Policy Recommendations for the Biden Administration: Reduce Barriers to Care

The Biden administration must reduce barriers to care by making coverage more available, accessible, and affordable.

On our Helpline, we frequently hear from older adults and people with disabilities who live on modest or limited incomes and are struggling to access and afford their care.[1] These financial challenges—which have in many cases been worsened by the coronavirus pandemic—along with rising health care and prescription drug costs, antiquated coverage rules, and burdensome program requirements can make it difficult for older adults and people with disabilities to obtain the care they need.[2] The following reforms would help reduce these barriers to care by making Medicare stronger, easier to navigate, and more affordable.

Improve Coverage and Access to Care

Expand Medicare Health Coverage. The word "Medicare" is often used as shorthand for the sort of comprehensive, equitable insurance that we want for all Americans. However, there are critical gaps in the benefit, such as Medicare's total or near-total lack of coverage for dental, vision, and oral health care services. To make the shorthand accurate—and the program stronger—the Biden administration must address these and other challenges.

- **Approve Coverage of Medically Necessary Dental Care**. Medicare Rights joins an array of advocates and stakeholders in calling on the administration to use its discretion and existing authority to clarify that Medicare can cover medically necessary oral health and dental services.[3] This revision to current CMS policy would better fulfill Congress' goal of ensuring access to and coverage of medically necessary treatment for major health problems while upholding the general statutory exclusion of basic, routine dental care.

- **Identify Opportunities to Expand Access to Oral Health, Vision, and Hearing Services**. Medicare Rights also urges the administration to pursue care expansions more broadly. This includes working with Congress to extend Medicare coverage to dental, hearing, and vision services, as

[1] Medicare Rights Center, "An Analysis of 2018-2019 Call Data from the Medicare Rights Center's National Helpline" (October 9, 2020), https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations.
[2] NPR, *et al*., "The Impact of the Coronavirus on Households in Major U.S. Cities" (September 2020), https://media.npr.org/assets/img/2020/09/08/cities-report-090920-final.pdf.
[3] "Community Statement on Medicare Coverage for Medically Necessary Oral and Dental Health Therapies" (September 2019), https://familiesusa.org/wp-content/uploads/2019/09/Community-Statement-on-Oral-Health-083019-update-1.pdf.

contemplated by recent legislation, and using existing demonstration authority to test these services for fee-for-service enrollees.[4]

- **Improve Medicare Coverage of Post-Hospital Skilled Nursing Facility (SNF) Care**. Medicare beneficiaries who need post-hospital care in a SNF may be forced to pay out-of-pocket for this care when the hospital chooses to assign them to "observation status" instead of admitting them as an inpatient. The administration should work with Congress to re-evaluate whether maintaining the requirement for a 3-day inpatient stay is appropriate. In the interim, CMS should use its existing authority to redefine inpatient status to count all time in the hospital towards the requirement.

- **Expand Medicare Coverage of Telehealth Cautiously, Following the Data**. We recognize the recent expansion of Medicare-covered telehealth services has helped beneficiaries and their families safely and responsibly obtain needed care during the pandemic, likely leading to improved outcomes and reduced transmission of the COVID-19 virus. We applaud these successes and understand the impulse to keep many of the underlying policies in place. However, doing so without further study risks locking in an unexamined expansion of services that was developed for and during a crisis. We ask the Biden administration to move forward deliberately, using outcomes, experiential, and financial data to ensure people are receiving the care they want and need in a way that is affordable for beneficiaries and sustainable for the program.[5]

- **Enforce Mental Health Parity in Medicare**. We encourage the administration to require equivalent Medicare coverage for mental and physical health conditions across the program, including by strengthening mental health and substance use disorder coverage and payment, ensuring the full range of appropriate behavioral health services providers are eligible for Medicare reimbursement, and revoking the lifetime limit on inpatient services in a mental health specific facility.[6]

Level the Medicare Playing Field. To best support people with Medicare and the program, the Biden administration must equalize payment and coverage between Medicare Advantage and Original Medicare.

- **Reduce Medicare Advantage Overpayments**. Overpayments to Medicare Advantage plans can increase program, beneficiary, and taxpayer costs.[7] These additional expenses are significant, and well documented. According to a 2017 *Health Affairs* study, one of the key drivers of the unacceptably high payments—plan abuses of patient categorization rules, known as

[4] H.R. 3—Elijah E. Cummings Lower Drug Costs Now Act (2019), https://www.congress.gov/bill/116th-congress/house-bill/3; H. R. 1393/S. 1423—Medicare Dental, Vision, and Hearing Benefit Act of 2019 (2019), https://www.congress.gov/bill/116th-congress/house-bill/1393 and https://www.congress.gov/bill/116th-congress/senate-bill/1423.
[5] Center for Medicare Advocacy & Medicare Rights Center, "Joint Principles: Telehealth" (July 23, 2020), https://www.medicarerights.org/pdf/072320-cma-joint-principles-telehealth.pdf.
[6] Medicare Interactive, "Inpatient Mental Health Care" (last accessed January 10, 2021), https://www.medicareinteractive.org/get-answers/medicare-covered-services/mental-health-services/inpatient-mental-health-care.
[7] *See* MedPAC, "The Medicare Advantage Program: Status Report" (March 2019), http://medpac.gov/docs/default-source/reports/mar19_medpac_ch13_sec.pdf ("Excess payments to MA plans allow them to offer additional benefits to enrollees, thus benefiting the MA program but costing taxpayers more than if MA beneficiaries had remained in FFS Medicare. Further, additional payments to MA plans increase the Part B premium for all Medicare beneficiaries. The size of the Part B premium is based on total Part B spending, which for MA is calculated as a proportion of all MA spending").

