21, 2020) <https://www.nytimes.com/2020/02/21/business/medicare-advantage-retirement.html>; See also Bob Herman, *Medicare has become more of a private marketplace — and it's costly*, *Axios*, (Aug 11, 2021) <https://www.axios.com/medicare-advantage-enrollment-spending-pandemic-risk-adjustment-d1a608ff-15eb-47bf-8952-0e1c5af097d5.html>; See also, [Trudy Lieberman](#), *This latest under-the-radar program could push Medicare deeper into private hands*, *USC Annenberg, Center for Health Journalism*, (Mar. 11, 2021) <https://centerforhealthjournalism.org/2021/03/10/latest-under-radar-program-could-push-medicare-deeper-private-hands>; See also, Center for Medicare Advocacy, *MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage*, (Sept. 20, 2021) <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-000000000001&ceid={{ContactsEmailID}}>.

³⁰ Kata Kertesz, *Expansions of Medigap Consumer Protections are Necessary to Promote Health Equity in the Medicare Program*, 13 *Stetson J. Aging L & Pol'y.* 39 (2022).

³¹ See Committee for a Responsible Federal Budget, *Reducing Medicare Advantage Overpayments*, (Feb. 23, 2021), <https://www.crfb.org/papers/reducing-medicare-advantage-overpayments>; See also Center on Budget and Policy Priorities, *Medicare Advantage Upcoding, Overpayments Require Attention*, (Oct. 30, 2018) <https://www.cbpp.org/blog/medicare-advantage-upcoding-overpayments-require-attention>; *June 2021 Report to Congress*, (Jun 2021), MedPAC, http://medpac.gov/docs/default-source/reports/jun21_executivesummary_medpac_report_to_congress_sec.pdf?sfvrsn=0.

make many of these changes, it should support and promote legislation that would, for example, expand Medigap rights (as discussed further below).

As a beneficiary advocacy organization, much of the Center for Medicare Advocacy’s work is devoted to identifying and addressing barriers to care for Medicare beneficiaries. While there are many such barriers in traditional Medicare, in our experience, **these problems are exacerbated for beneficiaries in Medicare Advantage.** While some MA enrollees are well served by their plans, the people who contact us are those who tend to be sicker and often have greater care needs than most MA enrollees – including those with chronic conditions. This is the population that is falling through the cracks when it comes to accessing medically necessary care in MA plans.

We deal with individual cases, but our experience about the plight of those who are sicker needing care from MA plans is borne out by others serving Medicare beneficiaries, as well as the research cited above. For example, access to the Medicare home health benefit, in general, has become more challenging in recent years. As the Center for Medicare Advocacy has repeatedly written,³² people who legally qualify for Medicare coverage frequently have great difficulty obtaining and affording necessary home care. There are legal standards that define who can obtain coverage, and what services are available. However, the criteria are often narrowly construed and misrepresented by providers and policy-makers, resulting in inappropriate barriers to Medicare coverage for necessary care. This is increasingly true for home health aide services, for example – the very kind of personal care services vulnerable people often need to remain safely at home.

But access to such care is generally more challenging for those enrolled in MA plans. From April 2021 through November 2021, CMA conducted a survey of 217 Medicare-certified home health agencies (HHA) in 20 states to learn what beneficiaries may experience when seeking home care.³³ In addition to finding widespread misunderstanding of Medicare coverage law, and that home health agencies apply improper coverage criteria in a number of ways, access to home health services by MA enrollees seemed even more challenging. Despite a statutory mandate that MA plans cover all medically necessary services that traditional Medicare covers, home health agencies themselves, according to both our experience and the survey, “describe a very different reality. Agencies from 16 different states volunteered that in their experience, Medicare Advantage plans provide less to patients and require more of agencies.” The report continues: “Major themes among agency comments were that Medicare Advantage plans deny more services, allow fewer visits per care modality, delay onset of care, lead to more changes to provider-approved plans of care, are significantly harder for agencies to work with, and require greater out-of-pocket costs. Many agencies also mentioned discrepancies in care caused by the pre-authorization process.”

Recommendations

Barriers to care for individuals with chronic conditions persist in the traditional Medicare program; these are often exacerbated in MA plans. Addressing these issues systemically across the entire Medicare program will accrue to the benefit of MA enrollees. Despite significant overpayments to

³² See, e.g., Center for Medicare Advocacy “Issue Brief | Medicare Home Health Coverage: Reality Conflicts with the Law” (April 2021), available at: <https://medicareadvocacy.org/issue-brief-medicare-home-health-coverage-reality-conflicts-with-the-law/>.

³³ Center for Medicare Advocacy “Home Health Survey | Medicare Beneficiaries Likely Misinformed and Underserved” (December 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>.

MA plans, though, health outcomes of enrollees are decidedly mixed; those who are sicker tend to disproportionately disenroll from MA plans. Our experience at the Center for Medicare Advocacy bears this out.

Further, enhanced oversight of MA plans is required to ensure that they are providing required medically necessary care.

In our comments below in response to section B.10 relating to re: utilization management/prior authorization, we offer recommendations that are applicable to this section too, including urging CMS to implement various recommendations from the Office of Inspector General (OIG) and the General Accounting Office (GAO).

GAO recommendations for CMS to monitor disenrollments from MA plans by beneficiaries in the last year of life; since other research (outlined above) shows that people who are generally in poorer health disproportionately disenroll from MA plans – regardless of whether they are in the last year of life – we urge CMS to broaden GAO’s recommendation

- According to GAO, CMS has begun analyzing disenrollments in the last year of life, which found such disenrollments “elevated in certain MA contracts” – and CMS plans to conduct these analyses annually
- CMS’ quality of care include beneficiary disenrollment –
 - Increase oversight and audit capacity
 - Monitor disenrollments

Enhance Audit Capacity and Increase Transparency on Enforcement Actions

As a growing number of Medicare beneficiaries enroll in MA plans, CMS must adjust its resources and staff accordingly, and enhance its oversight and enforcement of MA plan sponsors. Absent more dedicated CMS staff to conduct such activities, we urge CMS to revisit the agency’s prior proposal to increase audit and inspection authority. In a 2015 proposed rule³⁴, CMS details the criteria by which it determines which MA and Part D plan sponsors are audited each year and acknowledges that limited resources allow the agency to perform annual audits on only 10% of plan sponsors—30 of 300. CMS previously proposed, but chose not to finalize, a rule requiring plan sponsors to hire independent auditors. Given persistently poor plan audit results, namely involving appeals and grievances, we ask CMS to revisit this proposal.

Properly Administer Current Medicare Home Health Coverage Laws

As described in more detail in a CMA Home Health Survey (Dec. 2021)³⁵, CMS should do the following to ensure that the home health benefit is adequately administered in MA plans (and beyond), including:

- Provide Accurate, Ongoing Education About Medicare Home Health Coverage

³⁴ 80 Fed Reg 7919 (February 12, 2015).

³⁵ Center for Medicare Advocacy “Home Health Survey | Medicare Beneficiaries Likely Misinformed and Underserved” (December 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>.

- Provide ongoing education for all participants in the Medicare home health process, including, but not limited to: CMS, Medicare contractors and adjudicators, staff at 1-800-Medicare, state licensing and enforcement agencies, home health agencies, doctors and other authorized practitioners, HHS Office of the Inspector General, General Accounting Office and Medicare beneficiaries – and Medicare Advantage plans
- Review all CMS, provider, Medicare Advantage plan, contractor, and adjudicator print and on-line materials for consistent, accurate descriptions of Medicare-covered home health services in general, and home health aide services in particular
- Ensure Fair and Appropriate, Non-Discriminatory Implementation of Medicare- Covered Home Health Services, as Authorized by Law, in All CMS Practices and Policies
 - In the traditional Medicare setting, this would require developing a payment system that fairly compensates providers for all patients served and developing quality measurement programs that measure quality for all patients who are eligible for Medicare-covered home health care under the law
 - In the MA setting, in which plans set their payment rates to providers and the quality measurements are different, this will require more aggressive auditing of plans and tailoring MA quality measures to better account for plan failure to provide adequate care

Enforce the *Jimmo* Settlement³⁶ – barriers remain in traditional Medicare; addressing such barriers system-wide, including with respect MA plans, will help all Medicare beneficiaries

In order to ensure that the *Jimmo* settlement is properly implemented so that inappropriate denials due to an improper “improvement standard” cease, CMS must:

- Ensure CMS, its contractors, adjudicators, and providers are active partners in implementing *Jimmo*
 - This must include Medicare Advantage plans and their contracted providers, case management firms and other downstream entities involved in the provisions of care
- Require CMS to provide at least one training annually regarding the *Jimmo* Settlement for all contactors, adjudicators, and providers.
 - This must include Medicare Advantage plans and their contracted providers, case management firms and other downstream entities involved in the provisions of care
- Ensure Medicare providers know about the *Jimmo* Settlement, and provide appropriate access to coverage and care for people who need care to maintain their condition or slow decline, as authorized by law and confirmed by the court in *Jimmo v. Sebelius*.
- Monitor providers, contractors, and adjudicators at all levels of decision-making and appeals to ensure people who meet *Jimmo* criteria have appropriate access to coverage and care.
- Ensure CMS online and written materials and oral scripts recognize that Medicare can be available for necessary care to maintain an individual’s condition or slow decline, and that improvement is not a prerequisite to coverage.

³⁶ See, e.g., Center for Medicare Advocacy website at: <https://medicareadvocacy.org/medicare-info/improvement-standard/>.

CMS must enhance oversight of MA plans to ensure that they are providing required, medically necessary care, including:

- Enforce Current Law
 - With respect to individuals with chronic conditions, ensure fair and appropriate, non-discriminatory coverage of **home health** in both MA and traditional Medicare³⁷, and adequately enforce the *Jimmo v. Sebelius* settlement³⁸ to ensure that Medicare coverage is determined by a beneficiary’s need for skilled care, not on their potential for improvement
- Increase Oversight
 - Increase capacity to annually audit plans to ensure compliance with Medicare coverage and appeals rules, particularly as MA captures more beneficiary enrollment, HHS and CMS resources and staff must be allocated accordingly
 - This includes allocating staff and resources to carefully review all plan bids and conduct discriminatory impact reviews
 - While CMS has begun to analyze MA disenrollments in the last year of life (per GAO’s recommendation), such effort should be expanded beyond the last year of life to monitor disproportionate disenrollment by those in poorer health more generally. Importantly, findings should carry consequences for plan sponsors, including carrying greater weight in quality assessments and corresponding bonus payments, public disclosure of findings and sanctions for plans that are outliers
 - Given that MA plans want to maximize Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores re: enrollee satisfaction, they have an incentive to discharge unhappy enrollees, including encouraging Special Enrollment Periods (SEPs) that can help people leave an unwanted plan (not all such SEPs are currently reported to CMS); data regarding all SEPs that are exercised – even about those SEPs granted solely at plan discretion – should be collected and reported to CMS and factored into CMS’ oversight, including audits and quality ratings

Policies, Programs and Innovations that can Advance Health Equity in MA

With respect to individuals with serious or chronic conditions, require MA plans to track care that is not provided, or under-provided. In this respect, CMS can borrow from CMMI’s monitoring plans for REACH ACOs to track stinting on care.

³⁷ See, e.g., recommendations in Center for Medicare Advocacy, “Home Health Survey – Medicare Beneficiaries Likely Misinformed and Underserved” (Dec. 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>.

³⁸ See, e.g., recommendations in Center for Medicare Advocacy, HHS Transition Memo (Dec. 2020), available at: <https://medicareadvocacy.org/transition-memo-2020/#Jimmo>.

