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VIA ELECTRONIC SUBMISSION

August 31, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: CMS-4203-NC—Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Medicare Program; Request for Information on Medicare (RFI)**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

Medicare beneficiaries must have access to the quality care Medicare promises, regardless of whether they choose Original Medicare (OM) or Medicare Advantage (MA). While these decisions have long been high-stakes and complex, in recent years they have become even more so.

Among the most frequent calls to Medicare Rights' Helpline are from or on behalf of people trying to understand their options and navigate enrollment.¹ For many, including those who must actively enroll, this can be a confusing and overwhelming time.

Most people new to Medicare are automatically enrolled because they are receiving Social Security when they become eligible—but a growing number are not.² These individuals must enroll on their own, taking into consideration specific timelines, intricate Medicare rules, and

¹ Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of Call Data from the Medicare Rights Center's National Helpline, 2020-2021," (May 2022), <https://www.medicarerights.org/policy-documents/2020-2021-medicare-trends-and-recommendations>.

² See, e.g., Medicare Payment Advisory Commission, "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.

any existing coverage. Mistakes are common and carry serious consequences, including lifelong financial penalties, high out-of-pocket health care costs, disruptions in care continuity, and gaps in coverage.

People who choose MA face additional hurdles during the initial and annual plan selection processes. Like enrollment itself, these decisions can be complicated. One reason is the increasingly cluttered plan choice landscape.

Recent rule changes, such as the elimination of meaningful difference and uniformity requirements,³ in combination with burgeoning profits,⁴ have led to seemingly endless numbers of MA plans, giving beneficiaries more to wade through but few tools to effectively do so. In 2022, beneficiaries had access to 39 MA plans, on average; more than double the number in 2017.⁵ Plans can vary on everything from costs to coverage, sometimes in subtle but important ways. For most beneficiaries, this makes close analysis both critical and unattainable.

Indeed, identifying and simultaneously comparing each plan deviation, year after year, is a challenging, intimidating, and time-consuming task that alarmingly few people with Medicare perform.⁶ Enrollees who arguably have the most at stake—those who are older, have lower incomes, are living with cognitive impairments, or have serious health needs—are also the least likely to review and change their coverage.⁷ This inertia, and any sub-optimal selections, can have detrimental and unanticipated results, like higher costs and problems accessing preferred providers. As plans proliferate and stealth plan and brokerage marketing practices spread, coverage decisions are becoming more difficult. And as benefits diverge, individual and program costs escalate, and utilization management grows, missteps are becoming more frequent and more dire.

An increasing number of beneficiaries are interacting with this flawed system. Alongside plan growth, MA enrollment has also surged, more than doubling over the last decade.⁸ This trendline is expected to continue; the Congressional Budget Office (CBO) projects the share of

³ 86 FR 16440, 16491.

⁴ Paige Minemyer, “2022 forecast: Medicare Advantage is the industry’s hottest market. Don’t expect that to change next year,” Fierce Healthcare (December 22, 2021), <https://www.fiercehealthcare.com/payer/medicare-advantage-industry-s-hottest-market-2022-don-t-expect-to-change>.

⁵ Meredith Freed, *et al.*, “Medicare Advantage 2022 Spotlight: First Look,” Kaiser Family Foundation (November 2, 2021), <https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/>.

⁶ *See, e.g.*, Meredith Freed, *et al.*, “More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually,” Kaiser Family Foundation (October 29, 2020), <https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/>; Wyatt Korma, *et al.*, “Seven in Ten Medicare Beneficiaries Did Not Compare Plans Past Open Enrollment Period,” Kaiser Family Foundation (October 13, 2021), <https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/>.

⁷ *Id.*

⁸ Meredith Freed, *et al.*, “Medicare Advantage in 2022: Enrollment Update and Key Trends,” Kaiser Family Foundation (August 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>.

beneficiaries enrolled in MA, now at 48%, will hit 61% by 2032.⁹ Absent policymaker intervention, ever-more people will experience the pitfalls of the current program.

MA's expansion also has implications for Medicare. The Medicare Payment Advisory Commission (MedPAC) has long cautioned MA financing is worsening Medicare spending and long-term sustainability:¹⁰

The Commission has found that payments to MA plans are inflated as a result of plans maximizing the diagnoses they report for their enrollees in order to gain higher payments, while the underlying risk adjustment model relies on diagnoses collected from claims from fee-for-service (FFS) providers, who lack the same incentives to code diagnoses. MA plans also receive quality bonuses that increase Medicare spending for the majority of MA enrollees, yet the MA quality rating system does not provide meaningful information about plans' quality of care. MA spending is also driven up by plan benchmarks that are set so high that the Medicare program ends up subsidizing the substantial extra benefits that MA plans offer to their enrollees—benefits that are not available to FFS enrollees.¹¹

Researchers agree. Recent analysis shows payments to MA plans are climbing. As a share of total Medicare spending, these dollars increased from 26% in 2010 to 45% in 2020—and may reach 54% by 2030.¹² By themselves, plan abuses of patient categorization rules, known as “upcoding,” could cost Medicare an avoidable \$600 billion over the next decade.¹³ The Kaiser Family Foundation (KFF) warns “Medicare spending is higher and growing faster per person for beneficiaries in Medicare Advantage than in [Original] Medicare.”¹⁴ And that consequently, MA enrollment growth will continue to increase Medicare spending, which will raise Part B premiums for everyone and contribute to Medicare solvency challenges.¹⁵

KFF notes these projections pose questions of equity between OM and MA,¹⁶ as some of the latter's higher per person costs are due to rising Medicare rebate payments, which have grown

⁹ *Id.*

¹⁰ Medicare Payment Access Commission, “For the Record: MedPAC's Response to AHIP's Recent “Correcting the Record” Blog Post,” (March 3, 2021), <https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/>.

¹¹ Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress,” (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

¹² Jeannie Fuglesten Biniek, et al., “The Growth in Share of Medicare Advantage Spending,” Kaiser Family Foundation (April 7, 2022), <https://www.kff.org/medicare/slide/the-growth-in-share-of-medicare-advantage-spending/>.

¹³ Richard Kronick, et al., “Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity,” SSRN (November 17, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446.

¹⁴ Jeannie Fuglesten Biniek, et al., “Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges,” Kaiser Family Foundation (August 17, 2021), <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges/>.

¹⁵ *Id.*

¹⁶ *Id.*

by 53% since 2019 and now account for 15% of total Medicare payments to plans.¹⁷ MA plans use these dollars to offer benefits not available to OM enrollees. This may draw some to MA, further increasing enrollment, costs, and long-term financing concerns.¹⁸ If MA enrollment gains continue, this harmful cycle—in which more MA benefits and enrollees lead to higher Medicare spending, which leads to more MA benefits and enrollees—will only accelerate.