"upcoding"—could raise Medicare expenditures by $200 billion over the next decade.[8] Another report found that Medicare overpaid Medicare Advantage plans a $70 billion from 2008 through 2013,[9] and the Government Accountability Office estimates that in 2013 alone, Medicare Advantage plans received an extra $14.1 billion.[10] We urge CMS to be more aggressive in its attempts to control these costs, such as by increasing the coding intensity adjustment beyond the statutory minimum, better monitoring and auditing risk-adjusted payments, and more strictly deterring upcoding. We also encourage CMS to more closely oversee plans' use of at-home risk assessments, to ensure they result in services that effectively treat beneficiaries' clinical needs.[11] As we have long noted, there is a continued risk that such assessments serve as a vehicle for plans to collect diagnoses and increase payments without providing meaningful care.[12]

- **Examine Changes to the Medicare Advantage Payment System and Investigate Potential Steering**. Recent analysis from the Kaiser Family Foundation indicates that people who choose Medicare Advantage plans have lower spending and use fewer services relative to their peers with Original Medicare—even before they enroll. While additional data collection and study is needed, these initial findings suggest the current basis for Medicare Advantage payments, which assumes Medicare Advantage enrollees have the same overall health costs as people with Original Medicare, may be flawed, and contributing to the problem of plan overpayments.[13] They also raise questions about plan benefit designs, billing practices, and marketing strategies; and the extent to which plans are actually lowering spending or managing care. CMS must not leave these questions unanswered. As the authors note, given the increases and projected growth in Medicare Advantage enrollment and expenditures, "the stakes are high for making payments to plans as accurate as possible."[14] We urge the administration to heed this call. CMS must step up its enforcement of existing safeguards and identify ways to improve the current payment system to promote sustainability and equity.

- **Equalize Access to Supplemental Benefits**. While some Medicare Advantage enrollees have access to the recently expanded supplemental benefits that focus on non-medical concerns and risk factors, most Medicare beneficiaries—those with Original Medicare—do not.[15] As a result, these services may function more as an inducement to enroll in Medicare Advantage than as a true aid to beneficiaries or as an effective mechanism to address deeply rooted inequities. Amid growing evidence[16] that social factors can shape health across a wide range of indicators,

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[8] Richard Kronick, "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years" (February 2017), http://content.healthaffairs.org/content/36/2/320.abstract.

[9] The Center for Public Integrity, "Why Medicare Advantage Costs Taxpayers More Than It Should" (January 2015), https://publicintegrity.org/health/why-medicare-advantage-costs-taxpayers-billions-more-than-it-should/.

[10] U.S. Government Accountability Office, "Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments" (April 2016), https://www.gao.gov/assets/680/676441.pdf

[11] HHS Office of Inspector General, "Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns" (December 2019), https://oig.hhs.gov/oei/reports/oei-03-17-00470.asp.

[12] Medicare Rights Center, "Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter" (March 2018), https://www.medicarerights.org/pdf/030518-2019-call-letter-comments.pdf.

[13] Gretchen Jacobsen, *et al*., "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" (May 2019), https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/.

[14] *Id*.

[15] Tyler Comer & Elexa Rallos, "Newly Expanded Non-Medical Supplemental Benefits in Medicare Advantage: A Primer" (last accessed January 13, 2021), https://atiadvisory.com/newly-expanded-non-medical-supplemental-benefits-in-medicare-advantage-a-primer/.

[16] Paula Braverman & Laura Gottlieb, "The Social Determinants of Health: It's Time to Consider the Causes of the Causes" (January 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/.

settings, and populations, and that tackling these issues can help reduce health disparities and promote health equity, all people with Medicare should have equal access to these new benefits.[17] The Biden administration must advance this goal by testing ways to deliver these and other expanded benefit packages—including dental, vision, and hearing services—to people with Original Medicare, engaging in transparent data collection, and reporting on the availability, utilization, and outcomes associated with these benefits as currently offered in Medicare Advantage.[18]

- **Promote Meaningful Choice**. Due to outdated restrictions, not everyone is eligible to buy a Medigap plan, and most are only guaranteed the right to do so during very limited time frames. As a result, while Medicare Advantage enrollees can typically change plans on an annual basis, Medigap enrollees—people with Original Medicare—cannot. To address this inequity, we ask the Biden administration to support state and federal efforts to expand access to affordable, high-quality Medigap policies to all beneficiaries, along with the opportunity to re-evaluate their coverage choices on a regular basis and as their needs change. This includes extending the same federal Medigap protections to beneficiaries under 65 as those given to beneficiaries over 65 and providing for open enrollment, guaranteed issue, and community rating of Medigap for all people with Medicare. We also recommend making the plan selection process easier by embedding robust and accurate comparison data into consumer-facing tools.

- **Guarantee Objectivity**. In recent years, as Medicare Rights and others have highlighted, Medicare enrollment materials and outreach strategies have sometimes failed to provide objective, neutral information about coverage options, appearing to promote Medicare Advantage over Original Medicare.[19] The Biden administration must ensure that future Medicare communications are neutral and accurate.