Also, approximately 1.7 million Medicare beneficiaries have a diagnosed SUD³⁹ and one in four beneficiaries have a mental health (MH) condition.⁴⁰ However, a staggering 93% of Medicare beneficiaries ages 65 and older with a SUD do not receive treatment,⁴¹ nor do an estimated one in three with MH needs.⁴² Of those who do not receive treatment, 37% of Medicare beneficiaries ages 65 and old report financial reasons – including insurance not covering care – as a barrier to SUD treatment.⁴³ The ongoing opioid public health emergency (PHE), compounded by the COVID-19 PHE, has had a disproportionately devastating impact on Black, Indigenous, and people of color (BIPOC), where Black men ages 65 and older die of drug overdose at a 7-times higher rate⁴⁴ than white men of the same age and BIPOC beneficiaries with opioid use disorder (OUD) were less likely⁴⁵ to receive medications for opioid use disorder (MOUD) than white beneficiaries in outpatient settings as well as following opioid-related emergency department visits.⁴⁶ The Center urges CMS to act on the Office of the Inspector General’s recommendations⁴⁷ to improve access to MOUD, especially for BIPOC Medicare beneficiaries to reduce this significant health disparity.

Access to Language Services

CMS currently requires that plans must have interpreters available for customer service lines, along with a general requirement to provide needed interpreter services. While the current NPRM proposing regulations to implement Section 1557 of the Affordable Care Act also provide helpful standards with respect to when interpreter services are required and quality standards for interpretation, we ask that CMS provide MA plans with more specific regulatory requirements, as well as offer more detailed guidance and technical assistance to apply 1557 norms to the specific circumstances of Medicare managed care.

For example, MA plans should be required to have systems in place to ensure that providing interpreter services is easy for network providers and does not add to provider costs. Other issues include how language needs of limited English proficient (LEP) members are identified; reasonable criteria to

³⁹ William J. Parish, Tami L Mark, Ellen M Weber, Deborah G Steinberg, “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers” *Am J Prev Med.* 2022 Aug;63(2):225-232. doi: 10.1016/j.amepre.2022.01.021. Epub 2022 Mar 21, available at: <https://pubmed.ncbi.nlm.nih.gov/35331570/>.

⁴⁰ Commonwealth Fund, “Medicare’s Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement” (July 2020), available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities>.

⁴¹ Parish, *supra* note 39.

⁴² Commonwealth Fund, “Comparing Older Adults’ Mental Health Needs and Access to Treatment in the U.S. and Other High-Income Countries” (Jan 2022), available at: <https://www.commonwealthfund.org/publications/issue-briefs/2022/jan/comparing-older-adults-mental-health-needs-and-access-treatment>.

⁴³ Parish, *supra* note 39.

⁴⁴ US Department of Health and Human Services/Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, “Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020” *MMWR* / July 22, 2022 / Vol. 71 / No. 29, available at: <https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7129e2-H.pdf>.

⁴⁵ US HHS Office of Inspector General (OIG), “Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder” (Dec. 2021), available at: <https://oig.hhs.gov/oei/reports/OEI-02-20-00390.pdf>.

⁴⁶ Maria A Stevens, Jennifer Tsai, Samuel T Savitz, “Trends and Disparities in Access to Buprenorphine Treatment Following an Opioid-Related Emergency Department Visit Among an Insured Cohort, 2014-2020” *JAMA Netw Open.* 2022;5(6):e2215287. doi:10.1001/jamanetworkopen.2022.15287, available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792963>.

⁴⁷ OIG, *supra* note 45.

decide when telephone interpretation versus in-person interpretation is appropriate (recognizing the wide variability in the mix of plan membership, the availability of local language resources and many other factors); addressing language needs in supplemental services such as NEMT, congregate activities, etc.; and cultural competency training for MA plan staff and network providers.

We ask CMS to revisit current 42 C.F.R. § 422.2267(a)(2) and its companion regulation for Part D, 42 C.F.R. § 423.2267(a)(2), which require translation of certain marketing and communications materials “into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area.” As noted by our colleagues at Justice in Aging, with very few exceptions, this standard means that the translation requirement applies only to Spanish.

For both translation and interpretation, we urge CMS to increase its oversight of plan performance, including, e.g., through secret shopper testing of language access, monitoring of language access grievances, focus groups and other measures.

Special Needs Plans (SNPs)

We appreciate the D-SNP regulations recently adopted by CMS as a positive development for dual eligible enrollees. The regulations provide clarity on requirements for different types of D-SNPs, remove several technical barriers to oversight of D-SNPs, and begin to set federal minimums for certain beneficiary protections in D-SNPs.

We encourage CMS to build on the foundation of regulations recently finalized by CMS that strengthen beneficiary protections in D-SNPs. For example, we ask that CMS encourage SNPs to offer more comprehensive care management for enrollees, and to assist enrollees with navigating their benefits. In our experience, people with both Medicare and Medicaid can struggle to understand and access the full range of benefits to which they are entitled.

Further, we ask CMS to look particularly closely at supplemental benefits, ensuring that they neither duplicate nor supplant benefits under Medicaid, and that dual eligible enrollees can easily navigate between D-SNP supplemental benefits and complementary Medicaid benefits (e.g., having dental providers who belong to both networks). In particular, we ask that CMS ensure that supplemental benefits not work to erode rights to Medicaid benefits. We are concerned that the expansion of supplemental benefits can easily become an excuse for state Medicaid programs to fail to offer the robust services that Medicaid beneficiaries need.

In addition, beneficiaries should never be defaulted into a plan that does not include all of their providers. To the extent that CMS grants permission for the use of default enrollment, CMS must require a very high matching threshold for network congruency and withdraw permission where plans have inadequately congruent provider networks. This is particularly important for behavioral health. At the very least, there should be continuation of care requirements of at least 12 months in any default enrollment agreements between CMS, states, and plans.

B. Expand Access: Coverage and Care

Choosing Between Different Coverage Options

As noted in a 2022 Commonwealth Fund blog⁴⁸ exploring Medicare Advantage plans and choice, health economists and Medicare experts “said choosing among plans can be difficult, even for the savviest consumers” and such experts “agreed that most beneficiaries aren’t making informed or active decisions. Instead, many choose plans based on advertising, word-of-mouth, or brand loyalty, then stay with those plans year after year, even if another plan would better serve their interests.”

When deciding how they want to access their Medicare coverage, Medicare beneficiaries face myriad, complicated choices among unequal options. These choices include disparate enrollment rights and opportunities between Medicare Advantage and Medigap plans (for example, while people can get in and out of an MA plan on an annual basis, most people have limited opportunities to purchase a Medigap plan – a fact many people discover too late).

In recent years, Congress has made legislative changes that favor enrollment in Medicare Advantage plans, exacerbating inequities re: coverage choices. These changes include:

- Revising the Medicare Advantage Open Enrollment Period (MA-OEP) so that it favors MA enrollment over traditional Medicare by giving those in MA plans more flexibility to make changes to their coverage (someone with traditional Medicare can’t even switch Part D plans at this time) – pursuant to CURES Act of 2016, effective 2019
- Requiring MA plans to enroll individuals with ESRD (who were previously excluded) starting in 2021 (also pursuant to the CURES Act) without at the same time expanding federal Medigap guarantee issue rights to require Medigap issuers to sell policies to people with ESRD (or other individuals under 65)
- Restricting the scope of coverage by Medicare supplemental insurance policies (Medigaps) by eliminating coverage of the Part B deductible for policies purchased after January 1, 2020 – pursuant to MACRA of 2015

Further, most people do not compare MA plans,⁴⁹ and for those who do, there are barriers standing in the way of informed decision-making, such as flawed Star Ratings (discussed below) and increased complexity in MA benefits due to recent policy changes that, among other things, allow plans to target supplemental benefits to some, but not all, of their enrollees.⁵⁰ The erosion of MA uniformity standards

⁴⁸ Commonwealth Fund, “Taking Stock Of Medicare Advantage: Choice” (March 2022), available at: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

⁴⁹ Kaiser Family Foundation, “Seven in Ten Medicare Beneficiaries Did Not Compare Plans During Past Open Enrollment Period” (Oct. 2021), available at: https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/?utm_campaign=KFF-2021-Medicare&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz-82mijV6Zi5irMbwZs3q0kCrSzpqV7SIKq_NIRzO1i-6YBZNV637DTnnK-TetdTSIfDkWYm6S1LeNjt1-YnlcrsfQfcA&utm_content=2&utm_source=hs_email&emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d.

⁵⁰ For further discussions of limitations on consumer choice, see, e.g., CMA [here](#), [here](#) and [here](#); also see [Commonwealth Fund](#) (2022)).

and meaningful difference requirements have made informed choice more, not less, difficult.⁵¹ Starting in 2023, CMS rules allow plans to choose among three maximum out-of-pocket (MOOP) limits, each with different cost-sharing allowances, adding even more complexity to plan comparison.

Beneficiary “choice” and plan “flexibility” should not be stand-ins for adequate consumer protections. The processes for offering and selecting private Medicare plans should not be designed for the savviest consumer, as is now the case; rather, there must be standard, baseline means of plan comparison. Instead of making options more complex, we call for greater standardization of plans, akin to how Medigap plans were standardized in the ‘90s. In addition, with the average Medicare beneficiary in 2022 having access to 39 MA plans – the largest number of options available in more than a decade⁵² – CMS should make efforts to limit the number of plan options. Standardization, such as for Medicare Supplement (Medigap) policies, should be seriously considered since it greatly enhances the ability of beneficiaries to understand and compare plan offerings. There can be such thing as “too much choice” and in the interests of consumer protection, rather than take all comers who meet nominal standards, CMS should be more selective in plan sponsors that are allowed to offer their products to Medicare beneficiaries.

Recommendations

In order to help promote informed and unbiased decision-making among Medicare beneficiaries, CMS should:

- As a primary source of information about coverage options, CMS must provide balanced and neutral information about both the advantages and disadvantages of MA plans (see, e.g., this CMA report on the 2022 *Medicare & You Handbook*⁵³ noting improvement in this regard, but lingering deficiencies in explaining, e.g., MA out-of-pocket costs and prior authorization)
- More actively promote and advocate for increased funding and capacity for State Health Insurance Assistance Programs (SHIPs) and Senior Medicare Patrol (SMP)
- Urge Congress to expand federal Medigap guarantee issue rights in order to make Medicare coverage options between MA and traditional Medicare more equal and truly allow beneficiaries in MA plans to switch back to traditional Medicare
- As discussed below, while MA Star Ratings are promoted as tool for consumer comparison of plans, they do not adequately do so and must be overhauled in a manner that strengthens public reporting on plan quality and variation
- As discussed below, CMS must further strengthen consumer protections surrounding plan marketing, including further oversight of plan advertising and addressing agent/broker compensation issues

⁵¹ See, e.g., discussion in [CMA Special Report: Recent Changes in Law, Regulations and Guidance Relating to Medicare Advantage and the Prescription Drug Benefit Program](#) (Sept 2018).

⁵² Kaiser Family Foundation, “Medicare Advantage in 2022: Enrollment Update and Key Trends” (Aug. 25, 2022), available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>.

⁵³ Center for Medicare Advocacy, “MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage” (Sept. 20, 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-000000000001&ceid={{ContactsEmailID}}>.

