Policy Recommendations for the Biden Administration: Simplify Medicare Enrollment

Medicare Rights asks the Biden administration to simplify Medicare enrollment in order to ensure active, informed, and meaningful beneficiary choice.

A rapidly aging population, complex Medicare rules and timelines, and an ever-evolving health care landscape means a growing number of individuals will face increasingly difficult Medicare coverage decisions in the coming months and years. The Biden administration must act without delay to better empower current and future beneficiaries to make optimal choices, both initially and annually.

Modernize Part B Enrollment

Implement the Beneficiary Enrollment Notification and Simplification (BENES) Act. Recently signed into law, key provisions of the bipartisan BENES Act are set to take effect on January 1, 2023.[1] The enacted policies will update Medicare enrollment rules for the first time in over 50 years to end lengthy waits for coverage, expand critical administrative flexibilities, and inform future policymaking on enrollment period alignment.

- **Make Timely Updates**. We encourage the agencies to begin implementation now, so that all necessary changes are in place and well known prior to 2023. In particular, we urge updates to enrollment systems and the Programs and Operational Manual System (POMS), as well as employee training and education, well in advance of the effective date.

- **Engage Stakeholders**. Throughout the implementation process, we encourage thoughtful public dialogue that engages an array of stakeholders, including people with Medicare, beneficiary advocates, and State Health Insurance Assistance Program (SHIP) counselors.

- **Utilize Expanded Special Enrollment Period (SEP) Authority**. We also urge the administration to explore how the "exceptional circumstances" Special Enrollment Periods can advance universal coverage and equity goals. This includes, for example, making it available to ease transitions and increase timely enrollment for (1) formerly incarcerated individuals, (2) people who live in states that do not participate in a Part A buy-in agreement, (3) those whose enrollment period was impacted by the COVID-19 Public Health Emergency, and (4) Medicare-eligible people who mistakenly remain in Marketplace plans.

- **Update Enrollment Timelines**. Shifting Medicare's General Enrollment Period (GEP) to the fall would align it with sign-up periods for other types of coverage, greatly reducing the likelihood of

[1] "Consolidated Appropriations Act, 2021," P. L. 116-260 (December 27, 2020), https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

consumer confusion and enrollment mistakes. One of the recently-enacted BENES Act provisions directs the Secretary to submit a report to Congress on ways to achieve this alignment. We urge compliance with this requirement, and a parallel effort to effectuate the underlying enrollment period shift using existing authorities. We also support extending Medicare's Fall Open Enrollment Period from December 7 to December 15, for consistency with Marketplace open enrollment.

Effectively Engage and Educate Consumers. In our experience, many people who are approaching Medicare eligibility do not understand the program or its enrollment rules and experience mismanaged transitions as a result. The agencies that oversee Medicare—the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA)—could address these knowledge gaps by updating outreach strategies, decision-making tools, and educational materials in ways that empower consumers.

- **Notify People Nearing Medicare Eligibility**. Currently, far too many people make honest mistakes when trying to understand and navigate Medicare's confusing enrollment system. The consequences of such missteps can be significant—including lifelong late enrollment penalties, higher out-of-pocket health care costs, and gaps in coverage.[2] As noted by the Medicare Payment Advisory Commission (MedPAC), notice from the federal government to individuals approaching Medicare eligibility about basic enrollment rules could help prevent these errors.[3] But today, no such notice exists. We encourage the administration to correct this without delay, in fulfillment of its obligation to facilitate Part B enrollments.

- **Seek Public Input to Improve the "Welcome to Medicare" Packet**. Focus group testing could help identify needed updates to the Welcome to Medicare packet. Regular reviews are necessary to ensure these materials provide actionable information that newly Medicare eligible individuals can use to make informed decisions about their Medicare and supplemental insurance enrollments.