These trajectories are additionally concerning because the data are unclear when it comes to MA quality.¹⁹ And, despite increased Medicare spending on supplemental benefits, “we have no data about their use nor information about their value.”²⁰ Plans are simply not being made to account for their use of public dollars. There is also a lack of reported demographic information, which undermines transparency and stymies equity advancement efforts. Without these and other data points, it is impossible to know how well MA is working for people with Medicare, including those from underserved communities. This, in turn, makes it impossible for beneficiaries to make fully informed enrollment choices or for policymakers to hold MA plans responsible for their spending, promises, and behaviors.²¹

As a result, harmful plan practices are allowed to continue unabated. For example, while some MA plans may be good faith and lawful actors, others inappropriately deny millions of medically necessary claims and services each year, leaving their enrollees with high costs and care delays.²² They also engage in misleading advertising to pull beneficiaries into plans that may not meet their needs, such as by targeting lower-income seniors with low or zero premium plans that may have higher out-of-pocket costs.²³ Still others may “cherry-pick” healthier enrollees through geographic targeting and discriminatory benefit designs.²⁴ Such conduct only worsens health care access, outcomes, and disparities.

Further, much of the quality information we do have is troubling. A recent JAMA analysis found “little evidence” MA plans “provide meaningful improvements in access, affordability, or

¹⁷ Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress,” (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ See, e.g., Gretchen Jacobson, *et al.*, “Medicare Advantage Hospital Networks: How Much Do They Vary?,” Kaiser Family Foundation (June 2016), <https://bit.ly/3PLw5bQ>; 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/10.1377/hlthaff.2017.0974>; Momotazur Rahman, *et al.*, “High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare,” Health Affairs (October 2015), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0272>; Meredith Freed, *et al.*, “Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings,” Kaiser Family Foundation (August 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>.

²² U.S. Department of Health and Human Services Office of the Inspector General, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” (April 27, 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>.

²³ Allison Bell, “Medicare Keeps Bad Marketer Penalty Out of 2023 Rules,” Think Advisor (April 05, 2022), <https://www.thinkadvisor.com/2022/04/05/medicare-keeps-bad-marketer-penalty-out-of-2023-rules/>.

²⁴ Meredith Freed, *et al.*, “Medicare Advantage in 2022: Enrollment Update and Key Trends,” Kaiser Family Foundation (August 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>.

preventive care compared with [Original Medicare] for adults with low income.” The authors write this suggests “MA may not meaningfully advance health equity in the Medicare program” and that although “Medicare Advantage is widely thought to cost the federal government more than [Original Medicare] per beneficiary” MA may not “provide benefits commensurate with the increased costs, specifically among adults with low income.”²⁵

For these reasons, we welcome this RFI. In our comments below, we offer suggestions and recommendations based on our direct experience helping MA enrollees navigate their coverage and access needed care.

A. Advance Health Equity

Medicare has long been a powerful tool to reduce injustice and inequality.²⁶ While it continues to improve health equity and reduce disparities,²⁷ challenges persist, both across the health system and in MA.²⁸ We urge CMS to actively address the underlying, and overarching, policy decisions that maintain a health care, and societal, system that drive these divides.

This means working with plans, providers, enrollees, and other stakeholders to address discrimination in health care settings and encouraging a more diverse, culturally competent health care workforce; enhancing oversight of MA plans to ensure they are providing all required, medically necessary care to all enrollees; overhauling the Star Ratings and adopting quality measures that matter to beneficiaries—including those seeking care in their communities—and to physicians; and supporting only those enrollment mechanisms, tools, and materials that meaningfully promote informed, active decision-making. We also propose issuing clarifying guidance around coverage and appeals rules; stepping up plan audits, bid reviews, and discriminatory impact reviews; monitoring and publicly reporting disproportional disenrollment by those in poorer health and other efforts to identify plan gaming, discriminatory design or networks, and inappropriate denials; and requiring greater transparency around and penalties for documented plan misbehavior, including civil monetary penalties; suspension of marketing, enrollment, and payment; and termination of MA contracts.

1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

²⁵ Rahul Aggarwal, *et al.*, “Comparison of Medicare Advantage vs. Traditional Medicare for Health Care Access, Affordability, and Use of Preventive Services Among Adults With Low Income,” JAMA (June 7, 2022), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793106>.

²⁶ Steve Sternberg, “Desegregation: The Hidden Legacy of Medicare,” U.S. News & World Report (July 29, 2015), <https://www.usnews.com/news/articles/2015/07/30/desegregation-the-hidden-legacy-of-medicare>.

²⁷ Jacob Wallace, *et al.*, “Changes in Racial and Ethnic Disparities in Access to Care and Health Among US Adults at Age 65 Years,” JAMA (July 26, 2021), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2782345>.

²⁸ Centers for Medicare & Medicaid Services Office of Minority Health in Collaboration with the Rand Corporation, “Racial, Ethnic, & Gender Disparities in Health Care in Medicare Advantage,” (April 2021), <https://www.cms.gov/files/document/racial-ethnic-gender-disparities-health-care-medicare-advantage.pdf>.

Enrollees from racial and ethnic minority groups.

Black and Hispanic Medicare beneficiaries experience more problems paying for health care than white beneficiaries.²⁹ But across races and ethnicities, MA enrollees—especially those in poor or fair health—have the most cost-related problems, while OM enrollees with supplemental coverage have the least.³⁰

This is notable for many reasons, including because Black and Hispanic beneficiaries are more likely than their white peers to be enrolled in MA.³¹ They are also more likely to report health problems and trouble accessing care.³² They have higher rates of hospitalization, including readmissions, and of some chronic conditions; but lower income, savings, and use of preventive services.³³

Abundant analysis has documented these and other health inequities. A KFF research compilation notes, for example, “Black Medicare beneficiaries have higher hospital readmission rates than White beneficiaries even after controlling for multiple patient-level factors, and in some studies, these disparities persist even within the same hospital or skilled nursing facility, suggesting that systemic-level factors are driving forces behind these disparities. Moreover, studies have documented racial/ethnic disparities in cancer survival rates and receipt of optimal treatments.”³⁴ In addition, racial and ethnic minorities have borne the brunt of the coronavirus crisis. Throughout the pandemic, Black and Hispanic older adults have experienced nearly double the mortality rate of their white counterparts, while Black, Hispanic, and American Indian/Alaska Native Medicare enrollees have consistently accounted for a disproportionate number of cases and hospitalizations.³⁵

Significant research also shows Medicare enrollees of color commonly encounter racism in the health care system, including in provider settings.³⁶ This can both deter them from seeking care and make doing so less effective. Patients who feel disrespected by their providers do not adhere as well to their treatment plan and are more likely to avoid or delay care.³⁷ They may also experience “misdiagnoses as well as adverse physical health outcomes, including greater

²⁹ 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/>.

³⁰ *Id.*

³¹ Nancy Ochieng, *et al.*, “Racial and Ethnic Health Inequities and Medicare,” Kaiser Family Foundation (February 16, 2021), <https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/>.