Choosing Between an MA Plan or Traditional Medicare and Medigap

While we understand that changes to Medigap consumer protections, including allowing beneficiaries to enroll in a Medigap plan for any reason after their one-year MA trial period ends would require Congressional action, we do think that CMS can improve beneficiary understanding on this issue. Many beneficiaries do not understand that by enrolling in an MA plan they have such a limited window in which to decide that MA fits their long-term health needs; many beneficiaries do not understand that they are in effect giving up their right to the cost-sharing protections provided by Medigap plans if they enroll in MA instead of traditional Medicare. This is a complicated issue that does not get much attention. Not having access to Medigap can have catastrophic consequences for beneficiaries who cannot afford the out-of-pockets costs they could incur in traditional Medicare without a Medigap plan, but are not having their health care needs adequately met in MA and would like to switch to traditional Medicare. These beneficiaries are essentially stuck in MA. This is not the picture that MA plans would like to project when touting consumer choice, and retention rates of beneficiaries, but the reality is that many beneficiaries are simply unable to switch to traditional Medicare because of the limited Medigap consumer protections in most states.

An obvious place to explain this issue in detail is the annual *Medicare & You* handbook where many beneficiaries obtain their knowledge of the difference between MA and traditional Medicare. We thank CMS for improving the Handbook in its most recent revision from the previous years that had inaccuracies and clear bias toward MA. However, we think additional emphasis and more detailed explanations of this crucial issue would be helpful for beneficiaries. A section underscoring the long-term financial and health implications of forgoing Medigap and opting for MA would improve understanding of this issue.⁵⁴

As we noted in our comments to the 2022 *Medicare & You* handbook,

despite the MOOP, people in MA plans can pay more for their care than those in traditional Medicare. As we have noted in analyses of previous versions [...] [Medicare] materials often promote MA plans as an opportunity to have lower out-of-pocket costs than those in traditional Medicare, but downplays variables that could make the opposite true. The cost of monthly Medigap premiums, for example, can often total less than an annual MOOP for a given MA plan.⁵⁵

This is particularly true as the MOOP limits continue to rise – in 2023, the mandatory MOOP limit for in-network services will be as high as \$8,300 (\$12,450 for combined in- and out-of-network).

In addition to the *Medicare & You* Handbook, additional outreach from CMS to beneficiaries on this issue would be helpful. This is particularly important given the overwhelming amount of industry advertisements that beneficiaries receive from MA plans touting cost-savings in MA, which may or may not be accurate for specific beneficiaries. CMS is a trusted, non-biased source of information for

⁵⁴ CMA Report “MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage” (Sept. 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid={{ContactsEmailID}}>.

⁵⁵ *Id.*

beneficiaries, so a detailed explanation of the ramifications of enrolling in an MA plan in terms of future limits in access to Medigap in almost every state would be valuable beneficiary education.

Given the problems with MA plans for sicker, older beneficiaries and beneficiaries of color (explained in other sections of our comments), the health equity implications of limited Medigap consumer protections are clear. Beneficiaries with disabilities under age 65 are completely left out of federal protections. CMS should emphasize this issue in order to call attention to the need for change in this area.

Recommendations

CMS should:

- Actively promote and endorse legislation to expand federal Medigap rights in order to make choices between traditional Medicare and MA, along with the ability to change between these options, more equitable
- As noted elsewhere in these comments, CMS should more actively promote and advocate for increased funding and capacity for State Health Insurance Assistance Programs (SHIPs) and Senior Medicare Patrol (SMP) programs
- As discussed further below, overhaul agent/broker compensation to counteract the significant pecuniary advantage in selling MA plans vs. products in traditional Medicare
- Improve consumer materials to more accurately reflect trade-offs between MA and traditional Medicare, including financial risk (e.g., compare average annual Medigap premiums with MOOP amounts)

Medicare Advantage Marketing Efforts

While CMS' recent final Part C & D rule signaled a renewed dedication to providing oversight of MA plans, and included some nominal improvements in oversight, much more drastic changes are needed in order to adequately protect Medicare beneficiaries against an onslaught of overly-aggressive and often misleading Medicare Advantage marketing performed by those who have significant financial stakes in steering people towards MA plans, regardless of whether such option is the best course for an individual.

As noted in a 2021 Commonwealth Fund blog,⁵⁶ “[m]uch of the information available to beneficiaries shopping for Medicare Advantage, Medicare Supplement (Medigap), or Part D plans comes from agents (brokers) or health insurers.” MA plan payment rates, agent and broker compensation structures favoring MA enrollment, and ubiquitous MA plan advertising all drive a marketplace geared towards favoring MA enrollment above other options. For example, a different 2021 Commonwealth Fund blog⁵⁷ analyzing agent commissions for Medicare products states that “[d]iffering commission

⁵⁶ Commonwealth Fund, “How Agents Influence Medicare Beneficiaries’ Plan Choices” (April 2021), available at: <https://www.commonwealthfund.org/publications/fund-reports/2021/apr/how-agents-influence-medicare-beneficiaries-plan-choices?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

⁵⁷ Commonwealth Fund, “Agent Commissions in Medicare and the Impact on Beneficiary Choice” (Oct. 2021), available at: <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

rates could force agents to choose between their earning potential and helping beneficiaries choose coverage that meets their needs.” Unfortunately, marketing misconduct, particularly surrounding the sale of MA plans, is exacerbated by the increasing complexity of MA benefits (discussed above), including the offering of MA supplemental benefits.

Even the Medicare agency itself has put its thumb on the scale in favor of Medicare Advantage. Several years ago, CMS began to depart from a neutral, unbiased standpoint concerning Medicare coverage choices in its public outreach and education materials, and began to actively promote Medicare Advantage over traditional Medicare. This change seemed to reflect a philosophical viewpoint towards private plans in the Medicare program; for example, in October 2019, President Trump signed an Executive Order that, among other things, included a directive to HHS to “ensure that, to the extent permitted by law, FFS [aka traditional, or Original] Medicare is not advantaged or promoted over MA with respect to its administration.”⁵⁸ A 2021 Center for Medicare Advocacy report catalogues this bias since 2017, along with noting CMS’ more recent, and welcome, start to reversing this trend in, e.g., the 2022 *Medicare & You* handbook.⁵⁹

In the preamble to CMS’ proposed 2023 Part C & D rule, the agency noted that it “has seen an increase in beneficiary complaints associated with and has received feedback from beneficiary advocates and stakeholders concerned about the marketing practices of third-party marketing organizations (TPMOs) who sell multiple MA and Part D products” and highlighted that a review of sales calls showed significant beneficiary confusion, including “that the beneficiary may be unaware that they are enrolling into a new plan during these phone conversations”. Similarly, in a letter Senate Finance Committee Chairman Ron Wyden recently sent to 15 state insurance commissioners and SHIP programs seeking data about MA marketing complaints and other information, he wrote “I have heard alarming reports that MA and Part D health plans and their contractors are engaging in aggressive sales practices that take advantage of vulnerable seniors and people with disabilities.”⁶⁰ Chairman Wyden’s letter references a recent survey conducted by the National Association of Insurance Commissioners (NAIC) reporting that “there has been an increase in complaints from seniors about false and misleading advertising and marketing of MA plans.”

In May 2022, NAIC wrote to Congressional leaders asking them to revisit federal preemption of most state law regarding the oversight of MA plans, which “has led to a tremendous gap in protections for seniors, especially in the area of marketing.”⁶¹ The letter states:

⁵⁸ See, e.g., CMA Alert “Center for Medicare Advocacy Analysis of President’s Medicare Executive Order” (Oct 2019), available at: <https://medicareadvocacy.org/alert-analysis-of-presidents-medicare-executive-order/>.

⁵⁹ CMA Report “*MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage*” (Sept. 2021) – (also see Addendum re: A Recent History of Bias Towards MA in Medicare Materials): <https://medicareadvocacy.org/medicare-you-2022-an-important-first-step-towards-reversing-bias-in-favor-of-medicare-advantage/>

⁶⁰ Senate Finance Committee press release “Wyden Probes Deceptive Marketing Practices by Medicare Advantage Plans” (Aug. 23, 2022), available at: <https://www.finance.senate.gov/chairmans-news/wyden-probes-deceptive-marketing-practices-by-medicare-advantage-plans>.

⁶¹ NAIC letter (May 5, 2022) available here: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiR-9utmOX5AhXklmoFHeKzCmUQFnoECAwQAQ&url=https%3A%2F%2Fcontent.naic.org%2Fsites%2Fdefault%2Ffiles%2FState%2520MA%2520Marketing%2520Authority%2520Senate%2520Letter%2520.pdf&usg=AOvVaw2eZNF3HZ5wq_ipuf7FOVu.

as state insurance regulators, we are finding an increase in complaints from seniors about confusing, misleading and potentially deceptive advertising and marketing of [MA] plans. Unfortunately, because of federal law, state insurance regulators are not permitted to exercise their oversight authority in advertising and marketing of MA plans.

NAIC's survey of State Departments of Insurance "found that states have received consumer complaints about the following:

- Misrepresentations in the marketing and sales of MA plans, particularly Private- Fee-For-Service (MA-PFFS) plans, including misrepresentations about provider networks, provider acceptance of plans, reimbursements, benefits, premiums and other features.
- Inappropriate or confusing marketing practices leading beneficiaries to enroll in MA plans without adequately understanding the coverage into which they were enrolling. (i.e., beneficiaries believed they were signing up for a PDP or a Medicare Supplement (Medigap) Plan, rather than an MA plan, and they did not understand they were disenrolling from Original Medicare.)
- Fraudulent activity, including beneficiaries who were enrolled without any contact with a producer, or after only inquiring about the plan, forged signatures, misrepresentations by producers, or improper use of personal information.
- Aggressive sales practices such as cross-selling, whereby producers used access to beneficiaries (afforded under the MMA), which allows producers to discuss additional coverage options such as PDPs, but instead has led to pressuring beneficiaries into other types of insurance products such as annuities, funeral expense insurance policies or life insurance policies.
- Improper enrollment into these plans of individuals with Alzheimer's disease or dementia, mentally incapacitated individuals, or beneficiaries with limited English proficiency, as well as unsuitable enrollment of dual-eligible beneficiaries."

The experiences of Medicare beneficiaries and their counselors with whom the Center for Medicare Advocacy engages concur with NAIC's findings.⁶²

Unfortunately, marketing misconduct, particularly surrounding the sale of MA plans, is exacerbated by the increasing complexity of MA benefits (discussed above), including the offering of MA supplemental benefits. A far more aggressive regulatory response by CMS is required.

Recommendations

CMS should:

- Further strengthen consumer protections regarding plan marketing

⁶² See, e.g., CMA Alerts (Jan 2020) <https://medicareadvocacy.org/medicare-advantage-marketing-matters-case-study/> and (Dec 2018): <https://medicareadvocacy.org/in-her-own-words-a-beneficiarys-take-on-medicare-advantage-steering/>.