- **Update Standard COBRA Notices to Include Medicare Enrollment Information**. Medicare Rights recommends working with the Department to Labor (DOL) to update the standard COBRA notices to better reflect the program's interaction with Medicare.[4] This information should be presented in a consumer-friendly way, and consistently across agency websites and materials. Such notices must pay particular attention to the coordination of benefits and consequences for delaying Medicare Part B in favor of COBRA.[5]

- **Improve Employer and Employee Education**. For many individuals who must actively enroll in Medicare Part B, employers are a primary source of information about how and when to do so. But the enrollment rules are so complicated that many benefits departments are unable to provide complete advice, causing employers to issue well-intended but incorrect guidance. Current and former employees who act in reliance on this misinformation can experience

[2] Congressional Research Service, "Medicare: Part B Premiums" (May 6, 2020), https://crsreports.congress.gov/product/pdf/R/R40082, ("In 2019, an estimated 764,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP), with the average LEP amounting to nearly a 28% increase in their monthly premium.")
[3] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.
[4] U.S. Department of Labor, "Model General Notice" (last accessed January 13, 2021), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/cobra/model-general-notice.docx.

irreversible health and economic adversity. To help prevent this, we urge CMS to work with DOL to make sure employers have accurate, understandable, consumer-tested Medicare enrollment information to give their employees. Such notices should be tailored to the type and size of employer, so the information is specific and actionable.

- **Notify All Marketplace Enrollees About When and How to Enroll in Medicare**. Through timely Periodic Data Matching (PDM) and notification, people who are eligible for and/or enrolled in Medicare but who remain in a federal Marketplace plan can correct their enrollment, minimizing or avoiding harmful financial penalties and periods of non-coverage. We ask the Biden administration to continue this outreach and build upon its successes. In particular, we suggest speeding up the notifications, so they are received during the first three months of an individual's Initial Enrollment Period (IEP) and expanding current matching efforts to include people who are approaching Medicare eligibility due to the receipt of Social Security Disability Insurance (SSDI) payments. Further, since current data matching is limited to states with a federally-facilitated Marketplace, the administration should encourage state-run marketplaces to engage in a similar cross-walk and notification process.

- **Revisit Marketplace Terminations**. At the same time, the administration should re-examine policies permitting automatic or unexpected Marketplace disenrollments, as such transitions can lead to unexpected gaps in coverage and care. For example, plans should not be allowed to manipulate their offerings to sidestep guaranteed renewability requirements, and people should be notified before being disenrolled based on preferences noted in initial Marketplace applications, which in some instances may have been completed years ago.

Invest in Unbiased Counseling and Assistance. Few federal programs are dedicated to helping people with Medicare select the best coverage for their circumstances and better afford needed care. We urge Biden administration to champion those that are, by supporting sufficient, sustainable funding.

- **Request Adequate Funding for State Health Insurance Assistance Programs (SHIPs)**. With locations in every state, over 3,000 offices nationwide, and 16,000 trained staff and volunteers, SHIPs are a primary and trusted source of unbiased, one-on-one counseling for people with Medicare who need help with their coverage and options. Current funding levels are unable to keep pace with growing demands, which are in part being driven by swells in the Medicare beneficiary population and an increasingly complex program. To better help SHIPs provided needed counseling and other services, we recommend requesting adequate funding for the program in the President's budget requests to Congress.

- **Support Permanent Funding for Low-Income Outreach and Enrollment Activities**. Since 2009, the Medicare Improvements for Patients and Providers Act (MIPPA) has helped nearly three million low-income Medicare beneficiaries apply for and obtain assistance that makes their health care and prescription drugs more affordable.[6] Today, MIPPA provides targeted funding to community-based organizations in every state to conduct these outreach and enrollment activities.[7] But the program must be reauthorized on a regular basis, creating uncertainty that

[6] Medicare Rights Center, "Testimony of Fred Riccardi at a hearing of the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health titled Investing in America's Health Care" (June 2019), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Riccardi-Investing%20in%20America%27s%20Health%20Care_060419.pdf.
[7] *Id.*

can impede daily operations and long-term planning. We encourage the administration to support permanent funding for these critical activities. Doing so would allow MIPPA grantees to best serve the growing number of older adults and people with disabilities who need help accessing affordable health care.