Streamline Part D Appeals. The Medicare Part D appeals process is an essential safety valve that allows older adults and people with disabilities to obtain needed medications. However, the current process is overly onerous and deeply flawed.[20] Its inefficiencies can lead to delays in beneficiary access, abandonment of therapies, reduced adherence to treatment protocols, worse health outcomes, and higher costs.

- **Modernize Pharmacy Counter Communications**. We often hear from beneficiaries who were told at the pharmacy counter that their plan would not cover their medication—but not the reason why. Pharmacists do not tend to have details about the coverage decision, and can only provide the required standard notice, which directs enrollees to contact drug plan for an explanation.[21] As a result, affected enrollees often have no choice but to leave the pharmacy

[17] Hilary Daniel, *et al.*, "Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper" (April 17, 2018), https://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-american.
[18] *See* p. 14 "Expand Medicare Health Coverage"
[19] Medicare Rights Center, *et al.*, "Joint letter to CMS re: inaccuracies in the draft Medicare & You Handbook for 2019" (May 15, 2018), https://www.medicarerights.org/policy-documents/letter-to-cms-re-inaccuracies-in-the-draft-medicare-you-handbook-for-2019; Medicare Rights Center, *et al.*, "Joint letter to CMS re: education and outreach materials for the current Medicare Annual Coordinated Election Period" (November 16, 2018), https://www.medicarerights.org/pdf/11.16.18-joint-ltr-cms.pdf.
[20] Medicare Rights Center, "Medicare Prescription Drug Appeals Packet" (2021) https://www.medicarerights.org/fliers/Rights-and-Appeals/Part-D-Appeals-Packet.pdf?nrd=1.
[21] Medicare Interactive, "The Medicare Prescription Drug Coverage and Your Rights Notice" (last accessed January 13, 2021), https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/part-d-appeals/the-medicare-prescription-drug-coverage-and-your-rights-notice.

without their medication or a clear understanding of why it was denied. Confused about what to do next, some may bypass the appeals process—knowingly or not—returning later to pay what they can or deciding to forgo the medication altogether. Those who do take action must embark on a tedious fact-finding mission, winding their way through a multi-layered, burdensome system, often with little help. To best address these challenges, we recommend allowing a refusal at the pharmacy counter to function as the plan's initial coverage determination. This would allow the enrollee to obtain an individually tailored denial notice in real-time and initiate the appeals process for those who need it. We endorse legislation that would effectuate these changes, the bipartisan Streamlining Part D Appeals Process Act (S. 1861/H.R. 3924).[22] We urge the Biden administration to prioritize this commonsense solution and to use existing authorities to advance its goals and policies. This includes immediately requiring plans to issue pharmacy counter refusal notices that explain why the beneficiary is being turned away (i.e., prior authorization, step therapy, quantity limits, off-formulary, non-covered, etc.).

- **Address Incomplete Data on Point-of-Sale Refusals**. Current CMS reporting rules, and therefore the agency's data systems, do not capture all instances in which plans fail to properly interpret their own or Medicare's rules when making coverage decisions. While plans are required to report information and outcomes related to coverage determinations, including the number requested, appealed, and overturned, they are not required to report all point-of-sale rejections. And the data that is required on these interactions is often incomplete.[23] Requiring plans to treat the beneficiary's presentation of the prescription at the pharmacy as a coverage determination request, as outlined above, would capture refusals at the pharmacy counter and any resulting appeals and reversals through existing reporting mechanisms. This would ensure that CMS has more robust data on situations in which people are turned away at the pharmacy and may pay out-of-pocket or go without needed drugs.[24] We urge the Biden administration to support this legislative fix and encourage CMS to update its reporting requirements in the interim.

- **Improve the Specialty Tier and Allow Tiering Exceptions**. The current exceptions process allows people with Part D to request that their plan allow them to pay less for high-cost medications when a similar, lower-cost medicine is available on the plan's formulary. But this right is not available to beneficiaries whose prescription drugs are placed on the plan's specialty tier, where cost-sharing can be exorbitant.[25] In addition, the cost threshold for drugs to be included on the specialty tier is too low, leading to an expansion in the number of drugs that are eligible for this

[22] S. 1861 (2019) https://www.congress.gov/bill/116th-congress/senate-bill/1861, and H.R. 3924 (2019) https://www.congress.gov/bill/116th-congress/house-bill/3924?s=1&r=3; Medicare Rights Center, "Congress Must Streamline the Medicare Part D Prescription Drug Appeals Process" (2019), https://www.medicarerights.org/pdf/s.1861-hr.3924-fact-sheet.pdf, and Medicare Rights Center, "Streamlining Part D Appeals Process Act" (2019) https://www.medicarerights.org/pdf/s.1861-hr.3924-case-study.pdf.

[23] *See,* MedPAC "The Medicare Prescription Drug Program: Status Report" (March 2018) http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf, ("Sponsors are not required to report all rejections, but must report rejections associated with nonformulary claims, prior authorizations, step therapy, quantity limits, and certain high-cost edits. The plan-reported and IRE data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that are reported do not pass data validation requirements.").