³² *Id.*

³³ *Id.*

³⁴ Nancy Ochieng, *et al.*, “Racial and Ethnic Health Inequities an Medicare” Kaiser Family Foundation (February 16, 2021), <https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-overview/>.

³⁵ *Id.*

³⁶ Celli Horstman, *et al.*, “What an Ideal Health Care System Might Look Like: Perspectives from Older Black and Latinx Adults,” The Commonwealth Fund (July 21, 2022), <https://www.commonwealthfund.org/publications/2022/jul/what-ideal-health-care-system-might-look-like>.

³⁷ *Id.*

morbidity and mortality from chronic diseases.”³⁸ This is in addition to the negative, cumulative physical and mental health impacts associated with racism itself, such as stress, anxiety, high blood pressure, early aging, and depression.³⁹

Problematically, the perspectives of these enrollees are often underrepresented in existing data sets, making it difficult to understand their experiences.⁴⁰ We urge CMS to correct this without delay. We recommend greater collection and careful consideration of data on racial and ethnic status around MA enrollment, disenrollment, appeals, and grievances. Facially neutral plan designs or processes may hide discriminatory or disparate impact which, in turn, may be purposeful or accidental.

CMS must also ensure plan, and its own, beneficiary communications are fully accurate and accessible. As referenced above, cost-related problems are more common in MA than OM, largely because most people with OM—including 89% of Black enrollees and 92% of Hispanic enrollees⁴¹—have supplemental insurance, like a Medigap, Medicaid, or retiree coverage.⁴² However, some CMS materials imply that MA is universally less expensive.⁴³ We ask CMS to carefully review all materials for misleading statements.

Access to affordable behavioral health care in particular remains a challenge for people with Medicare, including for MA enrollees.⁴⁴ Approximately 1.7 million beneficiaries have a diagnosed substance use disorder (SUD)⁴⁵ and one in four have a mental health condition.⁴⁶ But 93% of Medicare beneficiaries age 65 and older with a SUD do not receive treatment,⁴⁷ nor do

³⁸ Shanoor Seervai, *et al.*, “Mental Health Experiences of Older Black and Latinx Adults in the U.S. Health System,” The Commonwealth Fund (July 21, 2022), <https://www.commonwealthfund.org/blog/2022/mental-health-experiences-older-black-and-latinx-adults-us-health-system>.

³⁹ Michelle M. Doty, *et al.*, “How Discrimination in Health Care Affects Older Americans, and What Health Systems and Providers Can Do,” The Commonwealth Fund (April 21, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/how-discrimination-in-health-care-affects-older-americans>.

⁴⁰ Shanoor Seervai, *et al.*, “Mental Health Experiences of Older Black and Latinx Adults in the U.S. Health System,” The Commonwealth Fund (July 21, 2022), <https://www.commonwealthfund.org/blog/2022/mental-health-experiences-older-black-and-latinx-adults-us-health-system>.

⁴¹ Nancy Ochieng, *et al.*, “Racial and Ethnic Health Inequities in Medicare,” Kaiser Family Foundation (February 16, 2021), <https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/>.

⁴² 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/>.

⁴³ See, e.g., Centers for Medicare & Medicaid Services, “Medicare & You Handbook for 2022,” (last accessed August 30, 2022), <https://www.medicare.gov/media/10991> (people in MA “can’t buy and don’t need Medigap”).

⁴⁴ Deborah Steinberg, *et al.*, “Medicare’s Discriminatory Coverage Policies For Substance Use Disorders,” Health Affairs (June 22, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210616.166523/>.

⁴⁵ William J. Parish, *et al.*, “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” American Journal of Preventive Medicine (August 2022), <https://pubmed.ncbi.nlm.nih.gov/35331570/>.

⁴⁶ Beth McGinty, “Medicare’s Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement,” The Commonwealth Fund (July 9, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities>.

⁴⁷ William J. Parish, *et al.*, “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” American Journal of Preventive Medicine (August 2022), <https://pubmed.ncbi.nlm.nih.gov/35331570/>.

an estimated one in three with mental health needs.⁴⁸ Among enrollees of color, financial challenges, lack of coverage, and a shortage of culturally competent providers are often cited as reasons for deferred behavioral health care.⁴⁹

As noted above, discrimination in health care settings can also chill or derail treatment. This may have an outsized impact on mental health service utilization. The Commonwealth Fund found older adults who experienced discrimination based on their race or ethnicity were nearly twice as likely to have a mental health diagnosis, such as depression or anxiety, than their peers.⁵⁰ They were also significantly more likely to feel socially isolated, have multiple chronic conditions, and experience financial hardship—underscoring the importance of access to appropriate, affordable, and trusted care.⁵¹

Moreover, the ongoing opioid public health emergency has had a disproportionately devastating impact on Black, Indigenous, and other communities of color. Research shows that “while overdose death rates across the US declined in 2018 in other age groups, the rates of hospitalization and overdose continued to rise among older adults. Overdose mortality rates have risen for Black Americans, Asian Americans, Latinx Americans, and Indigenous Americans, which are making up increasing segments of the population of older adults and people younger than 65 with chronic conditions who are enrolling in Medicare.”⁵²

Today, Black men ages 65 and older die of drug overdose at a seven-times higher rate than white men of the same age.⁵³ Access to treatment varies by race and ethnicity as well; in recent years beneficiaries of color with opioid use disorder (OUD) were less likely than white beneficiaries to receive medications for OUD in outpatient settings⁵⁴ or following opioid-related emergency department visits.⁵⁵

⁴⁸ Munira Z. Gunja, *et al.*, “Comparing Older Adults’ Mental Health Needs and Access to Treatment in the U.S. and Other High-Income Countries,” The Commonwealth Fund (January 21, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/jan/comparing-older-adults-mental-health-needs-and-access-treatment>.

⁴⁹ See, e.g., William J. Parish, *et al.*, “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” *American Journal of Preventive Medicine* (August 2022), <https://pubmed.ncbi.nlm.nih.gov/35331570/>; Lisa O’Malley, “Addressing the Lack of Black Mental Health Professionals” (November 17, 2021), <https://www.insightintodiversity.com/addressing-the-lack-of-black-mental-health-professionals/>.
⁵⁰ Michelle M. Doty, *et al.*, “How Discrimination in Health Care Affects Older Americans, and What Health Systems and Providers Can Do,” The Commonwealth Fund (April 21, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/how-discrimination-in-health-care-affects-older-americans>.

⁵¹ *Id.*

⁵² Deborah Steinberg, *et al.*, “Medicare’s Discriminatory Coverage Policies For Substance Use Disorders,” *Health Affairs* (June 22, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210616.166523/>.

⁵³ Mbabazi Karisa, *et al.*, “Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020,” *Morbidity and Mortality Weekly Report* (July 29, 2022), <https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7129e2-H.pdf>.