Expand Part B Data Collection and Public Reporting

Fill Gaps in Knowledge. Current data collection efforts fail to capture the constellation of impacts that Part B enrollment challenges and missteps can have on people with Medicare. Regular reporting on key underexamined elements—the equitable relief process and the Part B penalty—could increase public understanding and inform future policymaking.

- **Identify Equitable Relief Patterns and Barriers**. We urge HHS to collect and publicly report data on equitable relief patterns and barriers, including the number of beneficiaries requesting equitable relief and any trends over time; the entities most commonly cited as providing misinformation; the frequency with which the Social Security Administration (SSA) grants or denies equitable relief; the average amount of time it takes to process a request; and data on how SSA and CMS use this information to improve education and outreach to beneficiaries, employers, and others.

- **Examine Part B Late Enrollment Penalty (LEP) Rates and Efficacy**. Similarly, enhanced data collection on beneficiary experiences with the Part B LEP could improve both agency documentation and policy**.** We encourage HHS to regularly and publicly release national and state-specific data on the number of Medicare beneficiaries paying lifetime late enrollment penalties, information on the beneficiaries themselves (i.e., race, ethnicity, education completed, gender, pre-Medicare coverage source), the average penalty amount, and the length of any attendant coverage gaps. We also urge studying the efficacy of the LEP structure more broadly, as recommended by MedPAC in its June 2019 report.[8]

Improve Medicare Advantage Plan Offerings and Oversight

Strengthen Guardrails. One way to improve the onerous plan selection process is to improve the plan offerings and prohibit inappropriate marketing tactics, thereby reducing the risk a beneficiary will make a bad choice. The Biden administration must make plan selection easier—and less risky—by ensuring that plans are high-quality, limited in number, and easy to compare.

- **Reinstate Medicare Advantage Meaningful Difference and Uniformity Requirements**. People enrolled in Medicare Advantage face a daunting task each year as they attempt to assess their coverage options. Such decisions have become more challenging recently, spurred by regulatory changes that have allowed insurers to offer plans that are nearly indistinguishable from one another and target small subsections of the population.[9] These plan flexibilities have created an

[8] *See* MedPAC, "Medicare and the Health Care Delivery System" (June 2019), http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0 ("…the Secretary could examine whether the late-enrollment penalties are having the desired effects…Currently it is not known whether, and to what extent, the penalties are causing beneficiaries to further delay enrollment. Further study of these issues would be useful").
[9] 83 Fed. Reg. 16440, 16480.

illusion of choice, cluttering the marketplace in ways that can hinder decision-making. We urge the Biden administration to roll back these policies.[10]

- **Restore Medicare Advantage Network Adequacy Requirements**. Medicare Advantage network adequacy rules exist to help guarantee that enrollees can access needed care. CMS guidance outlining these requirements specifies that providers must meet certain "time and distance" standards to be considered "available" to enrollees in a given area.[11] Troublingly, the 2021 Part C & D rule dilutes this protection in non-urban counties, and in all areas with respect to certain telehealth services.[12] CMS is also loosening standards concerning access to dialysis providers—just as Medicare Advantage plans will be required to accept people with End Stage Renal Disease (ESRD) in 2021. These policy changes threaten beneficiary access to care, and we urge their immediate withdrawal.[13] If a Medicare Advantage plan cannot contract with an adequate number of providers to meet minimum "time and distance" standards, it should not be allowed to offer a plan in the area. Permitting plans to operate with too few providers that are too far away from enrollees does not serve people with Medicare well. Nor does using access to telehealth—services that should supplement and not supplant in-person care—as an excuse to reduce plan compliance.

- **Reinstate Medicare Communications and Marketing Guidelines (MCMG) that Protect Beneficiaries**. The MCMG is a set of rules that governs the selling and promotion of Medicare Advantage and Medicare Part D prescription drug plans. In 2019, CMS weakened the guidelines' distinction between marketing and educational events and removed the requirement that plan materials note the availability of non-English translations.[14] Both shifts leave beneficiaries more exposed to deceptive or confusing marketing strategies, and less able to access important information in a usable format. We support immediately restoring theses protections.