[24] S. 1861 (2019) https://www.congress.gov/bill/116th-congress/senate-bill/1861, and H.R. 3924 (2019) https://www.congress.gov/bill/116th-congress/house-bill/3924?s=1&r=3; Medicare Rights Center, "Congress Must Streamline the Medicare Part D Prescription Drug Appeals Process" (2019), https://www.medicarerights.org/pdf/s.1861-hr.3924-fact-sheet.pdf, and Medicare Rights Center, "Streamlining Part D Appeals Process Act" (2019) https://www.medicarerights.org/pdf/s.1861-hr.3924-case-study.pdf.

[25] Juliette Cubanski, et al., "The Out-of-Pocket Cost Burden for Specialty Drugs in Medicare Part D in 2019" (February 1, 2019), https://www.kff.org/medicare/issue-brief/the-out-of-pocket-cost-burden-for-specialty-drugs-in-medicare-part-d-in-2019/.

tier.[26] CMS must give Medicare beneficiaries the right to an exception for specialty tier medications and raise the cost threshold.

- **Deter Inappropriate Plan Denials**. Some challenges with Part D appeals are the result of plan behaviors that can exacerbate an already complicated process. Among the most egregious are instances in which plans deny coverage for insufficient and incorrect reasons, forcing beneficiaries to appeal bad decisions and go without needed medications in the interim. CMS should step up oversight and audits of plan denials, and more harshly sanction plans for patterns of inappropriate denials

- **Require Independent Redeterminations**. If a plan denies a beneficiary's exception request, they may then request a redetermination by filing a written appeal with the plan.[27] Our experience reveals that instead of engaging in a good faith effort to determine coverage eligibility, many redeterminations simply reiterate the plan's previous decision. This wastes valuable time (7 days for a standard appeal, 72 hours in an expedited process) and creates unnecessary medication delays and administrative burdens. To correct this, and to better incentivize plans to make accurate initial decisions, CMS should require that a plan's initial coverage decision be reviewed by an independent entity, rather than the plan itself. Overturned decisions should trigger a review of the file and necessary employee training.

- **Strengthen Processes and Timeliness**. As CMS notes, Part D appeals are inherently time-sensitive because "the majority of Part D coverage requests involve prescription drugs an enrollee has not yet received, which increases the risk of adverse clinical outcomes if access to the drug is delayed."[28] Yet, both the process can be onerous and time-consuming. In part, this is due to the significant backlog at the Administrative Law Judge (ALJ) and Medicare Appeals Council levels and plan failure to comply with response rules and timelines.[29] Although the regulations are clear, some plans do not issue coverage decisions or respond to grievances in a timely manner. Nor do they send the claim to the Independent Review Entity (IRE) when the required time frames are not met. The Biden administration should better encourage plans to submit timely determinations and communicate with enrollees effectively. We also recommend that CMS respond directly to enrollee complaints about plan non-compliance, require remedial actions by the plan when necessary, and clear the backlog at the ALJ and Appeals Council levels.

- **Address Prescriber Documentation and Plan Outreach**. From seeking coverage determinations and exceptions on behalf of beneficiaries to providing plans with needed clinical documentation, prescribers are vital to the Part D appeals process.[30] Yet, many are non-responsive and plans often make no effort to follow up appropriately. This is detrimental to beneficiaries, who may

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[26] Centers for Medicare & Medicaid Services, "Memo re: Updated Contract Year (CY) 2021 Final Part D Bidding Instructions" (May 22, 2020), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020_8.pdf.

[27] *See e.g.,* Medicare Interactive, "Introduction to Part D Appeals" (last accessed January 13, 2021), https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/part-d-appeals/introduction-to-part-d-appeals; Medicare Rights Center "Medicare Part D Drug Appeals" (2019), https://www.medicareinteractive.org/pdf/PartD_DrugAppeals_Chart.pdf.

[28] MedPAC, "Status report on the Medicare prescription drug program" (March 2017), http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch14.pdf?sfvrsn=0.

[29] HHS, "Medicare Appeals Backlog Primer" (last accessed January 13, 2021), https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf.

[30] Centers for Medicare & Medicaid Services, "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance" (effective as of January 1, 2020), https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.

end up going without needed medication and lose the ability to appeal entirely as deadlines pass.[31] Because plans have existing relationships with prescribers, they are well-positioned to establish in-plan requirements for timely prescriber engagement. In 2017 plan guidance, CMS acknowledged as much, and stated that the agency "expects that plans will be able to obtain requested documentation from contracted providers in a reliable and timely manner."[32] But this expectation has not been met. CMS must do more to require coordination between plans and prescribers, and to establish policies that hold beneficiaries harmless.

- **Strengthen Beneficiary Notices**. Plan communications to beneficiaries about coverage decisions, such as denial letters and redetermination notices, are often uninformative, unactionable, and confusing.[33] As a result, beneficiaries may not understand the reason for the plan's decision or what to do next. We encourage CMS to direct plans to provide readable and clear notices and enforce such standards. This includes requiring plans to make all beneficiary communications available in non-English language formats and increasing penalties for plans that do not send timely and adequate notices.

- **Require Plan Recognition of Beneficiary Representation**. An enrollee may appoint a representative to act on their behalf during the appeals process by submitting a written statement to the drug plan sponsor.[34] In our experience, plans are not always responsive to these statements, even after multiple requests. Some fail to list the beneficiary's appointed representative in their system or to send the representative copies of the plan's correspondence with the beneficiary. This can leave enrollees without the help they need. CMS must increase oversight of beneficiary representative requests.