⁵⁴ U.S. Department of Health and Human Services Office of Inspector General, “Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder,” (December 2021), <https://oig.hhs.gov/oei/reports/OEI-02-20-00390.pdf>.

⁵⁵ Maria A. Stevens, “Trends and Disparities in Access to Buprenorphine Treatment Following an Opioid-Related Emergency Department Visit Among an Insured Cohort, 2014–2020,” *JAMA* (June 3, 2022), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792963>.

To help address these inequities, we ask CMS to act on the Department of Health and Human Services Office of Inspector General’s (OIG) recommendations for improving access to OUD medications, with a focus on racial and ethnic minorities.⁵⁶ We also support requiring MA plans to develop, submit, and operationalize strategies to strengthen cultural competencies and address behavioral health provider shortages. Potentially effective approaches include contracting with more community-based mental health and SUD disorder providers, particularly in areas with large populations of underserved communities.

As a new Health Affairs study observes, “[p]eople with SUDs need and deserve the full continuum of care, access to practitioners with addiction expertise, and programs in their communities, just like people with cancer or diabetes. Medicare’s failure to address these gaps amounts to institutional discrimination that perpetuates the disparities we see today across all health care financing and delivery systems.”⁵⁷

Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.

We welcome the Nondiscrimination in Health Programs and Activities proposed rule that would prohibit discrimination on the basis of sexual orientation and gender identity in CMS programs, including Medicare Part B, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid, and qualified health plans.⁵⁸

These changes are a necessary first step. We recommend that CMS go further and engage in MA-specific oversight, paying close attention to any reports of plan discrimination, as well as to potentially discriminatory benefit designs and processes that may impede, deter, or prevent people from obtaining care. Dignity and respect are integral to appropriate, effective care.⁵⁹

To determine plan compliance with new and existing anti-discrimination rules, we urge CMS to collect additional data on demographics, including intersectional data that may reveal inequitable treatment for certain communities.

Enrollees who identify as transgender, nonbinary, or another gender identity.

As above, we eagerly anticipate the finalization of the Nondiscrimination in Health Programs and Activities proposed rule from the Office of Civil Rights that will expressly prohibit discrimination on the basis of sexual orientation and gender identity.⁶⁰ We find transgender people in particular may struggle to access appropriate care, including gender affirming care, in

⁵⁶ U.S. Department of Health and Human Services Office of Inspector General, “Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder,” (December 2021), <https://oig.hhs.gov/oei/reports/OEI-02-20-00390.pdf>.

⁵⁷ William J. Parish, *et al.*, “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” *American Journal of Preventive Medicine* (August 2022), <https://pubmed.ncbi.nlm.nih.gov/35331570/>.

⁵⁸ 87 FR 47824.

⁵⁹ Mary Catherine Beach, *et al.*, “Do Patients Treated With Dignity Report Higher Satisfaction, Adherence, and Receipt of Preventive Care?,” *Annals of Family Medicine* (July 2005), [10.1370/afm.328](https://doi.org/10.1370/afm.328).

⁶⁰ 87 FR 47824.

Medicare. It is vital that Medicare provide medically necessary and appropriate care for all individuals. CMS must closely monitor and respond to any reports of discrimination in MA plan design, administration, and operation. We also support additional data collection and plan accountability measures.

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

As we identified above, access to treatment for substance use disorders is disturbingly low across Medicare. While many factors contribute to this unmet need, including statutory coverage limitations, there are ways CMS can improve access and utilization. In other words, “[a]lthough Medicare is exempt from the Parity Act requirement that it cover addiction and mental health services at the same level as other medical conditions, nothing prevents Medicare from requiring more equitable coverage.”⁶¹

As mentioned, this includes requiring MA plans to develop and implement strategies to address provider shortages and improve cultural competency, such as by contracting with more community-based mental health and SUD providers, particularly in areas with large populations of underserved communities.

CMS could, and should, also require MA plans to contract with a minimum number of Opioid Treatment Programs (OTPs) based on their number of enrollees and set quantitative network adequacy standards for OTPs as a facility type. Currently, the lack of available clinics creates significant barriers. The average drive time to the OTP—a trip that patients who are prescribed methadone must make daily, for months, until any take-home medication is allowed—is over 37 minutes, compared to 16 minutes to the nearest federally qualified health center and 15 minutes to the nearest dialysis center.⁶² Rural residents must drive an average of almost 50 minutes to the nearest OTP, compared to 8 minutes for urban residents.⁶³

Similarly, we urge CMS to require MA plans to contract with a minimum number of providers who prescribe medication for OUD based on their number of enrollees and set quantitative network adequacy standards for such prescribers as a specialty provider type. According to HHS, “[m]ore 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.”⁶⁴

⁶¹ William J. Parish, *et al.*, “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” *American Journal of Preventive Medicine* (August 2022), <https://pubmed.ncbi.nlm.nih.gov/35331570/>.

⁶² Paul J. Joudrey, *et al.*, “Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States,” *JAMA* (October 1, 2019), <https://jamanetwork.com/journals/jama/fullarticle/2752051>.

⁶³ *Id.*

⁶⁴ U.S. Department of Health and Human Services, “HHS Announces Availability of \$10 Million for Rural Communities to Expand Treatment in Response to Surging Fentanyl and Other Opioid Overdoses,” (June 17, 2022), <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>.

Beyond SUD, we are extremely concerned that individuals who are sicker, have disabilities, or are nearing the end of life are experiencing barriers, inadvertent or purposeful, to care and equitable coverage. It is well documented that these MA enrollees leave the program at disproportionately high rates, which may indicate potential issues with access to and quality of care.⁶⁵

Indeed, in our experience, there are several such issues at work. First, delays in care or coverage and limits on the amount of services—for example, with Home Health⁶⁶ or Skilled Nursing Facility care⁶⁷—due to prior authorization or improper denials can often prove too much for enrollees with urgent, serious, or end-of-life needs. What may be a minor inconvenience for someone in good health may be an insurmountable burden as care needs rise. We again ask CMS to investigate patterns of disenrollment, curb the use of prior authorization, streamline appeals processes, ensure proper service delivery, and investigate allegations of steering, cherry picking, discriminatory benefit designs, and other behaviors that may attract healthier enrollees or push those who are sicker towards OM.⁶⁸

Second, narrow MA plan networks mean enrollees may lack access to providers and services that reflect their cultural values, a consideration that can gain importance during one's last months. The networks may also be too limited for people who need significant care from specialists, or stays in Skilled Nursing Facilities, and have strong geographic preferences. Likewise, limited provider participation in multiple plans can deter a beneficiary from switching to a more affordable plan. We urge careful consideration of network adequacy standards. When constructed and enforced appropriately, these rules act as guardrails that help connect MA enrollees with meaningful access to care as their needs change. To that end, such providers must not be solely accessible remotely. Network adequacy must be built to support beneficiary preferences and needs, which includes robust access to in-person, locally available care. Networks must also include high-quality providers so that enrollees are not trapped in a plan with sub-standard, lower-quality nursing homes and Home Health providers.⁶⁹

Third, the challenging MA plan evaluation process, which enrollees are typically advised to undertake annually, may also play a role. Balancing various medical needs while completing complex analyses of dozens of plan designs in order to maximize access to preferred providers and minimize out-of-pocket expenses is impossible for those with significant health needs, and

⁶⁵ See, e.g., [Health Affairs](#), 2021; [Health Affairs](#), 2020; [JAMA](#), 2019; [NEJM](#), 2018, [GAO](#), 2021.