- Build upon improvements made in the final 2023 Part C & D rule by further strengthening disclosures required by third party marketing organizations (TPMOs), including a reference to SHIPs (see, e.g., CMA comments⁶³)
- Rescind changes made in 2019 to the Medicare Communications & Marketing Guidelines (MCMG), that blurred the lines between marketing and educational events provided by those selling MA and Part D products⁶⁴
- Given that Medicare materials in recent years actively promoted MA enrollment, CMS must continue to review all of its outreach and enrollment materials (including *Medicare & You*, Medicare Plan Finder, online comparison and decision-making tools) and scrub any and all bias towards MA enrollment and coverage, and provide neutral, unbiased and accurate information about coverage choices
- Increase oversight of agents and brokers, including:
 - Overhaul agent/broker compensation to counteract the significant pecuniary advantage in selling MA plans vs. products in traditional Medicare – a 2021 Commonwealth Fund blog (cited above) highlights that CMS has set the maximum national commission for initial enrollment in MA plans in 2022 at \$573 per beneficiary in most parts of the country, whereas the maximum national commission for first-time Part D plan enrollment, for those in traditional Medicare, is \$87 (the blog post also notes that while MA commissions are increasing, those for Medigaps are decreasing).
 - Require agent/broker disclosure of commissions to beneficiaries they receive for sale of a given product compared to other products (e.g., MA vs. Part D plan, Medigap) – individuals should know if someone is being paid more to sell them one type of product vs. another, particularly if such a sale can fundamentally change the manner in which someone accesses their Medicare benefits
 - There is currently no required reporting of compensation that the insurers provide to agents and brokers, other than the commission. An increasing share of payments to agents and brokers, appears, however, to be non-commission payments, such as providing assistance in scheduling provider appointments. CMS should collect information about and require reporting of such arrangements
 - Impose stronger standards for enforcement, discipline and punishment relating to the sale of Medicare products – this should include more transparency surrounding how complaints against agents, brokers, or TPMO’s are received and processed, what enforcement process exists, or what actions if any are taken by a MA plan or by CMS as the result of a complaint

⁶³ Center for Medicare Advocacy, Comments on 2023 Part C and D Rules (March 2022), available at: <https://medicareadvocacy.org/cma-comments-on-2023-part-c-and-part-d-payment-policies/?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

⁶⁴ See, e.g., CMA [here](#) and [here](#).

- In an effort to ensure that consumers understand what product they are enrolling in, and the corresponding consequences, including any changes to their current coverage, CMS should explore requiring agents/brokers to sign attestations that whatever product is being sold by said agent/broker (MA, Part D) is appropriate for that beneficiary; such an attestation is currently required for the sale of a Medigap
- Tighten oversight of MA plans and their downstream marketing and sales entities, including a clear administrative process for complaints, and that process should include coordination with state regulators and the National Association of Insurance Commissioners (NAIC)
- As noted above, more actively promote and advocate for increased funding and capacity for State Health Insurance Assistance Programs (SHIPs) and Senior Medicare Patrol (SMP) programs

MA Plans and Behavioral Health Services, Including Mental Health and Substance Use Disorder Services

Given the devastatingly low rate at which Medicare beneficiaries access medications for opioid use disorder (MOUD), with significant disparities among BIPOC⁶⁵ and rural communities,⁶⁶ CMS should take the following steps – relating to coverage, affordability, utilization management practices, and network adequacy standards – to reduce barriers to OTPs and MOUD and ensure access to treatment for Medicare beneficiaries with SUDs in MA plans:

- Require MA plans to include coverage for all FDA-approved medications for the treatment of opioid dependence when medically necessary, just as such coverage is required for Part D plans. CMS should further require that these medications be on the lowest cost-sharing tier in drug formularies.
- Require MA plans to cover MOUD and OTP services without burdensome utilization management practices, including prior authorizations, step therapy, or fail first practices.
 - In 2018, CMS specifically indicated that it would not approve plans that require authorization more than one time per year for buprenorphine medications and required plans to carry over previous authorizations.⁶⁷ In response, the overwhelming majority of Medicare Part D plans removed prior authorization requirements entirely for at least one formulation of both generic and brand buprenorphine-naloxone.⁶⁸ Removing prior authorization for buprenorphine-naloxone in this context was associated with an increase in the medication use and decreases in health care utilization and

⁶⁵ US HHS Office of Inspector General (OIG), “Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder” (Dec. 2021), available at: <https://oig.hhs.gov/oei/reports/OEI-02-20-00390.pdf>.

⁶⁶ CMS, Rural-Urban Disparities in Health Care in Medicare (Nov 2020), available at: <https://www.cms.gov/files/document/omh-rural-urban-report-2020.pdf>.

⁶⁷ CMS, Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (April 2, 2018), available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>.

⁶⁸ Tami Mark, William Parish, Gary Zarkin, “Association Between Medicare and FDA Policies and Prior Authorization Requirements for Buprenorphine Products in Medicare Part D Plans” JAMA. 2019;322(2):166-167. doi:10.1001/jama.2019.6581, available at: <https://jamanetwork.com/journals/jama/fullarticle/2737670>.

expenditures.⁶⁹ CMS should similarly require all MA plans to eliminate or limit prior authorizations for MOUD and should replicate this policy for OTP services.

- Require MA plans to eliminate cost sharing for OTP services, comparable to coverage in Medicare Part B.
- Require MA plans to contract with a minimum number of OTPs based on their number of enrollees and set quantitative network adequacy standards for OTPs as a facility type.
 - One study found that the average drive time to the nearest opioid treatment program (OTP) – a trip that patients who are prescribed methadone must make on a daily basis for months until any take-home medication is allowed – is over 37 minutes,⁷⁰ compared to 15.8 minutes to the nearest FQHC and 15.1 minutes to the nearest dialysis center. Rural residents must drive an average of almost 50 minutes to the nearest OTP, compared to 7.8 minutes for urban residents.
- Require MA plans to contract with a minimum number of providers who prescribe MOUD based on their number of enrollees and set quantitative network adequacy standards for providers who prescribe MOUD as a specialty provider type.
 - According to HHS, “More than half of all rural counties still lack a Drug Enforcement Administration-waivered MAT provider, and almost 30 percent of rural Americans, compared to 2.2 percent of urban Americans, live in a county without a buprenorphine provider.”⁷¹
- Establish a maximum timeline for MA plans to complete contracts with OTPs and other SUD providers from the first inquiry.
- Establish a maximum timeline for MA plans to reimburse OTPs and other SUD providers from the date of services furnished.
- At a minimum, MA plans should adopt the FFS reimbursement standards for OTPs.

Telehealth

We support the recent rule that made audio-only telehealth permanent coverage for certain mental health and SUD treatment, and we generally support the expansion of telehealth services as long as careful consideration is given to issues such as facilitating consumer access and preventing exacerbation of health disparities. As outlined in a May 2022 report by the Center for Medicare Advocacy titled “Telehealth and the Medicare Population: Building a Foundation for the Virtual Health Care Revolution,”⁷²

we are also committed to ensuring that no beneficiaries are caught in the chasm created by the digital divide – created through disparities between those who can afford access and are able to

⁶⁹ Tami Mark, William Parish, Gary Zarkin, “Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries” JAMA Netw Open. 2020;3(4):e203132. doi:10.1001/jamanetworkopen.2020.3132, available at:

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764598>.

⁷⁰ Paul Joudrey, E. Jennifer Edelman, Emily Wang, “Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States” JAMA. 2019;322(13):1310-1312. doi:10.1001/jama.2019.12562, available at:

<https://jamanetwork.com/journals/jama/fullarticle/2752051>.

⁷¹ HHS Press Release “HHS Announces Availability of \$10 Million for Rural Communities to Expand Treatment in Response to Surging Fentanyl and Other Opioid Overdoses” (June 17, 2022), available at:

<https://www.hhs.gov/about/news/2022/06/17/hhs-announces-availability-10-million-rural-communities-expand-treatment-response-surgin-fentanyl-other-opioid-overdoses.html>.

⁷² The CMA report is available here: https://medicareadvocacy.org/wp-content/uploads/2022/05/Telehealth-Report_CMA_final.pdf.

utilize technology, and those who cannot. Furthermore, telehealth must supplement, not replace, in-person care options. In the early days of the pandemic, as the critical role of virtual care solutions became clear, the Center published 11 guiding principles to aid in making decisions about whether and how to expand Medicare coverage for telehealth. In addition to the findings and recommendations included in our most recent report, these guiding principles still hold true today.

While MA plans have more flexibility to cover more services via telehealth, we urge CMS to correspondingly make every effort to expand telehealth flexibilities and coverage in the traditional Medicare program. Further, as discussed below in comments relating to network adequacy, we urge CMS to roll-back recent policy allowing services from certain types of providers via telehealth to count towards network adequacy requirements.

MA Plan Networks

Unlike traditional Medicare, which allows beneficiaries the free choice of providers, MA plans can limit the providers available to enrollees by using a contracted provider network. In other words, plans can restrict the providers that their enrollees are able to see, which warrants strict rules concerning how plans employ this utilization management tactic, along with strict oversight by the regulator to ensure plan networks are not impermissibly or impractically too narrow.

In 2015, the General Accounting Office (GAO) released a report⁷³ entitled “Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy”. According to GAO testimony provided to Congress in June 2022⁷⁴, the report noted:

that CMS’s oversight did not ensure that MAO networks were adequate to meet the care needs of MA enrollees. For example, we found that CMS did not adequately verify the accuracy of provider network information submitted by MAOs, and accordingly could not verify whether MAO networks were in compliance with the agency’s provider network criteria. We also found that the agency’s network criteria did not account for aspects of provider availability, such as whether a provider is accepting new patients. We made two recommendations to address each of these issues: CMS should take steps to verify the accuracy of provider network information submitted by MAOs, and change its criteria for MAO provider networks to account for provider availability. CMS agreed with these two recommendations; as of March 2022, the recommendations had not yet been fully implemented [citations omitted].

Further, provisions of CMS’ final 2021 Part C & D rule weakened MA network adequacy requirements.⁷⁵ These provisions should be rescinded, specifically: the reduction in the percentage of

⁷³General Accounting Office (GAO), “Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy” (Sept. 2015), available at: <https://www.gao.gov/products/gao-15-710?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

⁷⁴ General Accounting Office (GAO) “Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight” (June 2022) GAO-22-106026, available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf.

⁷⁵ 85 Fed Reg 33796 (June 2, 2020). See discussion in the Center’s Weekly Alert “Final Rule for Medicare Parts C and D Includes Weakened Standards for Medicare Advantage Networks” (May 28, 2020), available at:

beneficiaries that must reside within the maximum time and distance standards in non-urban counties from 90 percent to 85 percent in order for an MA plan to comply with network adequacy standards; the 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with telehealth providers; and the elimination of time and distance limits from network adequacy requirements for dialysis facilities.

The Center for Medicare Advocacy regularly hears from MA plan enrollees with significant health conditions who are unable to obtain care from specialists in their plan's contracted network. This often includes people who are told by plan providers that they need to see specialists outside of the network, but such care is denied by the plan.

In addition to reinstating previous requirements, and enhancing oversight of existing rules, CMS should strengthen network adequacy requirements. Among the ways CMS could update MA network adequacy standards is to: 1) require that Long Term Care Hospitals (LTCH) be included among mandatory facility specialty types in a plan network; 2) include essential community providers among the types of providers, similar to the requirements for qualified health plans under the Affordable Care Act (ACA) – see, e.g., 45 CFR §156.230(a)(2) “network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay” and 45 CFR §156.235 – “reasonable and timely access to a broad range of [...] providers for low-income, medically underserved individuals.”

CMS has recognized a long-standing problem concerning the accuracy of MA plan **provider directories**. For example, in 2017, CMS announced the agency's findings from a review of 54 MA organizations, which showed widespread inaccuracies in MA provider directories.⁷⁶ In response, the agency released additional guidance reiterating the rules MA organizations must follow for provider directories and took appropriate compliance actions. The draft 2020 Call Letter noted that “there has been a lack of improvement in the accuracy of provider directories over the past three years.” Directory inaccuracies can present significant challenges for enrollees—up to and including a potential lack of access to care and significant out-of-pocket costs. We urge CMS to focus its attention on the undue burden that inaccurate, hard-to-access, and non-searchable provider directories place on beneficiaries. This is even more critical as CMS plans to make provider directories available through the Medicare Plan Finder in the coming years.