- **Curb Misclassifications of Appeals and Grievances**. In addition to the Part D appeals process that allows beneficiaries to challenge plan decisions about drug coverage, they have access to a grievance system through which they can dispute other, generally service-related, plan activities or decisions. It is up to the plan to correctly determine whether a beneficiary's filing should be handled through the appeals process or as a grievance. Unfortunately, plans do not always accurately classify these submissions, which can create significant problems for beneficiaries.[35] Again, increased oversight and transparency, as well as improved plan-to-beneficiary communications, would allow beneficiaries and advocates to track issues and recognize improper classifications more quickly.

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[31] MedPAC, "Status report on the Medicare prescription drug program" (March 2017), http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch14.pdf?sfvrsn=0.

[32] Centers for Medicare & Medicaid Services "Updated Guidance on Outreach for Information to Support Coverage" (February 2017), https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/HPMS-Guidance-on-Outreach-for-Information-to-Support-Coverage-Decisions-2017Feb22.pdf.

[33] For example, Medicare Rights finds these materials are often not in plain language; do not include the criteria the plan used to make the coverage decision; name incorrect reasons for denial; and rarely cite the Medicare rule at issue, instead using vague terms like "medical necessity" without explanation. Redacted sample letters may be available upon request.

[34] Congressional Research Service, "Medicare Part D Prescription Drug Benefit" (December 18, 2020), https://crsreports.congress.gov/product/details?prodcode=R40611, ("An enrollee may request a representative by using a government form (Form CMS-1696) or by submitting an equivalent written notice that includes information about enrollee and is signed and dated by both the enrollee and the representative. There are exceptions in the case of institutionalized or incapacitated enrollees.")

[35] AISHealth, "2016 Audit Notices Highlight Growing Misclassification Issue" (March 2017), https://aishealth.com/medicare-and-medicaid/2016-audit-notices-highlight-growing-misclassification-issue/.

- **Bolster Transparency and Data Collection**. The Part D appeals process is hampered by limited data and transparency.[36] Beneficiaries and advocates alike can struggle to track not only an individual's specific claim, but also improper denial patterns that may be tied to hundreds of thousands of beneficiaries. Better data could lead to better solutions, as a more transparent system would lend itself to targeted recommendations and self-correction. We ask CMS to conduct a comprehensive, in-depth analysis of the Part D appeals process and to release that information publicly. The analysis should include data collection on specialty tier medications and extend to all levels of appeals, from plans through the Medicare Appeals Council and federal court.

Improve Access to Long Term Services and Supports (LTSS). The lack of a national LTSS framework forces many older adults and people with disabilities to rely on a patchwork of programs and caregivers, often depleting their assets and increasing program costs in the process.[37] The Biden administration must update existing systems and test new ways to deliver sustainably financed LTSS.

- **Modernize Medicare LTSS Coverage**. Medicare does not cover many long-term services and supports, and pays for help with activities of daily living, like eating and bathing, in very limited circumstances. Reflecting broad national trends, many of our Helpline callers seek help paying for this care. The administration can take steps to modernize the Medicare program to meet this growing need by filling existing coverage gaps, such as eliminating the requirement that Medicare beneficiaries be homebound to qualify for home health coverage, and by changing payment incentives so that people can access care for as long as they need.

- **Strengthen Oversight of Nursing Facilities**. A recent Government Accountability Office report found that most nursing homes had at least one infection prevention and control deficiency between 2013 and 2017, with many facilities cited year after year and few actions taken to enforce standards.[38] To date, over one hundred thousand nursing home residents and staff have died during the COVID-19 public health emergency, and poor infection control fueled by negligent regulation, inspection, and deterrence is at the heart of the problem.[39] We urge strong oversight of all nursing facility deficiencies, including close monitoring and auditing of state agency activities and the imposition of appropriate and meaningful sanctions for noncompliance.

- **Improve Non-Medicare Home and Community-based Services**. Absent comprehensive Medicare coverage for home and community-based services (HCBS), many beneficiaries typically rely on a constellation of other programs to fully participate in their communities, such as Medicaid and the Older American's Act (OAA). The Biden administration should ensure these programs are up to the task. This includes best positioning Medicaid to serve beneficiaries in the least restrictive, most appropriate setting; ensuring states are facilitating access to HCBS, in part

[36] In 2014, MedPAC and the Senate Select Committee on Aging both pointed to this lack of data as an urgent problem. *See, e.g.*, Medicare Rights Center, "Letter to MedPAC" (October 10, 2014), https://www.medicarerights.org/pdf/101014-medpac-part-d-appeals.pdf; Senator Bill Nelson, *et al.*, "Letter to Marilyn Tavenner" (March 10, 2014), https://www.aging.senate.gov/imo/media/doc/03.10.14_CMS%20Part%20D%20Appeals%20Letter2.pdf.

[37] Melissa Favreault, *et al.*, "Financing Long-Term Services And Supports: Options Reflect Trade-Offs For Older Americans And Federal Spending" (December 2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1226.

[38] U.S. Government Accountability Office, "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic" (May 20, 2020), https://www.gao.gov/assets/710/707069.pdf.