⁶⁶ Center for Medicare Advocacy, "Medicare Home Health Coverage In Light of Jimmo v. Sebelius" (last visited August 30, 2022), <https://www.medicareadvocacy.org/wp-content/uploads/2018/09/Home-Health-Jimmo-Checklist.pdf>.

⁶⁷ Cinnamon St. John, "Report: Nursing Home MA Issues Survey," Center for Medicare Advocacy (August 18, 2022), <https://medicareadvocacy.org/report-nursing-home-ma-issues-survey/>.

⁶⁸ Medicare Rights Center, "Policy Recommendations for the Biden Administration," (January 18, 2021), <https://www.medicarerights.org/pdf/012021-biden-harris-transition-memo.pdf>.

⁶⁹ David J. Meyers, *et al.*, "Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees," *Health Affairs* (January 2018), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0714>.

unrealistic for everyone else. Evidence is clear that having too many plan choices can lead to poor or no decisions.⁷⁰ In our experience, some switch to OM to avoid this exercise and risk.

While leaving MA may remove enrollment decisions and allow easier access to care, it is not a magic wand. People may still be locked into an MA plan for a full year before they can disenroll, and they may face higher-than-expected costs once they do, in particular if they are not eligible for affordable supplemental coverage.⁷¹ They may also experience disruptions in care continuity and coordination, which can be especially harmful for people with high needs and during the stressful end-of-life period.⁷² Perversely, the only clear winner in these disenrollment scenarios is the abandoned MA plan. It reaps financial rewards by avoiding the higher spending associated with the disenrolled beneficiary after collecting premiums and capitated payments during previous, lower cost periods. This cost shifting only incentivizes the plan to continue those behaviors that led to the disenrollment, harming an ever-growing number of enrollees.

If people are leaving MA, or certain plans, at high or increasing numbers when they are sicker, something in MA's benefit design, processes, or fundamental structure is making that the rational choice. CMS must investigate, report on, and put an end to these patterns.

Enrollees with diverse cultural or religious beliefs and practices.

Providing culturally sensitive and appropriate care for the diversity of cultural, religious, and ethical beliefs and practices among MA enrollees is vital. It is uniquely important at the end of life, when enrollees may be more likely to seek care that reflects their physical, spiritual, and familial needs. We encourage CMS to establish and enforce network adequacy standards that encompass provider diversity, cultural competence, and cultural humility.

Enrollees of disadvantaged socioeconomic status.

Medicaid integration and coordination is essential if MA enrollees with limited income and assets are to have meaningful access to care. CMS should continue to ensure that MA plans provide the cost sharing protections that apply to individuals enrolled in the Medicare Savings Programs, that MA plan networks include enough providers who accept Medicaid, and that claims transmission processes for Medicaid-covered benefits are easy to navigate. CMS should also eliminate look-alike Dual Eligible Special Needs Plans (D-SNPs) and require all MA plans to

⁷⁰ 87 FR 584, 690.

⁷¹ Cristina Boccuti, et al., "Medigap Enrollment and Consumer Protections Vary Across States," Kaiser Family Foundation (July 11, 2018), <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>.

⁷² See, e.g., Shana Alex Lavarreda, et al., "Switching health insurance and its effects on access to physician services," Medical Care (October 2008), https://journals.lww.com/lww-medicalcare/Abstract/2008/10000/Switching_Health_Insurance_and_Its_Effects_on.11.aspx; Peter S. Hussey, et al., "Continuity and the costs of care for chronic disease," JAMA Intern Med (May 2014), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1835350>.

screen their enrollees for low-income assistance programs, such as Extra Help and the Medicare Savings Programs, annually.

Enrollees with limited English proficiency or other communication needs.

We ask that CMS assure all direct communication with enrollees—including about coverage, benefits, denials, and appeals—is provided in the individual’s preferred language and format. We also support requiring plans to provide equitable access to all covered health services. This includes, but is not limited to, ensuring that qualified medical translation and interpreter services are available, with limited administrative burden and no cost, to all network providers. Contracted providers should be incentivized to utilize interpreters, translation, and other assistive communication technologies as appropriate.

In addition, we urge 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.” With very few exceptions, this standard means that the translation requirement applies only to Spanish.

Because the measure is a percent without any reference to the absolute number in individuals in a service area, this standard leaves significant swaths of LEP individuals, particularly those in large diverse service areas, without access to any translated materials from their MA plans. For example, both Los Angeles County and New York City have larger Chinese speaking populations than San Francisco, yet because percentages alone determine translation responsibilities, MA plans in San Francisco are required to translate documents into Chinese but those in Los Angeles and New York City are not. The inequities are even greater when looking at Part D plans that serve entire states such as California where despite significant LEP populations statewide, Part D plans are only required to translate documents into Spanish.

For both translation and interpretation, we encourage CMS to increase its oversight of plan performance. Through secret shopper testing of language access, monitoring of language access grievances, focus groups and other measures and hold plans accountable for compliance with language access requirements.

Enrollees who live in rural or other underserved communities.

Rural enrollees may also experience unique, disproportionate challenges. Researchers have identified high rates of switching from MA to OM among rural enrollees, particularly for those who use high-cost services. Access-related concerns, likely driven by MA’s more restrictive

provider networks, are often cited as a key reason why, especially among those with greater health needs.⁷³

MA enrollees in rural communities may be acutely vulnerable to inadequate networks due to travel times and population density. And these restrictive networks are likely more impactful in rural than nonrural areas because the overall provider supply tends to be more constrained. Analysis typically finds MA market concentration is higher in rural areas than urban areas, suggesting less choice for rural beneficiaries.⁷⁴

CMS should address this by gathering data and strengthening guardrails. We specifically support implementing more stringent network adequacy standards for rural counties in a plan's service area. However, we urge CMS not to permit plans to compensate for network inadequacy through telehealth-only providers. While telehealth may extend access for some rural enrollees, broadband in such areas is often insufficient.⁷⁵ Further, if networks are permitted to move toward telehealth-only providers, enrollees who prefer in-person appointments may find they have even fewer—or no—suitable options.

2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

Currently, the lack of public information from MA plans may conceal health equity issues. We reiterate our request for greater collection and careful consideration of demographics, including intersectional data that may reveal inequitable treatment for certain communities within MA enrollment, disenrollment, appeals and overturn rates, and grievances. Facially neutral plan designs or processes may hide discriminatory or disparate impact which, in turn, may be purposeful or accidental.