CMS should **strengthen consumer protections surrounding MA plan mid-year provider network terminations**. The most effective way to protect consumers from being trapped in their plans after their own doctors are involuntarily terminated is to prohibit MA plans from terminating network providers mid-year without cause. Not only did CMS retreat from this option in the final 2015 Call Letter, but there has been no attempt to extend the current 30-day advance notice to affected beneficiaries, as also suggested in the 2015's Draft Call Letter. Further, CMS has failed to strengthen or otherwise expand the right to a limited special enrollment period (SEP), which is only available to beneficiaries affected by “significant” network terminations (42 CFR §422.62(b)(23)). Availability of this SEP for loss of access to a terminated provider should not hinge upon an unspecified number of

<https://medicareadvocacy.org/final-rule-for-medicare-parts-c-and-d-includes-weakened-standards-for-medicare-advantage-networks/>.

⁷⁶ CMS, “Online Provider Directory Review Report” (January 2017), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf.

additional individuals similarly impacted; rather, it should be available to plan enrollees who wish to continue to see their provider(s) by changing plans mid-year. In addition, the availability of this limited SEP right is not adequately expressed in beneficiary-oriented materials, including those issued by plan sponsors (e.g. the Annual Notice of Change) or by CMS (e.g. Medicare & You and the www.medicare.gov website). More accurate provider directories, while a welcome improvement in consumer information, is not a solution to this problem.

Recommendations

In order to ensure that MA networks are indeed adequate, CMS should:

- Fully Implement GAO’s 2015 recommendations⁷⁷ that CMS “augment oversight of MA networks to address provider availability, verify provider information submitted by MAOs, conduct more periodic reviews of MAO network information, and set minimum information requirements for MAO enrollee notification letters”
- Rescind the May 2020 network adequacy changes and strengthen the requirements – If a plan does not have enough providers to realistically serve enrollees in an area, then CMS should not permit the plan to operate in that area. The solution is not for CMS to lower requirements for the plans
- Strengthen protections for beneficiaries re: mid-year provider network terminations, including prohibit MA plans from terminating providers mid-year without cause, and strengthening the currently limited Special Enrollment Period (SEP) only for “significant” network terminations (in other words, provide an SEP for individuals whose providers will no longer be in the plan’s network – such a right should not be contingent upon an unspecified number of other impacted individuals)
- Strengthen network adequacy standards by requiring that Long Term Care Hospitals (LTCH) be included among mandatory facility specialty types in a plan network, and include essential community providers among the types of providers, similar to the requirements for qualified health plans under the Affordable Care Act (ACA) – see, e.g., 45 CFR §156.230(a)(2)
- Adequately enforce requirements concerning plan provider directories – there have been long-standing problems regarding the accuracy of these directories, which can present significant challenges for enrollees (this is even more critical as CMS plans to make provider directories available through the Medicare Plan Finder in the coming years)
- Require network requirements for supplemental benefits – there are currently no network adequacy requirements for supplemental benefits and thus no way to measure whether a plan has enough dentists or audiologists, for example, to provide the benefits promised to members
- Incorporate equity issues into network adequacy standards, including: collecting demographic data about plan providers in order to explore whether plans are successfully recruiting and contracting with providers that serve specific racial or ethnic communities; require cultural sensitivity training (including addressing sexual orientation and treatment of transgender and

⁷⁷ General Accounting Office (GAO), “Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy” (Sept. 2015), available at: <https://www.gao.gov/products/gao-15-710?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

non-gender conforming individuals); and up-to-date lists of accessible providers (those that adhere to disability access standards)

MA Supplemental Benefits

MA plans have long been able to use rebate dollars to cover benefits that traditional Medicare does not cover (such as vision, hearing and dental) but such coverage is often limited in scope. Further, coverage expansions such as the ability to provide new supplemental benefits (SSBCI) were added for MA, but not for traditional Medicare. CMS should make every effort to explore expanding such benefits in traditional Medicare, including supporting legislation to do so.

MA supplemental benefits are a powerful marketing tool for MA plans, and often draw in prospective enrollees. In order to promote informed choice, plans should be required to clearly inform the public and enrollees of all restrictions regarding supplemental benefits, including particular qualifying criteria and benefit limitations. This information should be prominent in all advertising and marketing materials. Too often prospective enrollees devote too much attention to the extras – which are often limited in scope – rather than more critical aspects of their plan benefits, such as provider network, prior authorization, cost-sharing, formulary coverage, etc.

Particularly since SSBCI are not available to all of a given plan’s enrollees, CMS must ensure that plans and their downstream contractors, including agents/brokers and community-based organizations administering the benefits don’t over-promise their availability.⁷⁸ Further, plans and their contractors must accurately describe that before someone has access to such benefits, plans must confirm through an individualized assessment – after enrollment - both an individual’s chronic condition and that the given benefit has a “reasonable expectation of improving or maintaining the health or overall function” of the enrollee.⁷⁹

CMS should expand data collection and reporting requirements with respect to supplemental benefits, including how many plan members are actually receiving these benefits, which benefits they are receiving, and whether supplemental benefits are equitably available to all plan members.

Utilization Management, Including Prior Authorization

Prior authorization and other utilization management tools can serve as significant barriers to care that both current and prospective Medicare Advantage enrollees are often unaware of until they need to access services.

⁷⁸ See, e.g., discussion of SSBCI in Center for Medicare Advocacy Issue Brief “MEDICARE & YOU: An Important First Step Towards Reversing Bias in Favor of Medicare Advantage” (Sept 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid={{ContactsEmailID}}>.

⁷⁹ See, e.g., Center for Medicare Advocacy Issue Brief – “New Medicare Advantage Supplemental Benefits: An Advocates’ Guide to Navigating the New Landscape” (Oct 2019), available at: <https://www.medicareadvocacy.org/wp-content/uploads/2019/10/Fully-Informed-Advocates-Guide-to-MA-Supplemental-Benefits-2019.pdf>.

As noted by the Kaiser Family Foundation in a June 2021 report⁸⁰, virtually all Medicare Advantage enrollees are in plans that require prior authorization:

Medicare Advantage plans can require enrollees to receive prior authorization before a service will be covered, and nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services in 2021. Prior authorization is most often required for relatively expensive services, such as inpatient hospital stays, Part B drugs, and skilled nursing facility stays, and is rarely required for preventive services. Prior authorization is also required for the majority of enrollees for some extra benefits (in plans that offer these benefits), including comprehensive dental services, hearing and eye exams, and transportation. [...] In contrast to Medicare Advantage plans, traditional Medicare does not generally require prior authorization for services and does not require step therapy for Part B drugs.

In 2018, the Department of Health & Human Services, Office of Inspector General (OIG) issued a report titled “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials”.⁸¹ This report found “widespread and persistent problems related to denials of care and payment in Medicare Advantage’ plans”. The report’s findings included that when beneficiaries and providers appealed preauthorization and payment denials, MA plans “overturned 75 percent of their own denials.” At the same time, “beneficiaries and providers appealed only 1 percent of denials to the first level of appeal.”

In April 2022, OIG issued another report focusing on Medicare Advantage plan denials titled “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care”.⁸² OIG reviewed a sample of denials of prior authorization requests and payment denials issued by 15 of the largest MA plans during one week in June 2019. In short, among the prior authorization requests denied by MA plans, OIG found that 13 percent met Medicare coverage rules – “in other words, these services likely would have been approved for these beneficiaries under original Medicare”. With respect to payment requests denied, OIG found that 18 percent met Medicare coverage rules and MA billing rules.

OIG described the “Key Takeaway” of the report that “MAOs denied prior authorization and payment requests that met Medicare coverage rules by:

- Using MAO clinical criteria that are not contained in Medicare coverage rules;
- Requesting unnecessary documentation; and
- Making manual review errors and system errors.

⁸⁰ Kaiser Family Foundation, “Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits” (June 2021), available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/>.

⁸¹ Department of Health & Human Services, Office of Inspector General (OIG) “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials” (September 2018) available at: <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>.

⁸² Department of Health & Human Services, Office of Inspector General (OIG) “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022, OEI-09-18-00260), available at: <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

OIG’s findings – in both its 2018 and 2022 reports – are consistent with the Center for Medicare Advocacy’s experiences assisting Medicare Advantage enrollees.⁸³ All too often, MA plans deny or, even more frequently, prematurely terminate care that would otherwise be covered through traditional Medicare. As discussed in a *CMA Alert*,⁸⁴ many providers concur. In addition, as discussed in another *CMA Alert*,⁸⁵ we have reason to believe that OIG’s estimates of MA plan denials of care might be understated and that an even higher percentage of necessary care is likely reduced. As discussed further in the cited *CMA Alert*, this is based on: 1) our experience with OIG audits of Medicare home health claims that employ more restrictive standards than allowed under Medicare; and 2) the recent increase in MA plans’ use of artificial intelligence (AI) driven coverage software that, in our experience, appears to lead to shorter periods of coverage and more frequent terminations of care.

Based upon the Center’s experience assisting MA enrollees, including those receiving SNF care – particularly in the state of Connecticut, we have witnessed a dramatic growth in MA plans’ use of artificial intelligence (AI)-driven decision-making tools through naviHealth, MyNexus and other third-party entities that plans contract with to make coverage decisions in certain care settings, including skilled nursing facilities. The required assessment of each individual patient’s needs has been replaced by “artificial” general rules of thumb, in conflict with Medicare law.

The use of these post-acute care management companies and their AI-driven decision-making tools, in our experience, has led to frequent and repeated denials of Medicare-covered care – sometimes every few days, necessitating multiple appeals for ongoing services that the facilities often agree should continue. This phenomenon is outlined in an April 2022 *CMA Alert*,⁸⁶ which provided a case study of such use, and included a link to a report on the topic we issued in January 2022.⁸⁷

Outside of our experience, the data to determine how widespread the use of such algorithm-driven tools is often proprietary and unavailable. As noted in our January report, we are concerned that tools focusing on utilization management (UM) err on the side of cost-savings rather than on streamlining UM or improving the quality of patient care. At the very least, CMS, OIG and others with oversight of the Medicare program should study the impact of the use of these tools.

⁸³ On occasion, the Center will publish examples of MA care denials/prior authorization from our casework; *see, e.g.*: CMA Case Study: Medicare Advantage and Repeated Coverage Denials Amid the COVID Crisis (May 2020) available here: <https://medicareadvocacy.org/case-study-medicare-advantage-and-repeated-coverage-denials-amid-the-covid-crisis/>; CMA Case Study re: Waiting for Prior Auth (Dec 2019) available here: <https://medicareadvocacy.org/medicare-advantage-story-series/>; CMA Case Study re: MA plan authorizing colonoscopy (Nov. 2019) available here: <https://medicareadvocacy.org/medicare-advantage-plans-impede-access-to-care-case-study-2/>; and CMA Case Study re: MA prior auth causing problems re: SNF coverage, leading to re-hospitalizations (Nov. 2019), available here: <https://medicareadvocacy.org/medicare-advantage-plans-impede-access-to-care-a-case-study-1/>.

⁸⁴ Center for Medicare Advocacy Weekly Alert “Insurance Industry v. Provider Response to the recent OIG Report re: MA Denials” (May 5, 2022), available at: <https://medicareadvocacy.org/insurance-industry-v-provider-response-to-oig-report-re-ma-denials/>.

⁸⁵ Center for Medicare Advocacy Weekly Alert “OIG Report Estimates of Inappropriate MA Plan Denials May be Understated” (May 5, 2022), available at: <https://medicareadvocacy.org/oig-report-estimates-of-inappropriate-ma-plan-denials-may-be-understated/>.