[39] AARP, "AARP Nursing Home COVID-19 Dashboard" (last updated January 14, 2020), https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html?cmp=RDRCT-350d888f-20201013.

by fully implementing the spousal impoverishment protections for HCBS and expanding or starting the Money Follows the Person program; and requesting adequate funding for OAA and other programs that help older adults, people with disabilities, and their caregivers maintain their health and independence.

- **Test LTSS Delivery and Financing Reforms**. Currently, more than 24 million adults have LTSS needs,[40] and demand is likely only to grow due to demographic and other trends.[41] At the same time, the cost of these services is also expected to rise considerably in the coming years, putting an increasingly heavy burden on individuals, families, and government programs.[42] While positioning existing programs to better serve older adults and people with disabilities is an important first step, these changes alone will not build the type comprehensive, cohesive system that will be necessary to meet future LTSS needs. We strongly encourage the administration to test broad systemic LTSS changes. Using CMMI demonstration authority, HHS could work to develop a robust, effective program that is equitable and universal; promotes consumer choice, quality of life, and quality of care; is affordable and financially sound; and adequately compensates direct care and professional staff.

Bolster Family Caregivers and the Health Care Workforce. The existing community-based health and social services infrastructure, which relies on family and paid caregivers, is essential to allowing millions of older adults and people with disabilities live in their homes and communities. The administration should pursue funding, policies, and programs that recognize the contributions of and challenges facing direct care professionals, health care workers, and family caregivers.

- **Support Caregivers**. The nation's fragmented LTSS system means that unpaid family caregivers and undervalued home care workers play a critical role in helping people with Medicare age in the community. The administration can support these families and paid workers by championing paid leave that recognizes caring for relatives of all ages; requesting robust funding for annually appropriated HCBS and caregiver support programs; and developing promising practices to recruit and retain a robust workforce.

- **Promote Safety and Equity**. All of those who work in care fields must have greater access to training and certification, higher pay with opportunities for advancement, sick and overtime pay, personal protective equipment, and supportive systems. Ensuring better conditions and supports for these invaluable workers helps older adults and people with disabilities remain safely in their homes; combats racial and gender inequity; and more effectively aids women of color, who provide a disproportionate percentage of care both for their own families and for the families of others.[43]

Enhance Health Care and Prescription Drug Affordability

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[40] Edem Hado & Harriet Komisar, "Long-Term Services and Supports" (August 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.doi.10.26419-2Fppi.00079.001.pdf.
[41] Nga Thach & Joshua Weiner, "An Overview of Long-Term Services and Supports and Medicaid: Final Report (August 8, 2018), https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report.
[42] I*d*., and "Genworth 17th Annual Cost of Care Survey" (December 2, 2020), https://newsroom.genworth.com/2020-12-02-Genworth-17th-Annual-Cost-of-Care-Survey-COVID-19-Exacerbates-Already-Rising-Long-Term-Care-Costs-Care-Providers-Foresee-Additional-Rate-Hikes-in-2021#assets_20295_124101-118.
[43] *See, e.g.*, National Partnership for Women and Families, "The Female Face of Family Caregiving" (November 2018), https://www.nationalpartnership.org/our-work/resources/economic-justice/female-face-family-caregiving.pdf.

Increase Access to Medicare Assistance Programs. Medicare's low-income assistance programs, the Medicare Savings Programs and Part D's Extra Help/Low-Income Subsidy, were established to help qualifying Medicare beneficiaries afford needed care. But burdensome processes and outdated requirements unnecessarily limit participation. We urge the Biden administration to modernize these programs to help more people obtain the financial assistance they need to pay for their coverage and care.

- **Encourage Outreach and Enrollment in Medicare Savings Programs (MSPs)**. Administered by states through a combination of federal and state funding, MSPs—including the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs—help people with very low incomes and assets pay for Part B. In doing so, MSPs allow beneficiaries to stretch their limited budgets and better afford groceries, utilities, and other basic needs. Troublingly, less than half of those eligible for this assistance are enrolled, in part to due to ineffective outreach and complex rules.[44] Since CMS plays an important role in convening states and disseminating best practices on the administration of MSPs, the agency has a unique opportunity to improve enrollment. We recommend encouraging states to identify and implement strategies to enhance MSP participation rates, including easing eligibility criteria, expanding outreach, simplifying enrollment, participating in a Medicare Part A buy-in, and improving provider payment.

- **Continue to Minimize Inappropriate Billing of Qualified Medicare Beneficiaries (QMB)**. By law, people with QMB, among the lowest-income Medicare beneficiaries, are shielded from Medicare Part A and Part B cost-sharing.[45] However, they are often billed illegally by their providers, to the detriment of their financial stability.[46] Medicare Rights appreciates CMS's ongoing work to curb these practices. We encourage the Biden administration to expand on existing strategies, which include increased assistance for health care providers; the involvement of Medicare Advantage plans in related efforts with network providers; and the development of beneficiary supports through 1-800-MEDICARE, the Medicare & You handbook, and more.[47]

- **Ease Access to and Administration of the Extra Help/Low-Income Subsidy (LIS) Program**. Extra Help/LIS helps beneficiaries afford their Part D premiums and reduces their out-of-pocket prescription drug costs,[48] saving beneficiaries an average of $4,900 a year.[49] Improving enrollment in this important program—by increasing eligibility thresholds and eliminating the asset test —and making it more effective—by eliminating cost-sharing on generics, sending the LIS "Choosers Notice" to all enrollees with premium liability, and allowing intelligent assignment—would further reduce costs and improve health outcomes for low-income