Importantly, the payment and coverage differences between MA and OM create one of the Medicare program's starkest equity divides. By many accounts, MA plans neither save Medicare dollars nor demonstrate improved health outcomes, as Congress intended.⁷⁶ Rather, Medicare ends up subsidizing MA plans, allowing them to offer attractive marketing perks in the form of supplemental benefits that are not available to OM enrollees, like gym memberships or limited dental care.

⁷³ Sungchul Park, *et al.*, "Rural Enrollees In Medicare Advantage Have Substantial Rates Of Switching To Traditional Medicare," *Health Affairs* (March 2021), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01435>.

⁷⁴ Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

⁷⁵ Sascha D. Meinrath, *et al.*, "Broadband Availability and Access in Rural Pennsylvania," (June 2019), https://www.rural.pa.gov/download.cfm?file=Resources/PDFs/broadband/Executive_Summary_Broadband_Access_Availability_2019.pdf.

⁷⁶ Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System: Report to the Congress," (June 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf.

This discrepancy has contributed to an unlevel playing field, which inadequate oversight and enforcement has worsened. Lax and absent rules fail to set standards for marketing these supplemental benefits, and allow plans to blur the difference between educational and marketing events.⁷⁷ In addition, language from Medicare itself that touts benefits of MA (such as the potential for lower costs and the availability of supplemental benefits) without noting drawbacks (such as the potential for higher costs for vital services; loss of access to chosen physicians, hospitals, and Skilled Nursing Facilities; the limits of supplemental benefits; delays or denials of needed care; high out-of-pocket limits when compared to Medigap) may lead beneficiaries to, perhaps incorrectly and without additional information-gathering, conclude MA is the right choice for them.⁷⁸

It is evident MA enrollment is growing, but we know little else. Data are lacking on how MA is working for those it is supposed to serve. We urge the immediate and thorough collection and release of additional data on enrollee demographics, including race, ethnicity, primary language, disability status, gender identity, LGBTQ identity, and income; on enrollment and disenrollment patterns; on the use and potential abuse of prior authorization; on the rate of appeal, the rate of overturned determinations, including what level of appeal; on network adequacy, provider availability, and directory accuracy; and on the marketing, access, utilization, spending, and denial of supplemental benefits. This information should be granular, regularly reported, and used to drive MA improvements. CMS must finally hold plans accountable for the public dollars they use and the promises they make.

4. What have been the most successful methods for MA plans to ensure access to language services for enrollees in different health care settings? Where is improvement needed?

Translation services should be easily available to all network providers and at no cost, and plans should encourage and incentivize the use of such services. We support revising network adequacy standards to reflect the need for providers and practices to have multi-lingual staff.

7. What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically-tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.

⁷⁷ Centers for Medicare & Medicaid Services, "Medicare Communications and Marketing Guidelines," (August 6, 2019), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf.

⁷⁸ See, e.g., "Medicare & You Handbook for 2022," <https://www.medicare.gov/media/10991> ("MA plans may have lower out-of-pocket costs than Original Medicare" with no notice of potential for higher out-of-pocket costs).

It is unclear how many enrollees have access to nutrition-related supplemental benefits, how many use them, what the promised or accessed benefits are, what the enrollees thought they would be getting and if the benefits met those expectations, how the benefits were marketed, and what the appeal processes are. Given this alarming lack of data, we cannot know how many enrollees thought they were going to be eligible for a benefit only to never gain access, or what, if anything, they may do in response. Based on our experience, however, these are not isolated or inconsequential occurrences. It is extremely troubling that the dearth of national, systemically collected data makes judging the efficacy of such benefits completely impossible. Whether or not the benefits are even delivered, much less if they improve enrollees' health or well-being, should not be a question mark. We recommend data collection on these issues to determine how or if supplemental benefits are being provided.

We also ask for rulemaking, or at least enforceable guidance, about acceptable plan marketing of supplemental benefits. Enrollees and the public need more, and more accurate, information about these benefits and their limitations, such as enrollee eligibility for more than one benefit. Clear rules would allow CMS to better oversee marketing materials, and to verify that plans are not merely using the existence of supplemental benefits as a marketing tool, but are providing them adequately, equitably, and with reasonable promptness.

We were pleased to see the new requirement for MA organizations to separately submit expenditures for supplemental benefits in Medical Loss Ratio reporting.⁷⁹ This information can be helpful in determining if beneficiaries are truly getting any value from MA supplemental benefits. However, we encourage CMS to do more with this data than passively allow beneficiaries to seek it out. Specifically, we support listing this and other additional information on supplemental benefits on Medicare Plan Finder to help people compare and understand the scope and availability of each benefit.

We urge CMS to work with the Department of Agriculture to make sure food and nutrition-related benefits are meeting basic needs in ways that do not undermine eligibility for other assistance, like Medicaid or SNAP. This clarity and intra-agency cooperation is particularly vital for low-income D-SNP enrollees who could lose Medicaid coverage if the value of debit cards were subject to Medicaid income counting rules.

We also ask CMS to ensure that when MA plans rely on community-based providers to deliver nutritional assistance and other services, they adopt fair and transparent processes and compensation.

8. What physical activity-related supplemental benefits do MA plans provide today? At what rate do enrollees use these benefits? How do these benefits improve enrollees' health? What

⁷⁹ 87 FR 27704, 27832.

physical activity-related policy changes within the scope of applicable law could lead to improved health for MA enrollees?

As we state in our answer above, the lack of data makes this question impossible to answer. Here, it is a critical area of concern because studies show that physical activity benefits such as gym memberships attract younger and healthier enrollees who require fewer health services.⁸⁰

We urge CMS to closely examine the value and usage of these benefits, including from an equity perspective. This includes analyzing data on physical activity-related supplemental benefits and their relationship to self-reported health status of enrollees while concurrently reviewing utilization and denials for medically necessary therapies, like physical and occupational therapy, Skilled Nursing Facility stays,⁸¹ Home Health care,⁸² and discharge services. We also ask CMS to review the extent to which these benefits are conveniently available in disadvantaged communities, the level of uptake among different population groups, and the extent of program adherence by plan members. Such analysis may reveal that plans are deliberately erecting barriers to care for sicker enrollees while attempting to draw in healthier, less costly enrollees.

Relatedly, we encourage CMS to investigate the relationship between the self-reported health status of enrollees and their plan-reported risk scores to determine whether these data correlate. It is well and long documented that plans may financially benefit if they attract healthier enrollees but get paid as if those enrollees are sicker than the OM population.⁸³

9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

We recommend 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. Employees of plans and states, and providers and their staff, may also

⁸⁰ Alicia Cooper, *et al.*, "Fitness Memberships and Favorable Selection in Medicare Advantage Plans," *The New England Journal of Medicine* (January 12, 2012), <https://www.nejm.org/doi/full/10.1056/NEJMsa1104273>.