⁸⁶ Center for Medicare Advocacy Weekly Alert “When Artificial Intelligence in Medicare Advantage Impedes Access to Care: A Case Study” (April 21, 2022), available at: <https://medicareadvocacy.org/ai-plus-ma-equals-bad-care-decisions/>.

⁸⁷ Center for Medicare Advocacy Special Report “The Role of AI-Powered Decision-Making Technology in Medicare Coverage Determinations” (January 2022), available at: <https://medicareadvocacy.org/wp-content/uploads/2022/01/AI-Tools-In-Medicare.pdf>.

Recommendations

In order to ensure that MA enrollees have adequate access to medically necessary care, CMS should:

- Implement the OIG’s recommendations from 2018 and 2022 reports to better protect beneficiaries and providers from inappropriate denials (for an updated list of recommendations, see OIG’s June 2022 Congressional testimony⁸⁸), including:
 - Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews to ensure the use of appropriate coverage criteria, in accord with Medicare law
 - Incorporate the issues identified by OIG in their evaluation into CMS’ audits of MA plans
 - Direct MA plans to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors
 - Enhance its oversight of MA contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate
 - Provide beneficiaries with clear, easily accessible information about serious violations by MAOs
- Revise regulations, manual provisions and other CMS guidance to require plans to provide both providers and enrollees with the criteria upon which Medicare coverage denials/terminations are made, along with relevant citations, (“proprietary” should not be a blanket defense to an MA plan’s obligation to provide criteria upon which decisions are made); all MA coverage and payment criteria should be available and accessible to the public
- In order to address frequent and repeated denials/terminations following reversals by external reviewers (e.g., Independent Review Entity, or IRE), revise guidelines to require a minimum number of days between notices of termination/discharge and/or some type of presumption of coverage
 - Require MA plans to report data on length of time between a successful appeal and another denial for the same care (e.g., we are hearing regularly about MA enrollees who are denied coverage, appeal and receive a favorable decision, only to be denied again in a matter of days)
 - Require the MA plan to demonstrate that there has been a significant change in the enrollee’s condition and/or care plan when a denial is issued within 30 days of a successful appeal for the same level of care
- Analyze MA plans’ use of AI-powered decision-making tools to ensure that plans using such tools are complying with Medicare coverage rules, including:

⁸⁸ Office of Inspector General (OIG), “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 28, 2022), available at:

https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_BLISS_OI_2022.06.28_1.pdf.

- Ensuring that such tools do not lead to coverage decisions that are more restrictive than Medicare coverage guidelines or replace the judgement of clinicians
- Require transparency and disclosure surrounding the use of such tools, including plans and providers to disclose to individuals and report to CMS when:
 - They rely on AI-powered clinical decision-making tools,
 - If such tools are used, for what services,
 - Denial rates when tools are used, and
 - Subsequent appeal rates
- Ensure that CMS-created materials, and MA plan materials, fully explain prior authorization, including the scope of its use (how widespread it is) and the limitations on access to services it imposes (see discussion of *Medicare & You* above)
- Enhance plan data reporting requirements re: denials and appeals (as discussed in the next section)
- Enhance Audit Capacity and Increase Transparency on Enforcement Actions
 - We urge CMS to revisit the agency’s prior proposal to increase audit and inspection authority. In a 2015 proposed rule, CMS details the criteria by which it determines which MA and Part D plan sponsors are audited each year and acknowledges that limited resources allow the agency to perform annual audits on only 10% of plan sponsors—30 of 300. CMS previously proposed, but chose not to finalize, a rule requiring plan sponsors to hire independent auditors. Given persistently poor plan audit results, namely involving appeals and grievances, we ask CMS to revisit this proposal.⁸⁹
- Reinstate the long-standing policy that prohibited MA plans from imposing step therapy (or “fail first”) for Part B drugs
- See the comments above re: Advancing Health Equity concerning enforcing current law and enhancing oversight of plans, including:
 - Direct MA plans to abide by and implement the *Jimmo v. Sebelius* settlement, requiring equal Medicare coverage for enrollees who require skilled care to maintain their condition or slow decline as for those who require care to improve their condition

Data Concerning Prior Authorization and Utilization Management Techniques

Access to information regarding a plan sponsor’s number and outcome of expedited appeals is critical information to have before enrolling in a Medicare Advantage plan. One could use this information to evaluate and compare Medicare Advantage plan performance and specifically how they treat their members who are receiving covered care in various settings. In fact, when we speak to a Medicare beneficiary who is considering enrolling in an MA plan, we often advise them to request information regarding appeals to fully evaluate the plan. If, for example, a Medicare Advantage plan reports a high

⁸⁹ 80 Fed Reg 7919 (February 12, 2015).

number of expedited appeals and denials per case one might seriously consider not enrolling in that Medicare Advantage plan.

Currently, Medicare Advantage plans are required to disclose grievances and appeals information regarding the number of disputes and their disposition to any MA plan eligible individual who requests this information.⁹⁰ The language in both the Social Security Act and the Medicare regulations is clear and unambiguous. MA plans must report all appeals. Both the Social Security Act and the Medicare regulations specifically require that upon request of a MA eligible individual, a MA plan must provide to the individual information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.⁹¹ The regulations specifically refer to “Appeals according to §422.578 et. seq.”⁹² This includes expedited and second level appeals.

As discussed in detail in an October 2020 *CMA Alert*⁹³, in September 2020 CMS issued a memorandum to plan sponsors that outlined changes to the Appeal and Grievance Data Form. The changes were made “[i]n an effort to identify opportunities to reduce MA plan burden and provide a simplified, easy to read report to MA plan eligible individuals...” (emphasis added). The revised data form specifically removed the following data elements:

- Expedited appeals
- Disposition of expedited appeals
- IRE (level 2) appeals
- Disposition of IRE (level 2) appeals
- Withdrawals

In essence, CMS decided that it is acceptable for MA plans to not fully comply with the clear reading of the Social Security Act and the Medicare regulations by not having to report information about expedited or second level appeals. CMS expressly states in the revised Form Instructions CMS-R-0282 that the MA plan will meet the disclosure requirements set forth in the regulations using the revised form.⁹⁴ However, clearly missing from the revised form is data regarding expedited and second level appeals, which is included in the disclosure requirements of the MA regulations. This is important information for beneficiaries and oversight of MA plans.

Given the problems facing beneficiaries concerning prior authorization and repeated denials (as discussed above), the relative uselessness of plan Star Ratings for purposes of plan comparison (as discussed below), the need for Medicare beneficiaries to have access to this appeals data is even greater. In short, the public needs more – not less – information about MA appeals. **CMS must rescind the September 2020 guidance and reinstate the previous reporting requirements.**

In addition, in order to give both the government and the public more and better information concerning MA plan performance, **CMS should enhance reporting requirements for plans and make such information publicly available.**

⁹⁰ §1852(c)(2)(C) of the Social Security Act and 42 C.F.R. §422.111(c)(3).

⁹¹ §1852(c)(2)(C) of the Social Security Act and 42 C.F.R. §422.111(c)(3).

⁹² See 42 C.F.R. Subpart M – Grievances, Organization Determinations and Appeals.

⁹³ CMA Alert, “MA Plans Allowed to Report Less Data about Appeals Outcomes” (Oct 1, 2020), available at: <https://medicareadvocacy.org/ma-plans-allowed-to-report-less-data-about-appeals-outcomes/>.

⁹⁴ CMS <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/downloads/AppGrievDataFormINS.pdf>.

On July 27, 2022, the House Ways & Means Committee marked up H.R. 8487 - “Improving Seniors’ Timely Access to Care Act of 2022”.⁹⁵ If enacted, the bill will, among other things, improve data collection requirements. As of the time that these comments are due, the full House has not voted on, nor has the Senate taken up the bill. If the bill is not enacted, we urge CMS to use the full extent of its authority to implement the transparency requirement contemplated by the bill, in requiring plans to annually submit to the Secretary – and the Secretary to publish on its website on the individual plan level – the following (found at (3)(A)(i)):

“(I) A list of all applicable items and services that were subject to a prior authorization requirement under the plan during the previous plan year.

“(II) The percentage and number of specified requests (as defined in subparagraph (F)) approved during the previous plan year by the plan in an initial determination and the percentage and number of specified requests denied during such plan year by such plan in an initial determination (both in the aggregate and categorized by each item and service).

“(III) The percentage and number of specified requests submitted during the previous plan year that were made with respect to an item or service identified by the Secretary pursuant to paragraph (2)(C)(ii) for such plan year, and the percentage and number of such requests that were subject to an exception under paragraph (2)(C)(iv) (categorized by each item and service).

“(IV) The percentage and number of specified requests submitted during the previous plan year that were made with respect to an item or service identified by the Secretary pursuant to paragraph (2)(C)(ii) for such plan year that were approved (categorized by each item and service).

“(V) The percentage and number of specified requests that were denied during the previous plan year by the plan in an initial determination and that were subsequently appealed.

“(VI) The number of appeals of specified requests resolved during the preceding plan year, and the percentage and number of such resolved appeals that resulted in approval of the furnishing of the item or service that was the subject of such request, broken down by each applicable item and service and broken down by each level of appeal (including judicial review).

“(VII) The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved, by the plan during the previous plan year through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

“(VIII) The average and the median amount of time (in hours) that elapsed during the previous plan year between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service, excluding any such requests

⁹⁵ Text of the bill is available here: <https://www.congress.gov/bill/117th-congress/house-bill/8487/text?r=1&s=1>; video of the hearing is available here: <https://waysandmeans.house.gov/legislation/markups/markup-improving-seniors-timely-access-care-act-2022>.

that were not submitted with the medical or other documentation required to be submitted by the plan.

“(IX) The percentage and number of specified requests that were excluded from the calculation described in subclause (VIII) based on the plan’s determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

“(X) Information on each occurrence during the previous plan year in which, during a surgical or medical procedure involving the furnishing of an applicable item or service with respect to which such plan had approved a prior authorization request, the provider of services or supplier furnishing such item or service determined that a different or additional item or service was medically necessary, including a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

“(XI) A disclosure and description of any technology described in subclause (VII) that the plan utilized during the previous plan year in making determinations with respect to specified requests.

“(XII) The number of grievances (as described in subsection (f)) received by such plan during the previous plan year that were related to a prior authorization requirement.”

In addition, CMS should consider requiring additional information, including:

- “[I]nformation regarding the percentage and number of specified requests made with respect to an individual and an item or service that were denied by the plan during the preceding plan year in an initial determination based on such requests failing to demonstrate that such individuals met the clinical criteria established by such plan to receive such items or services” (which H.R. 8487 would give plans the option to provide);
- A survey of plan enrollees re: how much time they spend trying to resolve problems accessing care in the plan and resolving complaints; and
- Measure service wait times in MA, compared to traditional Medicare, especially for specialist services; the Center is hearing more about long wait times to get appointments, and at least in traditional Medicare there are more options than in MA networks to seek alternative providers.

If CMS is concerned about any undue “administrative burden” on MA plan sponsors that additional reporting might require, it should be noted that the even the insurance industry supports H.R. 8487, which includes the heightened reporting requirements outlined above.⁹⁶

⁹⁶ See, e.g., Better Medicare Alliance press release “Better Medicare Alliance Urges ‘Yes’ Vote in Ways and Means Markup of H.R. 8487, the Improving Seniors’ Timely Access to Care Act” (July 27, 2022), available at: <https://bettermedicarealliance.org/news/better-medicare-alliance-urges-yes-vote-in-ways-and-means-markup-of-h-r-8487-the-improving-seniors-timely-access-to-care-act/>.