Enhance Consumer Tools and Protections. To further promote meaningful beneficiary choice, we encourage the administration to provide needed guidance and protections, minimize default and sub-optimal enrollments, and prevent discriminatory practices.

- **Provide Marketing Guidance and Oversight for Supplemental Benefits**. The MCMG does not sufficiently address how Medicare Advantage plans and brokers may market supplemental benefits to current or potential enrollees. Clarity is urgently needed, given that plans and brokers may have financial incentives to use these benefits to steer enrollees into coverage that may not be right for them.[15] In drafting this guidance, we ask CMS to reinforce that supplemental benefits should not be merely or primarily a sales tool, or used to persuade beneficiaries to enroll in a plan. We also ask the agency to be vigilant in its enforcement, including by watching for unusual spikes in enrollment and other patterns that might indicate

[10] Medicare Rights Center, "Comments on [CMS-4182-P] Medicare Advantage, Medicare Fee-for-Service, and the Medicare Prescription Drug Benefit programs" (January 16, 2018), https://www.medicarerights.org/pdf/Medicare-Rights-Center-C-D-Comments-CMS-4182-P.PDF.
[11] Centers for Medicare & Medicaid Services, "Medicare Advantage Network Adequacy Criteria Guidance" (January 2017), https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.
[12] Medicare Rights Center, "Comments on Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" (April 6, 2020), https://medicarerights.org/pdf/medicare-rights-2021-c-d-rule-comments.pdf.
[13] *See* 85 Fed. Reg. 33796, 33797.
[14] Medicare Rights Center, *et al*., "Joint Letter to CMS" (September 27, 2019), https://www.medicarerights.org/pdf/082719-mpf-mcmg-2020-letter-cms.pdf.
[15] *Id*.

inappropriate behavior. When identified, such practices must be corrected through plan and broker penalties and enrollee Special Enrollment Periods.[16]

- **Modernize Medicare Plan Finder**. Beneficiaries are often confused about the differences between plans or how to compare them and lack sufficient tools and supports for confident decision-making.[17] The Biden administration can begin to address these unmet needs through improvements to Medicare Plan Finder. Priority upgrades should include integrated plan network information and accurate provider directories, clearer definitions and details about supplemental benefits, and the ability for unbiased assistors like SHIP counselors to easily save and send search results.[18]

- **Individually Tailor the Annual Notice of Change**. CMS should require Medicare Advantage and Part D plans to provide a tailored Annual Notice of Change (ANOC) to all enrollees. The individualized notice should be based on claims data and clearly describe how the enrollee's plan and costs will change, if at all, in the coming year. This includes listing any of the individual's providers or pharmacists who will no longer be in network, any of their prescription drugs that will no longer be on the plan's formulary, and any instances in which utilization management tools will be newly applied.

- **Make Medicare Advantage Provider Directories Accurate**. The Biden administration must address the long-standing problem of inaccurate Medicare Advantage provider directories.[19] This lack of accuracy can thwart beneficiary decision-making, rendering informed choices impossible. It also prevents CMS from conducting proper oversight, as the insufficient data may hide non-compliance with network adequacy and other requirements. CMS should improve the directories without delay, to guarantee accuracy before they are incorporated into Medicare Plan Finder, and to hold beneficiaries harmless with respect to any enrollment decisions they may make in reliance on provider directory-contained misinformation.

- **Hold Beneficiaries Harmless from Mid-Year Network Changes**. Medicare Advantage enrollees must be able to count on stability in their plan networks and the knowledge that their doctors will be there when they need them. We urge the Biden administration to work with plans to minimize the practice of dropping doctors without cause in the middle of the plan year. When such changes are necessary, affected enrollees must receive adequate notice and relief, including access to a Special Enrollment Period.