[44] MedPAC, "Medicare Savings Program Enrollees and Eligible Non-Enrollees" (June 2017), https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.
[45] Centers for Medicare & Medicaid Services, "Medicare Savings Programs" (last accessed January 13, 2021), https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs.
[46] Centers for Medicare & Medicaid Services, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)" (July 2015), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-CoordinationOffice/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.
[47] Centers for Medicare & Medicaid Services, "Reducing Inappropriate Billing of Qualified Medicare Beneficiaries" (December 2016), http://nhelp.org/conf2016/uploads/presenters/28_MMCO%20Inappropriate%20QMB%20Billing.pdf.
[48] Medicare Interactive, "Extra Help Basics" (last accessed January 13, 2021), https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/the-extra-helplow-income-subsidy-lis-program/extra-help-basics.
[49] Social Security Administration, "Extra Help with Medicare Prescription Drug Plan Costs" (last accessed January 13, 2021), https://www.ssa.gov/benefits/medicare/prescriptionhelp/.

Medicare beneficiaries, and likely generate Medicare savings.[50] We ask the Biden administration to support these reforms, and to provide states with models for expanding access to the Medicare Savings Programs, enrollment in which automatically qualifies one for Extra Help.

Address High and Rising Costs. Many people with Medicare live on fixed or limited incomes and cannot keep paying ever-rising health and prescription drug costs. Even before the pandemic, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—were living on $29,650 or less per year, while one quarter had incomes below $17,000 and less than $8,500 in savings.[51] At the same time, health care costs are taking up a larger and more disproportionate share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so.[52] Out-of-pocket costs for prescription drugs represent a significant share of this spending, accounting for nearly one out of every five beneficiary health care dollars.[53] The Biden administration must work administratively and with Congress to rein in health care and prescription drug prices, lowering costs for consumers and for Medicare.

- **Improve Prescription Drug Affordability**. Prescription drug affordability consistently presents as a top trend on Medicare Rights' Helpline.[54] Given that many people with Medicare live on limited incomes that cannot keep pace with high and rising drug prices, the perennial nature of these calls is alarming, but not surprising.[55] Changes are urgently needed to meaningfully reduce drug prices and lower costs both for people with Medicare and for the program as a whole. Important strategies to do so include restructuring the Part D benefit in ways that firmly cap beneficiary out-of-pocket spending, expanding low-income assistance programs, allowing Medicare to negotiate drug prices, and increasing pricing transparency and accountability throughout the supply chain. Reforms to the current system must not undermine beneficiary protections or access to care, and savings achieved through drug pricing reform should be reinvested in improvements to the program, as outlined in the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3).[56] We urge the administration to prioritize these reforms, and the needs of beneficiaries, in any regulatory or administrative changes it may seek.[57]

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[50] Congressional Budget Office, "Effects of Drug Price Negotiation Stemming From Title 1 of H.R. 3, the Lower Drug Costs Now Act of 2019, on Spending and Revenues Related to Part D of Medicare" (October 2019), https://www.cbo.gov/publication/55722.
[51] Wyatt Koma, *et al*., "Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic" (April 24, 2020), https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-financial-security-before-the-coronavirus-pandemic/.
[52] Juliette Cubanski, *et al*., "The Financial Burden on Health Care Spending: Larger for Medicare Households than for Non-Medicare Households" (March 1, 2018), https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care- spending-larger-for-medicare-households-than-for-non-medicare-households/.
[53] Kaiser Family Foundation, "10 Essential Facts about Medicare and Prescription Drug Spending" (January 29, 2019), https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/.
[54] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center's National Helpline" (April 2019), https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf.
[55] Leigh Purvis, *et al*., "Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update" (September 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/09/trends-in-retail-prices-of-prescription-drugs-widely-used-by-older-americans.doi.10.26419-2Fppi.00073.003.pdf.
[56] H.R. 3—Elijah E. Cummings Lower Drug Costs Now Act (2019), https://www.congress.gov/bill/116th-congress/house-bill/3.
[57] For more information on Medicare Rights' recommendations for drug pricing reform, *see* Medicare Rights feedback on draft Medicare Part D legislation (June 6, 2019) http://medicarerights.org/pdf/060619-partd-legislation-medicare-rights-response.pdf; Joint letter to Senate leaders about Part D reforms (June 27, 2019) http://medicarerights.org/pdf/062719-joint-letter-part-d.pdf; Joint letter about Part D reforms and drug pricing (September 10, 2019) https://www.medicarerights.org/pdf/091019-partd-reforms-joint-letter.pdf; Medicare Rights letters of support for H.R. 3 (October 16, 2019) https://www.medicarerights.org/pdf/101619-letter-support-hr3.pdf and (December 11, 2019) https://www.medicarerights.org/pdf/121119_hr3_letter.pdf.