C. Drive Innovation to Promote Person-Centered Care

MA Star Ratings

A June 2022 House Energy & Commerce Committee briefing memorandum⁹⁷ for a hearing concerning MA oversight summarizes issues relating to the MA Star Ratings and quality bonus program:

The quality bonus program with its star rating system is intended to be a source of information about the quality of MA plans for beneficiaries. However, MedPAC has found that the program, which cost \$6 billion in 2019 and is projected to cost \$94 billion over 10 years, is flawed. MedPAC found that the way that measures are examined and reported are not particularly useful as an indicator of quality of care provided in a beneficiary's local area. Additional studies also suggest that the MA quality bonus program has not improved plan quality [citations omitted].

Currently, 9 out of 10 MA members are in plans that achieve 4 or 5 stars.⁹⁸ With so many plans achieving ratings high enough to earn bonus payments, using star ratings as a means of comparison between plans does not actually help consumers make informed decisions. As OIG⁹⁹ has noted, audit violations are no longer reflected in Star Ratings, which diminishes the ability of consumers to measure plan performance. Further, MedPAC¹⁰⁰ has documented the “continuing erosion of the reliability of data on the quality of MA plans” and declared that “[t]he current state of quality reporting is such that the Commission’s yearly updates can no longer provide an accurate description of the quality of care in MA.”

Recommendations

CMS should:

- Overhaul and/or replace the Star Ratings system and corresponding bonus payments
 - Follow MedPAC’s recommendations for replacing the current program with an MA value incentive program (see, e.g., MedPAC’s June 2022 Congressional testimony¹⁰¹)

⁹⁷ Memorandum to Subcommittee on Oversight and Investigations Members and Staff from Committee on Energy & Commerce Staff Re: Hearing on “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 24, 2022), available at:

https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Briefing_Memo_OI_Hearing_2022.06.28_0.pdf.

⁹⁸ See, e.g., “The Lake Wobegon Effect in Medicare Advantage” by Bob Herman, *Axios* (Oct 11, 2021), available at: <https://www.axios.com/2021/10/11/medicare-advantage-star-ratings-2022?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

⁹⁹ Office of Inspector General (OIG), “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials” (Sept 2018), available at: <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

¹⁰⁰ Medicare Payment Advisory Commission (MedPAC), “Report to Congress: Medicare Payment Policy” (March 2021), available at: <https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>.

¹⁰¹ Medicare Payment Advisory Commission (MedPAC), “Improving the Medicare Advantage Program” (June 28, 2022), available at:

https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf.

- Eliminate double bonuses, that by some measures, drive racial disparity in payments¹⁰²
- Align Star Ratings and Enforcement Actions – Implement OIG’s 2018 suggestion that CMS “also revisit policy options for adjusting Star Ratings in response to audits and enforcement actions, such as adding a new Star Ratings measure that takes enforcement actions into account, or by directly adjusting an MAO’s overall and summary Star Ratings in response to enforcement actions.”
- Account for coverage denials that are overturned on appeal

CMMI Testing

In order to both improve Medicare beneficiary health outcomes and provide more equal access to benefits across the board, we suggest that CMMI study the effect of providing supplemental benefits in traditional Medicare in order to determine the efficacy of such benefits in preventing hospitalization, improving outcomes, improving well-being, lowering out-of-pocket costs for beneficiaries, lowering Medicaid costs, and other relevant questions.

Employer Group Waiver Plans (EGWPs)

According to the Kaiser Family Foundation, nearly 5.1 million Medicare Advantage enrollees (18% of MA enrollees) are in group plans offered by an employer or union.¹⁰³ Increasingly, employers and unions that offer retirement health benefits are contracting with private insurance carriers to provide group Medicare Advantage benefits instead of traditional retiree health benefits, with little or no other options provided to such individuals.¹⁰⁴ In light of this trend, CMS should enhance oversight of such plans in order to ensure adequate consumer protections, including both a review of how employers and unions effectuate enrollment as well as a review of waivers currently given to such plans, including more lax network adequacy requirements and plan customization of enrollee materials. Further, CMS should monitor the practical ability of retirees to choose traditional Medicare and ensure that option is fully available.

D. Support Affordability and Sustainability

MA Payment, Including Risk Adjustment

There is consistent, and growing evidence that Medicare Advantage plans are paid more than traditional Medicare would spend on the same beneficiary, and that such spending is growing per

¹⁰²Adam A. Markovitz et al., *Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements*, Health Affairs (Sept. 2021), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00349>

¹⁰³ Kaiser Family Foundation, “Medicare Advantage in 2022: Enrollment Update and Key Trends” (Aug. 25, 2022), available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/?utm_campaign=KFF-2022-Medicare&utm_medium=email&_hsmt=223948822&_hsenc=p2ANqtz-W3TYDMG15Os9Tz858DUfYBZ6OyuoAEYNYOGj5AV7LmD4rpmj0zS1YM4helehdqgwZmp6unwcLEWQFhFVhTQFTDm5H0qcKAshOEQonyQwrTzPMjdE&utm_content=223948822&utm_source=hs_email.

¹⁰⁴ Center for Medicare Advocacy Issue Brief “Retiree Auto Enrollment in Medicare Advantage Plans – Choice is Under Threat” (October 2021), available at: <https://medicareadvocacy.org/wp-content/uploads/2021/10/Issue-Brief-MA-Auto-Enrollment.pdf>.

person, with significant implications for Medicare programmatic spending. As noted by MedPAC in their March 2022 report¹⁰⁵, Medicare spends 4 percent more on MA than it would spend on traditional Medicare (an estimated \$12 billion in excess payments this year alone) and **“private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.”** MedPAC continues: **“continu[ing] to overpay MA plans [...] will further worsen Medicare’s fiscal sustainability [emphasis added].”**

These overpayments occur, in part, due to manipulation of the risk-adjusted payment system and quality bonus payments based on a flawed quality ratings system (see MA Star Ratings above). While we recognize that CMS doesn’t have complete authority over MA payment rates and formulas, we urge CMS to use the tools at its disposal to rein in excessive MA payment, primarily its discretion to increase the statutory minimum coding intensity adjustment, meant to adjust for differences in patterns of coding between MA and traditional Medicare.

As noted by OIG in written testimony¹⁰⁶ before Congress, MedPAC, GAO, OIG and CMS have all raised concerns about the current risk-adjusted payment system, including health risk assessments (HRAs) and chart reviews being used to submit more diagnoses to increase payment rather than to improve plan enrollee care. For example, in its written testimony, OIG stated:

MAOs received an estimated \$9.2 billion in payments in 2017 for beneficiary diagnoses reported solely on chart reviews or health risk assessments, with no other records of services for those diagnoses in the encounter data. This finding raises three concerns: (1) payment integrity—if the diagnoses were inaccurate, then MAOs received inappropriate payments; (2) quality of care—if the diagnoses were accurate, then beneficiaries may not have received appropriate care to treat these often serious conditions; and (3) data integrity—if the diagnoses were accurate and beneficiaries received care, then MAOs may not have reported all provided services in the encounter data as required [emphasis in original].

Various non-insurance industry influenced analysis and reports continue to point out how the current MA payment system based on maximizing profits through risk adjustment leads to excessive payment. Recent examples include: research by Richard Kronick, highlighted¹⁰⁷ by *Kaiser Health News* in November 2021, which analyzed MA billing data and estimated that “Medicare overpaid the private health plans by more than \$106 billion from 2010 through 2019 because of the way the private plans charge for sicker patients” (nearly \$34 billion of this new spending came during 2018 and 2019).

Among other things, these overpayments allow MA plans to offer supplemental benefits, which in turn drives up enrollment in MA plans, exacerbating the strain on Medicare’s finances. Wasteful overpayments to MA plans both exacerbate Part A Trust Fund and overall programmatic financing

¹⁰⁵ MedPAC, Report to Congress (March 2022), available at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d.

¹⁰⁶Office of Inspector General (OIG), “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_BI_iss_OI_2022.06.28_1.pdf.

¹⁰⁷ See, e.g., CMA Alert “New Analysis Provides More Evidence of Wasteful Medicare Advantage Overpayments” (Nov 18, 2021), available at: <https://medicareadvocacy.org/new-analysis-provides-more-evidence-of-wasteful-medicare-advantage-overpayments/>.

concerns, and, as discussed in the next section, deplete resources that could otherwise be used to improve coverage for all beneficiaries. Further, these higher payments have led to higher Part B premiums paid by all beneficiaries.¹⁰⁸

Recommendations

CMS should:

- Use all tools at its disposal to achieve **payment parity between MA and traditional Medicare**; in other words, ensure that MA plans are paid no more per enrollee than is spent on average for traditional Medicare beneficiaries
- Implement GAO’s recommendations¹⁰⁹ re: the validity of encounter data, audits and recovery of improper payments to MA plans
 - Validate encounter data (including completing medical record reviews)
 - In June 2022, GAO noted that “In 2014, GAO recommended that CMS validate MA encounter data for completeness and accuracy. However, as of June 2022, CMS had completed some, but not all, of the necessary steps. For example, CMS has not reviewed beneficiaries’ medical records to verify the accuracy of the diagnosis information CMS uses in its risk adjustments. By using encounter data that have not been fully validated for completeness and accuracy, the soundness of adjustments to MA organization payments remains unsubstantiated.”
 - Improve Timeliness of MA Audits and Appeals to Recover Improper Payments, including through risk adjustment data validation (RADV) audits
 - GAO notes: “Although CMS has taken some steps to improve audit timeliness, contract-level audits continue to be delayed significantly. For example, as of June 2022, CMS has not yet issued final contract-level audit findings for payments made in 2011 through 2014. In contrast, CMS uses a specific timetable that allows the agency to complete national-level RADV audits on an annual basis to calculate estimated improper payments for MA. Until CMS improves the timeliness of its contract-level RADV audits, the agency may miss out on recovering hundreds of millions of dollars in improper payments annually [citation omitted].”
 - Further, GAO noted that “CMS estimated that in fiscal year 2021 improper payments accounted for about 10 percent of total payments to MAOs and totaled about \$23 billion”

¹⁰⁸ Kaiser Family Foundation, “Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges” (Aug 2021), available at: <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/>.

¹⁰⁹ General Accounting Office (GAO), “Medicare Advantage – Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf.

- Implement OIG’s recommendations re: chart reviews and health risk assessments (HRAs) (see OIG’s June 2022 Congressional testimony¹¹⁰)
 - Conduct targeted oversight of MAOs that are driving a high or disproportionate share of payments from chart reviews and/or health risk assessments,
 - Require MAOs to implement best practices for care coordination for beneficiaries who receive health risk assessments.
- Implement MedPAC’s recommendations (see June 2022 Congressional testimony¹¹¹), including:
 - Increase coding pattern adjustment above the statutory minimum (see MedPAC Comments to CMS¹¹², March 2022)
 - Eliminate health risk assessments as a source of diagnoses for risk-adjusted payments (a recommendation since 2016)
 - Establish thresholds for the completeness and accuracy of MA encounter data (upon which payment, in part, is based)

Impact of Growing MA Enrollment on Medicare Writ Large

The traditional Medicare program – our nation’s bedrock social insurance program – is endangered. With legislative and administrative action over many years, the steady increase in measures and payment that disproportionately favor the private Medicare Advantage program over traditional Medicare has led to increased enrollment in the plans and corresponding concerns about the traditional Medicare program being chipped away and slowly becoming privatized.¹¹³ This has all occurred

¹¹⁰ Office of Inspector General (OIG), “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_BI_iss_OI_2022.06.28_1.pdf.