- **Minimize Default Enrollment and Enhance Related Protections**. We support curtailing the use of default, passive, or auto-enrollment into Medicare Advantage and Part D plans. Such enrollments deny beneficiaries active choice and can create confusion and distrust by forcing

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[16] Medicare Rights Center, "Comments on 2019 Final Medicare Communications and Marketing Guidelines" (August 10, 2018), http://medicarerights.org/pdf/2019-final-mcmg-comments.pdf; Medicare Rights Center, "Comments on 2020 Final Medicare Communications and Marketing Guidelines" (April 4, 2019), https://www.medicarerights.org/pdf/040419-mcmg-2020-comments.pdf.

[17] National Council on Aging, "The Modernizing Medicare Plan Finder Report" (April 2018), https://www.ncoa.org/public-policy-action/health-care/better-coverage-choices/medicare-plan-finder-report/.

[18] Medicare Rights Center, "2019 Medicare Plan Finder Review" (September 18, 2019), https://www.medicarerights.org/policy-documents/comments-2019-medicare-plan-finder-review.

[19] *See, e.g.*, Centers for Medicare & Medicaid Services, "Online Provider Directory Review Report" (March 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf; Centers for Medicare & Medicaid Services, "Online Provider Directory Review Report (January 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

them into coverage they did not choose or want, and which requires them to take deliberate action to undo. In addition, due to plan network and formulary restrictions, these enrollments can cause beneficiaries to lose access to their medications or providers, interrupting care continuity and delaying needed treatment. To the extent that any default enrollments are necessary, they must be accompanied by increased oversight and data collection to assess disruptions and patterns, and to ascertain whether and why beneficiaries subsequently disenroll from the default coverage.[20]

- **Increase Plan Oversight to Prevent Discriminatory Practices**. Recent analysis shows that Medicare Advantage enrollees are less expensive than the general Medicare population, even before they join a plan.[21] This discrepancy suggests that plans may be targeting lower cost beneficiaries, perhaps through discriminatory benefit designs that do not appeal to those with high needs—and high costs. It also suggests plans are abusing patient categorization rules to increase payment rates.[22] We are especially concerned about plan efforts to enroll beneficiaries with well managed chronic conditions, allowing the plan to benefit from higher risk adjustment rates, even though their actual costs are lower, and about marketing and outreach practices that might exacerbate or rely on racial and economic health disparities. Robust data collection, aggressive oversight, and steep penalties should be employed to root out and discourage such practices.

- **Enforce Anti-Discriminatory Benefit Design Protections for End Stage Renal Disease (ESRD) Enrollees**. In 2021, individuals with ESRD will be permitted to join Medicare Advantage plans. With this change comes the need for heightened oversight. CMS must ensure plans do not discriminate against these beneficiaries, including by curtailing dialysis networks and increasing cost sharing in an effort to make their offerings less attractive. We also urge the administration to work with Congress to expand equitable access to Medigap policies for people with ESRD Medicare, and to impose a program-wide cap on out-of-pocket costs, so that all beneficiaries have access to this critical financial protection.

- **Improve Integration in Duals-Special Needs Plans (D-SNPs)**. Medicare Advantage Duals-Special Needs Plans (D-SNPs) can spur greater integration of benefits between Medicare and Medicaid, as well as improve care coordination and administrative simplicity. However, this is often not the case. Dually eligible individuals may be lured into Medicare Advantage plans by claims of enhanced benefits that they are already eligible for through Medicaid or that are so limited as to be nearly worthless. For example, D-SNP plans may claim to offer transportation or over-the-counter benefit cards that are no greater than Medicaid's assistance. And once enrolled, they may struggle to navigate complex Medicare Advantage plan networks and rules that are different from those for their Medicaid benefits. We ask the Biden administration to monitor D-SNPs to ensure their practices match their promises and that they are truly meeting beneficiary needs. This includes requiring that, at a minimum, integrated plans have unified grievance and appeals processes; assigned care managers for coordinating care; seamless access to data; coordinated access to all services, including Durable Medical Equipment and prescriptions; and