⁸¹ Cinnamon St. John, "Report: Nursing Home MA Issues Survey," Center for Medicare Advocacy (August 18, 2022), <https://medicareadvocacy.org/report-nursing-home-ma-issues-survey/>.

⁸² Center for Medicare Advocacy, "Medicare Home Health Coverage In Light of Jimmo v. Sebelius," (last visited August 30, 2022), <https://www.medicareadvocacy.org/wp-content/uploads/2018/09/Home-Health-Jimmo-Checklist.pdf>.

⁸³ See, e.g., Michael Geruso, *et al.*, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," NBER Working Paper (May 2015, rev. April 2018), <https://www.nber.org/papers/w21222>; Paul D. Jacobs, *et al.*, "Getting What We Pay For: How Do Risk-Based Payments to Medicare Advantage Plans Compare with Alternative Measures of Beneficiary Health Risk?," *Health Services Research* (May 22, 2018), <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12977>; Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

not grasp what benefits are covered and, if so, by whom. This may be especially true in cases where the SNP offers supplemental benefits that may appear to resemble Medicaid benefits. Despite looking similar, they are generally far less comprehensive. But even equivalent overlapping benefits can cause harm when it results in confusion or delays in navigation, and may become an excuse for state Medicaid programs to fail to offer the robust services that Medicaid beneficiaries need. We recommend that CMS require D-SNPs to design benefits that complement and amplify, rather than overlap with or supplant, those available through Medicaid.

Disappointingly, to date, D-SNPs do not truly integrate Medicare and Medicaid benefits to create a seamless experience for enrollees. This can be rooted in several causes: carve-outs of certain benefits, like long-term care or behavioral health; incongruent provider networks; difficulty navigating benefit sets; unintegrated appeals processes; and poor communication from providers, plans, or states that reveal ignorance of Medicare or Medicaid rules. Beneficiaries can even experience FIDE-SNPs as two separate plans—a Medicare plan and a Medicaid plan.

Importantly, beneficiaries should never be defaulted into a plan that does not include all their providers. To the extent that CMS grants permission for the use of default enrollment, we strongly recommend not only requiring a very high matching threshold for network congruency, but also withdrawing permission where plans have inadequately congruent provider networks. 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.

We urge close attention to robust behavioral health provider networks in general, and in D-SNPs in particular. As discussed throughout, beneficiaries need access to these providers with as few delays as possible.

Accurate data remains critical to understanding and improving these plans. We ask that CMS continue to investigate the use of combined Medicare and Medicaid Medical Loss Ratios to enable better evaluations of plan performance, greater transparency about potential cost-shifting between the programs, and additional insight into the true value of MA supplemental benefits for people who already have Medicaid benefits.

CMS should also explore data collection at the plan level rather than the contract level to identify health outcomes for D-SNP enrollees that are currently obscured by the inclusion of health outcomes for all of a plan sponsor's MA enrollees. Relatedly, we urge CMS to require separate contracts for all MA plans, especially D-SNPs, to better reflect the outcomes, needs, satisfaction, and quality of care for people in these plans and allow for better oversight.

Today there is huge variability in the extent to which SNPs and D-SNPs, tailor care for enrollees. Much depends on state actions—what expectations the state sets and what parameters the state imposes, particularly in State Medicaid Agency Contracts (SMACs). Also important is how

much the state works on the Medicaid to facilitate coordination with Medicaid services. To further identify specific and measurable care coordination activities, CMS should work with states to strengthen their MIPPA contracts and SMACs.

We also propose strengthening D-SNP Model of Care (MOC) requirements by adding descriptions of access and delivery of Medicaid benefits, including assessments; delivery of care plans; reassessments; and notice procedures. As CMS explains, the “is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan’s care management practices.”⁸⁴ Given the critical role of the MOC in ensuring the delivery of coordinated care, it must reflect the full range of enrollee needs and plan responsibilities. The suggested updates above would advance these goals by ensuring the D-SNP is aware of relevant Medicaid benefits for a given individual and prepared to help the enrollee if issues arise. Lack of coordination on either the Medicare or Medicaid side can lead to barriers to care, incorrect information sharing, and enrollee frustration. We ask CMS to encourage and, where possible, require all administering parties to have working understandings of both programs.

We also support adequately funding ombuds programs. In general, this includes developing an ombuds program for dual eligible enrollees in every state. We further recommend making sure such funds are available after the wind-down of Medicare-Medicaid Plans (MMPs) so D-SNP enrollees have access to the supports they need, and which have proven successful from the Financial Alignment Initiative (FAI) demonstrations. Requiring and funding ombuds programs would ensure that dually eligible individuals have access to care and assistance if things go wrong. Local, community-based ombuds programs can bring knowledge of both Medicare and state Medicaid services, creating an invaluable resource for beneficiaries who may be struggling to understand how their benefits work together and who to contact with problems.

11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

As we indicate in our answers to Questions Seven and Eight, above, the lack of data makes this question impossible to answer. We again request better data collection and public reporting on all uses of rebate dollars, with a special focus on supplemental benefits. We also urge CMS to improve existing and develop new, more robust, decision-making tools to better empower beneficiaries. During the plan selection process, it has been nearly impossible to determine if a beneficiary is eligible for some supplemental benefits that could help address SDOH, such as home and environmental modifications. More usable personalized information would help make this process and its outcomes more equitable.

⁸⁴ Centers for Medicare & Medicaid Services, “Model of Care (MOC),” (last visited August 31, 2022), <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC>.

B. Expand Access: Coverage and Care

1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

The cluttered plan landscape, a lack of usable information, and inadequate decision-making tools can contribute to beneficiaries becoming overwhelmed by their coverage options and making sub-optimal enrollment choices. Some may rely on word of mouth, or simply default to the same plan friends, neighbors, or family members have because they are unaware of ways to get more complete, personalized information. Others may overly value information from sources that have more loyalty to the plan than to its enrollees—such as TV spokespeople, brokers, and agents.⁸⁵

Beneficiaries need accurate and easily understood information, and often, individualized assistance. Although Medicare Plan Finder has information about specific plans, it is limited in terms of cost comparisons and supplemental benefits and can be confusing to use, due to the number of plan choices and the complexity of MA and Part D structures. In addition, extant provider directories are wholly inadequate and riddled with errors.

We suggest improving Medicare Plan Finder by integrating plan network data, individual claims history, and more realistic and predictive estimated costs. We also support including more information about supplemental benefits, like coverage and eligibility limits. Beneficiaries may not know how supplemental benefits work, in general or for any specific plan. They may be expecting to receive all the supplemental benefits listed rather than a subset or even none; they may be expecting broad, comprehensive benefits rather than narrow, limited ones. Medicare Plan Finder must not be a marketing tool for MA plans, or act as a conduit for claims that do not result in real access to valuable benefits.