- **Limit Beneficiary Exposure to Out-of-Pocket Costs, Program-wide**. Much of the Part A and Part B benefit structure has not been updated in over 50 years. As a result, Original Medicare can lack consumer protections that have become prevalent in private insurance, like an out-of-pocket spending cap. While Medicare Advantage plans are required to include an out-of-pocket maximum in their benefit packages, the threshold is too high—$7,550 for in-network care in 2021—and does nothing for the two-thirds of beneficiaries with Original Medicare.[58]As discussed above, Part D also lacks a hard cap on beneficiary spending. We request the administration to work with Congress and limit beneficiary financial exposure across the program in a way that preserves the Part A Trust Fund. Such arrangements have long been a feature of private health plans, including employer-sponsored insurance, and are now more broadly required under the Affordable Care Act.[59] People with Medicare, who already incur relatively high out-of-pocket costs, must not be left behind.[60]

Make Organizational Changes

Update Structures and Practices. We recommend that CMS and SSA examine internal policies for ways to promote beneficiary protections and strengthen relationships with stakeholders.

- **Immediately Pause New "Geo" Demonstration Model**. The incoming administration must immediately halt implementation of the Direct Contracting "Geo" model aimed at coordinating care and clinical management for beneficiaries with Original Medicare.[61] We are concerned by the Trump administration's last-minute rush to implement this model, especially amid a lack of complete information about how it will work. There is no valid policy or program reason to proceed in a hurried manner, or without ample study and stakeholder feedback. We urge a pause and at least a one-year delay, to allow for additional investigation.

- **Rescind the SUNSET Rule**. A proposed rule issued on November 4, 2020 would impose an expiration provision on most HHS regulations and establish an onerous review process for the agency to use to determine which, if any, regulations should be retained or revised. This proposal, the Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) rule,[62] would lead to chaos for Medicare beneficiaries, providers, and payers and would force federal agencies to engage in hundreds of hours of pointless busywork each year, reducing their capacity to manage other, more critical issues like ensuring access to coverage and care in a pandemic. As we noted at the time, we oppose this ill-conceived and destructive proposal and ask the administration to withdraw it in its entirety.[63]

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[58] Meredith Freed, *et al.*, "A Dozen Facts About Medicare Advantage in 2020" (January 13, 2021), https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.
[59] AHIP, "Patient Cost Sharing under the Affordable Care Act" (November 2015), https://www.ahip.org/wp-content/uploads/2015/11/CostSharing_IssueBrief_11.19.15.pdf.
[60] Juliette Cubanski, *et al.*, "Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future" (January 26, 2018), https://www.kff.org/medicare/report/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future/.
[61] Centers for Medicare & Medicaid Services, "CMS Announces New Model to Advance Regional Value-Based Care in Medicare" (December 3, 2020) https://www.cms.gov/newsroom/press-releases/cms-announces-new-model-advance-regional-value-based-care-medicare and "Geographic Direct Contracting Model" (December 3, 2020) https://www.cms.gov/newsroom/fact-sheets/geographic-direct-contracting-model-geo.
[62] *See* RIN 0991–AC24; Docket No. HHS–OS– 2020–0012.
[63] Medicare Rights Center, "Comments on Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) proposed rule" (January 4, 2021), https://www.medicarerights.org/pdf/010421-comments-sunset-rule.pdf.

- **Institute a Competitive Bidding Program for Durable Medical Equipment with Strong Beneficiary Protections**. The Durable Medical Equipment Prosthetics, Orthotics and Supplies (DME-POS) Competitive Bidding Program (CBP) established important price controls and beneficiary protections, including the CBP Ombudsman and the requirement that contract suppliers serve all beneficiaries within their geographic area. When the Trump administration allowed the program to lapse without a replacement, beneficiaries again faced limitless cost sharing on their DME and no centralized place to turn for assistance. We urge the Biden administration to create equitable processes for suppliers to participate in the competitive bidding program with fair prices and reasonable cost sharing; re-authorize and empower the CBP Ombudsman to resolve both supplier and beneficiary issues; and ensure equitable access to needed equipment and supplies.

- **Elevate the Office of the Medicare Ombudsman**. The Ombudsman works to resolve beneficiary problems not addressed through 1-800-MEDICARE and other means, and presents systemic challenges facing people with Medicare to CMS, Congress, and the public. Given the importance of this office, the administration must make sure it is adequately resourced.

- **Create the Alternative Payment Models Beneficiary Ombudsman**. In December 2016,[64] and again in 2017,[65] CMS announced plans to create an Alternative Payment Models Beneficiary Ombudsman to help support Medicare beneficiaries in these models. We ask the Biden administration to act upon this promise as soon as possible.

- **Engage Stakeholders**. It is critical that the agencies administering Medicare are aware of and responsive to challenges facing beneficiaries. To further and ongoingly incorporate the beneficiary perspective and lived experience into agency policies and structures, we recommend convening regular meetings with advocates for older adults and people with disabilities.

- **Fill Vacancies at the Medicare Board of Trustees**. The two public representatives on the Medicare Board of Trustees provide important and independent perspectives on the state of the program. These positions have been vacant since 2015, violating the intent of federal law and depriving Congress and the public of key objective insights into the health of the Trust Funds. We encourage the Biden administration to swiftly appoint well-suited individuals to these positions.[66]

[64] Centers for Medicare & Medicaid Services, "Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) and Medicare ACO Track 1+ Model" (December 20, 2016), https://www.cms.gov/newsroom/fact-sheets/advancing-care-coordination-through-episode-payment-models-cardiac-and-orthopedic-bundled-payment.
[65] 82 Fed. Reg. 180, 430; 82 Fed. Reg. 22895, 22897.
[66] Centers for Medicare & Medicaid Services, "About the Board of Trustees" (last accessed January 13, 2020), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/AboutTheBoard.