[20] Medicare Rights Center, "Proposal for New York State FIDA Replacement-Future of Integrated Care" (May 2018), https://www.healthinnovation.org/news/newsletter/health-innovation-highlights-june-27-2018/body/FINAL-MRC-Future-of-Integrated-Care-Proposal-May-2018.pdf.
[21] Gretchen Jacobson, *et al*., "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" (May 7, 2019), https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/.
[22] *See* p. 14, "Reduce Medicare Advantage Overpayments"

robust oversight at both the federal and state levels.[23] We also recommend empowering CMS to build upon the successes of prior demonstrations to support truly integrated care with beneficiary protections, state-federal partnerships, and high quality outcomes.

- **Restore Continuous Special Enrollment Period (SEP) Rights**. We urge CMS to reinstate continuous SEP rights for dual eligible and Low-Income Subsidy (LIS) beneficiaries.[24] This important protection was unnecessarily eliminated in recent rulemaking.[25] Especially where dually eligible individuals may be navigating separate Medicare and Medicaid plans, this enrollment flexibility is essential to preserving access to care and services.

- **Address Prior Authorization in Medicare Advantage**. On December 10, 2020, CMS announced a proposed rule to "streamline processes related to prior authorization" in Medicaid, CHIP, and Marketplace plans—but not Medicare Advantage.[26] Finalized on January 15, just days after the comment period closed, the rule limits the amount of time payers have to make a decision and requires them to specify a reason when denying a request.[27] In the final rule, CMS notes that "Medicare Advantage plans are not prohibited from adopting any of these policies" and "anticipate[s] that some of them may do so."[28] But in our experience, hoping for outcomes that center the needs of Medicare beneficiaries is not an effective strategy. We recommend that Medicare Advantage plans be part of future efforts to prevent harmful prior authorization practices, including any re-issuances of this this hastily advanced rule.

- **Improve Communications about Prior Authorization**. We are also concerned about the frequency with which prior authorization has been described as a plan benefit in draft CMS materials comparing Medicare Advantage and Original Medicare.[29] While prior authorization may help providers manage their financial exposure, beneficiaries experience it almost universally as a restriction on access to needed services or medicines. CMS should address this as part of its review of educational materials.

Reduce Inappropriate Medicare Advantage Denials. Year after year, among the most frequent calls to Medicare Rights' Helpline are those concerning Medicare Advantage coverage and service denials.[30] Far too many of these plan decisions are erroneous, which can lead to harmful delays in treatment and

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[23] Medicare Rights Center, "RE: Request for Stakeholder Input: Implementing the Dual Eligible Special Needs Plans (D-SNPs) Provisions of the Bipartisan Budget Act of 2018" (April 12, 2018), https://www.medicarerights.org/pdf/041218-dsnp-comments-section-50311.pdf.
[24] Medicare Rights Center, "Comments on the Medicare Advantage, Medicare Fee-for-Service, and the Medicare Prescription Drug Benefit programs" (January 16, 2018), https://www.medicarerights.org/pdf/Medicare-Rights-Center-C-D-Comments-CMS-4182-P.PDF.
[25] Centers for Medicare & Medicaid Services, "CMS Finalizes Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-F)" (April 2, 2019), https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-policy-changes-and-updates-medicare-advantage-and-prescription-drug-benefit-program.
[26] Centers for Medicare & Medicaid Services, "Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information CMS-9123-P: Fact Sheet" (December 10, 2020), https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients.
[27] Centers for Medicare & Medicaid Services, "Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications" (January 15, 2020) https://www.cms.gov/files/document/11521-provider-burden-promoting-patients-electronic-access-health-information-e-prior.pdf.
[28] *Id.*
[29] Medicare Rights Center, "Letter to Seema Verma Re: Medicare & You Inaccuracies" (May 15, 2018), https://www.medicarerights.org/pdf/JIA-CMA-MRC-Letter-re-2019-Medicare-You.pdf.
[30] 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.

worse outcomes.[31] Better oversight and enforcement is needed to deter and prevent these harmful plan behaviors.