¹¹¹ Medicare Payment Advisory Commission (MedPAC), “Improving the Medicare Advantage Program” (June 28, 2022), available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf.

¹¹² MedPAC letter to CMS (March 3, 2022), available at: https://www.medpac.gov/wp-content/uploads/2022/03/03032022_MA_Coding_MedPAC_COMMENT_SEC.pdf?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d.

¹¹³ See, Center for Medicare Advocacy, *Tipping the Scales Toward Medicare Advantage*, (Mar. 21, 2018), <https://medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage/>; See also, David A Lipschutz, *Commentary: Don’t Further Privatize Medicare*, Inquiry (Aug 5, 2019), See also, Emily Gee, Maura Calsyn & Nicole Rapfogel, *Trump’s Plan To Privatize Medicare*, Center for American Progress (CAP), (Oct. 11, 2019) <https://www.americanprogress.org/issues/healthcare/news/2019/10/11/475646/trumps-plan-privatize-medicare/>; See also The New York Times, *Medicare’s Private Option Is Gaining Popularity, and Critics*, (Feb. 21, 2020) <https://www.nytimes.com/2020/02/21/business/medicare-advantage-retirement.html>; See also Bob Herman, *Medicare has become more of a private marketplace — and it’s costly*, Axios, (Aug 11, 2021) <https://www.axios.com/medicare-advantage-enrollment-spending-pandemic-risk-adjustment-d1a608ff-15eb-47bf-8952-0e1c5af097d5.html>; See also, *Trudy Lieberman, This latest under-the-radar program could push Medicare deeper into private hands*, USC Annenberg, Center for Health Journalism, (Mar. 11, 2021) <https://centerforhealthjournalism.org/2021/03/10/latest-under-radar-program-could-push-medicare-deeper-private-hands>; See also, Center for Medicare Advocacy, *MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage*, (Sept. 20, 2021) <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid={{ContactsEmailID}}>.

without a public debate about whether or not this is country’s vision for the direction that our flagship health insurance program should be going.

A recent article in *Health Affairs Forefront*¹¹⁴ analyzes various issues surrounding the current MA payment structure. The article highlights, among other things, that “having the public sector overpay crowds out other governmental services, requires higher taxes, or increases fiscal deficits” and points out how MA sponsors’ supposed efficiencies (based on their bids) can actually work to the detriment of those in traditional Medicare:

Despite MA plans being able to deliver traditional Medicare benefits at an average of 87 percent of what spending would have been in traditional Medicare, MedPAC’s latest estimate is that MA payments exceed what the beneficiaries would have cost in the traditional program by 4 percent. [...] **A policy that links deliberately overpaying MA plans to the availability of better benefits—by restricting better benefits to MA enrollees—essentially requires Medicare beneficiaries to leave traditional Medicare to share in the added benefits.** [Emphasis added.]

It appears that more people enrolling in MA, despite the increased costs borne by the Medicare program, disincentivizes policymakers from filling in some of the gaps in traditional Medicare that MA plans are allowed to offer with their overpayments. As long as someone has the option of obtaining extra benefits, the thinking apparently goes, there is no need to ensure that everyone enjoys such benefits. However, expanding such benefits in traditional Medicare would not be “duplicative” as coverage of these extra benefits in the MA program is optional and often limited.¹¹⁵ And, as briefly discussed during the Build Back Better debate last year, reining in MA overpayments can be used as a potential “pay for” to expand Medicare benefits, such as dental, hearing and vision, to all Medicare beneficiaries.¹¹⁶

Another recent *Health Affairs Forefront* article provides a thoughtful – and dire – analysis of the future of the Medicare program as traditional Medicare (TM) “withers” and Medicare Advantage (MA) becomes “dominant.”¹¹⁷ The author calls for a “course correction” for the trajectory of Medicare, and given that congressional action is unlikely in the short term, outlines what CMS can do, namely, “preserve and strengthen TM enough to make it and, by extension, MA perform as well as possible until more definitive reform can occur.” CMS can “claw back more of the payments that plans receive as a result of greater coding intensity in MA” and “begin to progressively reduce [the coding subsidy] while monitoring benefits.” The author notes that “[d]oing so faces strong political headwinds to the extent that payment cuts amount to benefit cuts, but evidence of partial pass-throughs and lower incremental value of benefits in MA should ease this concern.”

¹¹⁴ *Health Affairs Forefront*, “[The Debate On Overpayment In Medicare Advantage: Pulling It Together](https://www.healthaffairs.org/doi/10.1377/forefront.20220223.736815)” by Paul B. Ginsburg and Steven M. Lieberman (Feb. 24, 2022), available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20220223.736815>.

¹¹⁵ See, e.g., CMA Alert “Medicare is at a Crossroads – Time to Dispel Myths Hindering an Historic Expansion of Benefits” (Sept 2, 2021), available at: <https://medicareadvocacy.org/stop-the-myths-about-expanding-medicare-benefits/>.

¹¹⁶ See, e.g., CMA Alert, “House GOP Accuses Dems of Trying to Rein in Medicare Advantage Overpayments in Order to Expand Benefits to All Medicare Beneficiaries: If Only This Were True...” (March 3, 2022), available at: <https://medicareadvocacy.org/we-must-end-ma-overpayment/>.

¹¹⁷ “Don’t Look Up? Medicare Advantage’s Trajectory And The Future Of Medicare“, *Health Affairs Forefront*, March 24, 2022, by J. Michael Williams (DOI: 10.1377/forefront.20220323.773602), available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20220323.773602>.

Much more than wasted overpayments is at stake as MA gains dominance in the Medicare program. A May 2022 *JAMA Viewpoint* article notes that a “Medicare Advantage–dominated system [...] raises questions about how Medicare would work through private plans to achieve the many other public purposes that Medicare has served.”¹¹⁸ Challenges stemming from relative decline in traditional Medicare and the rise in MA:

involve the potential loss of the vital role that traditional Medicare has had in shaping the health care system generally. Traditional Medicare has led the way in developing quality standards and measures that have been widely applied and in transparently sharing results with the public. The resulting quality data provide unique insight into the performance of the US health care system and can help purchasers and consumers of health care in both the public and private sectors choose among alternative sources of care.

In addition, the article notes, traditional Medicare has also helped support rural health care centers and fund graduate medical education and has guided innovations in payment models.

Other issues to consider:

- As MA enrollment grows, it is unclear whether HHS and CMS have allocated resources and personnel accordingly; CMS needs to enhance oversight of MA
- As sicker people disenroll from MA, what does that do to the traditional Medicare risk pool?
- This imbalance raises health equity concerns, including the fact that MA does not provide better care, so many people disenroll

MA Plan Consolidation

On the one hand, according to the Kaiser Family Foundation (KFF), the average Medicare beneficiary in 2022 has access to 39 Medicare Advantage plans.¹¹⁹ There can be such a thing as “too much choice” which can impact informed decision-making by consumers.¹²⁰ There are far too many plans being offered with far too many variables. **We urge CMS to work with Congress to standardize MA plan offerings rather than give them more flexibility.**

On the other hand, the actual number of plan sponsors that dominate enrollment are few. KFF notes that:¹²¹

¹¹⁸ G. Jacobson, D. Blumenthal, “Medicare Advantage Enrollment Growth Implications for the US Health Care System” *JAMA Viewpoint* (May 23, 2022): <https://jamanetwork.com/journals/jama/article-abstract/2792809>.

¹¹⁹ Kaiser Family Foundation, “Medicare Advantage in 2022: Enrollment Update and Key Trends” (Aug. 25, 2022), available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/?utm_campaign=KFF-2022-Medicare&utm_medium=email&_hsmt=223948822&_hsenc=p2ANqtz-W3TYDMGI5Os9Tz858DUfYBZ6OyuoAEYNYOGj5AV7LmD4rpmj0zS1YM4helehdqgwZmp6unwcLEWQFhFVhTQFTDm5H0qcKAshQEOnyOwrTzPMjdE&utm_content=223948822&utm_source=hs_email.

¹²⁰ See, e.g., CMA Alert “Medicare and the Dilemma of ‘Choice’” (March 11, 2021), available at: <https://medicareadvocacy.org/medicare-and-the-dilemma-of-choice/>; Consumer Reports “The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making” (Nov. 2012), available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiKuIWu7uz5AhXOoWoFHbBV CscQFnoECAkQAO&url=https%3A%2F%2Fadvocacy.consumerreports.org%2Fwp-content%2Fuploads%2F2012%2F11%2FToo_Much_Choice_Nov_2012.pdf&usq=AOvVaw3nimjy_VSz6zSi01ghcsHP.

¹²¹ Kaiser Family Foundation, “Medicare Advantage in 2022: Enrollment Update and Key Trends” (Aug. 25, 2022), available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/?utm_campaign=KFF-2022-Medicare&utm_medium=email&_hsmt=223948822&_hsenc=p2ANqtz-

Medicare Advantage enrollment is highly concentrated among a small number of firms. UnitedHealthcare and Humana together account for 46 percent of all Medicare Advantage enrollees nationwide. In nearly a third of counties (29%; or 945 counties), these two firms account for at least 75% of Medicare Advantage enrollment. (BCBS affiliates (including Anthem BCBS plans) account for 14 percent of enrollment, and four firms (CVS Health, Kaiser Permanente, Centene, and Cigna) account for another 24 percent of enrollment in 2022.

A handful of corporate insurers, then, have an outsized role in the Medicare program, collecting billions of dollars in taxpayer money, yet, as argued throughout these comments, are subject to far too little oversight and regulation, and have far too little to show for it.

E. Engage Partners

Information Gaps and the Need for Additional Data

In addition to the recommendations concerning marketing and data collection outlined in the comments above, CMS can do more to assist stakeholders in accessing information about the MA program. For example, in past years, CMS has issued a draft Advanced Notice to Part C and D insurers who plan to contract with the Medicare program in the following year (“Call Letter”). CMS did not publish a Call Letter for 2021, 2022 or 2023 in part, because of the agency’s interpretation of its obligations under *Allina* decision.

Instead, CMS issued Part C and Part D bidding instructions and information previously provided through the Call Letter in other issuances. Instead of collecting policy updates, benefit and cost-sharing figures, and other important information about MA and Part plans in one document, CMS now issues a range of documents that cross-reference yet other documents, some of which are difficult to access or unavailable to non-industry stakeholders.

We urge CMS to compile MA and Part D policy and benefit parameter updates in one, uniform, widely-accessible document each year.

Promoting Collaboration Amongst Stakeholders and Enhancing the Voice of MA Enrollees

In order to ensure that CMS is provided with more than just an industry perspective about how the MA program is functioning, it should regularly engage, through periodic forums, listening sessions, RFIs or other means, the experience of SHIP and SMP programs, advocacy and community-based organizations, providers and other stakeholders that engage with MA plans in order to identify emerging or ongoing trends and issues that merit attention.

CMS should more actively collect data about and publicize MA plan grievance and appeal data (discussed further above). In addition, CMS should solicit the feedback of MA enrollees directly –

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particularly those who have encountered barriers to care (e.g., filed appeals and grievances) and have disenrolled from plans. This feedback should be collected through channels other than the plans themselves, their contractors, or industry support “advocacy” groups.

III. Conclusion

It is long past time for CMS to heighten oversight of MA plans to ensure that they are providing necessary care to their enrollees, and that taxpayer dollars are not wasted.

Thank you for the opportunity to submit these comments. For additional information, please contact David Lipschutz, Associate Director at DLipschutz@medicareadvocacy.org, or Kata Kertesz, Senior Policy Attorney at KKertesz@medicareadvocacy.org, both at (202)293-5760.

Sincerely

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