- **Enhance Oversight of Medicare Advantage Coverage and Care Denials**. A recent report from the U.S. Department of Health and Human Services (HH) Office of Inspector General (OIG) found that from 2014 to 2016, only 1% of Medicare Advantage service and coverage denials were appealed. Of those that were, a stunningly high amount—75%—were eventually overturned by the plan, with independent reviewers issuing additional reversals.[32] While this not necessarily mean that plans acted inappropriately, these findings strongly suggest a pattern that warrants attention and correction. We urge CMS to investigate further, and to increase its oversight of and penalties for Medicare Advantage plans that inappropriately deny care.[33] This includes conducting program audits more frequently and incorporating those findings into Medicare Advantage Plan Star Ratings in more concrete and transparent ways. CMS must also notify beneficiaries about plan violations and offer enrollment relief where needed.

- **Increase Audit Capacity**. In rulemaking for CY 2015, CMS acknowledged that limited resources mean the agency can audit only 10% of Medicare Advantage and Part D plan sponsors each year. To build up this capacity, CMS issued, but did not finalize, a proposal to require plans to hire independent auditors. We ask CMS to revisit this idea, with caution. As we said at the time, we agree that more regular auditing is needed and we support CMS efforts to effectuate that oversight.[34] However, we do not recommend wholly replacing those directed by CMS. The delegation of audits requires assurance that independent auditors will provide meaningful, truly independent, analysis. Accordingly, we ask CMS to enhance its own audits, and to strictly oversee any that are plan-directed.

- **Strengthen Data Collection and Reporting**. We also urge CMS to monitor Medicare Advantage coverage and care decisions for high denial and overturn rates as well as for low appeal rates, and for any patterns therein, like inappropriate denials for specific services. Any trends that emerge should trigger a more comprehensive review to determine the underlying cause of the error and to obligate the plan to resolve it. Plans that regularly engage in such practices should lose the ability to enroll new members or, if the violations are severe, to contract with CMS, until corrections are made and publicly documented. Offending plans should remain subject to higher levels of review going forward and all captured data should be made publicly available.

<u>Update the Medicare Advantage Appeals Process</u>. The Medicare Advantage appeals process is unnecessarily complicated, often trapping beneficiaries in a burdensome struggle to access care. CMS must simplify this system, working with Congress in any areas where the agency lacks the authority to make necessary changes.

- **Improve Plan Communications with Enrollees**. Under current rules, when plans issue a denial, they are required to notify the affected enrollee in a timely manner. This notification should

[31] HHS Office of the Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials" (September 25, 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.
[32] *Id*.
[33] We also urge CMS to increase oversight over Medicare Advantage plans for other issues that affect beneficiaries, including plan designs that drive those in poorer health to disenroll from Medicare Advantage and inaccurate online provider directories. *See*, *Id*.
[34] Medicare Rights Center, "Comments on Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" (March 7, 2014), available upon request.

contain everything the enrollee needs to determine next steps, which may involve pursuing an appeal. Without this notice, beneficiaries may not understand their rights, how to appeal, or even that they have been denied coverage. Despite the importance of this obligation, many plans fail to comply.[35] CMS must do more to make sure plan notices are correct, promptly delivered, available in languages other than English, and accessible to people with varying levels of health literacy. We also support invalidating and immediately escalating coverage denials that were not accompanied by proper notice.

- **Require Independent Redeterminations**. To make the appeals process more manageable and accessible, the first level of appeal should be handled by an independent entity, rather than the plan itself. This would simplify the system, help ensure that beneficiaries have more timely access to care, and further encourage plans to make accurate initial coverage determinations.[36]

[35] In 2015, 45% of Medicare Advantage plans sent denial letters with incomplete or incorrect information. *See* HHSS Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials" (September 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.

36 American Cancer Society Cancer Action Network, "The Medicare Appeals Process: Reforms Needed to Ensure Beneficiary Access" (November 17, 2020), https://www.fightcancer.org/sites/default/files/Medicare%20Appeals%20Paper%20FINAL.pdf.