We were pleased to see more attention paid to MA marketing, including television commercials, in the recent C & D rule (CMS-4192-F),⁸⁶ and urge CMS to build upon this work. Additional clarity on and guardrails around the marketing of supplemental benefits and Medical Loss Ratio reporting is needed to strengthen oversight and enforcement.

CMS must also ensure that any informational materials and decision-making tools put out by the agency, as well as by other agencies, like the Social Security Administration and the Department of Labor, are complete, unbiased, and usable. For example, if information about MA touts the potential for MA to decrease beneficiary costs, it must also alert the consumer to the potential that it will raise costs. If information includes references to supplemental benefits,

⁸⁵ Martha Hostetter, *et al.*, “Taking Stock of Medicare Advantage: Choice,” The Commonwealth Fund (March 3, 2022), <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice>.

⁸⁶ 87 FR 27704, 27824.

it should also explain the limits of supplemental benefits, the potential that the reader will not be eligible for the given benefits, any available remedies and appeals processes, and information about how to get coverage for some supplemental benefits without the potential downsides of MA. If the information includes the out-of-pocket cap for MA, it should include information showing that out-of-pocket costs may be comparable or lower with Medigap. Currently, even CMS materials such as the Medicare & You Handbook and website pages fail to flag these issues, giving people an incomplete picture on which they may base coverage decisions, to their detriment.⁸⁷

We strongly urge CMS to standardize some or all MA plans. The current plan choice environment is overwhelming for beneficiaries and their assisters, who often do not have the time or resources to do a detailed analysis of benefit designs and instead may choose plans based on more readily available comparison points, like premiums or potential supplemental benefits. Complex analyses of dozens of plan designs may be intensely burdensome for consumers with limited English proficiency, those with significant health needs, and people with inadequate internet access. Despite the severe consequences of making a poor plan choice—such as high costs, restricted provider access, and delayed care—there are few remedies. If an enrollee makes a mistake, they may be stuck in a plan that does not meet their needs for up to a year, or locked into MA indefinitely because of the high cost of Medigap coverage.

Standardization, with only high-quality options, removes some of this complexity and risk. There is precedent for such an approach. Medigap plans are standardized to facilitate comparison.⁸⁸ Similarly, CMS has moved forward with standardization in the Marketplace to heighten transparency, improve decision-making, and streamline plan selection.⁸⁹

In addition to easing plan evaluations, offering standardized plans would advance equity by making it easier for CMS, consumers, advocates, and researchers to identify and prevent discriminatory benefit designs, such as plans that leave individuals with particular conditions or medication needs with substantial out-of-pocket costs.

We also ask CMS to more actively promote and advocate for increased funding and capacity 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

⁸⁷ See, e.g., Centers for Medicare & Medicaid Services, “Things to know about Medicare Advantage Plans,” (last visited August 25, 2022), <https://www.medicare.gov/types-of-medicare-health-plans/things-to-know-about-medicare-advantage-plans> (“4. Your out-of-pocket costs may be lower in a Medicare Advantage Plan. If so, this option may be more cost effective for you.” “5. You can’t buy and don’t need Medigap.”)

⁸⁸ Centers for Medicare & Medicaid Services, “How to compare Medigap policies,” (last visited August 30, 2022), <https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies>.

⁸⁹ Centers for Medicare & Medicaid Services, “HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet,” (April 28, 2022), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet> (“CMS finalizes changes to require issuers in the Federally-facilitated Marketplace (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs) to offer standardized plan options at every product network type, at every metal level, and throughout every service area that they offer non-standardized options in PY 2023 and beyond”).

source of unbiased 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 MA enrollment growth and an increasingly complex plan selection process. To better help SHIPs provided needed assistance, we recommend requesting adequate funding for the program in the President’s budget requests to Congress.

Similarly, we recommend more rigorous oversight of MA plans and their downstream marketing and sales entities. This includes realigning and requiring the disclosure of financial incentives, developing stronger rules and enforcement mechanisms regarding the sale of Medicare products, and increasing transparency around consumer complaints and experiences with brokers, agents, and marketers.

2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Original Medicare and Medigap?

People approaching Medicare eligibility need timely, complete, accurate, and actionable information about their coverage options and Medicare enrollment rules. Without it, as our experience reflects, people who must actively enroll may not know how or when to do so. Often, they experience mismanaged transitions or make sub-optimal plan choices as a result. As discussed below, the agencies that oversee Medicare, CMS and SSA, could begin to address this by updating outreach strategies, decision-making tools, and educational materials in ways that center and empower consumers.

A core problem is that beneficiary demographics and information needs are shifting, but Medicare is not keeping pace. While most people new to Medicare are still automatically enrolled because they are receiving Social Security benefits, a growing number are not. In 2016, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to 92% who were in 2002.⁹⁰ This growing cohort must make an active enrollment choice, taking into consideration specific timelines, complex Medicare rules, and their existing coverage.

Far too many people make mistakes when trying to navigate this confusing system. The consequences of missteps are significant and may include lifetime financial penalties, higher out-of-pocket health care costs, and gaps in coverage. In 2021 alone, nearly 800,000 people were paying a Part B Late Enrollment Penalty. The average amount increased their monthly premium by nearly 30%.⁹¹

As recommended by MedPAC, notice from the federal government to individuals approaching Medicare eligibility about basic enrollment rules could help prevent these errors.⁹² But today,

⁹⁰ Medicare Payment Advisory Commission, “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.

⁹¹ Congressional Research Service, “Medicare Part B: Enrollment and Premiums,” (May 19, 2022), https://www.everycrsreport.com/files/2022-05-19_R40082_143a23f28239eec6ef87bac952856d5a14d0a22e.pdf.

⁹² Medicare Payment Advisory Commission, “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.

no such notice exists. We encourage CMS and SSA to correct this without delay, in fulfillment of obligations to facilitate Part B enrollments.⁹³ We also urge better remedies to enrollment errors and mistaken delays, including through increased use of equitable relief, and maximum flexibility in the implementation of BENES Act’s special enrollment periods.⁹⁴

We also support updates to materials explaining the differences between OM and MA, and the trade-offs of each, to better reflect beneficiaries’ primary considerations. For example, one of the most significant decision points for many is access to the provider of their choosing. Most MA plans have ever-shifting networks that may exclude an individual’s chosen provider, but this may not be well or widely understood. Even when it is, discovering what providers are in network can be difficult⁹⁵ and the networks can change at any time,⁹⁶ leaving MA enrollees at risk of losing—or never even having—access to their preferred provider. Few resources make this plain.

Another often overlooked or under-explained trade-off is access to Medigap. Each year, Medicare’s annual enrollment periods allow beneficiaries to change from one MA plan to another, or to switch coverage pathways. But changing from OM to MA, or vice versa, has serious consequences for affordable Medigap access. Most states lack Medigap enrollment flexibilities and protections that mirror MA’s, so residents can only sign up during very limited times.⁹⁷ Beneficiaries may not know this, or the implications of forgoing their Medigap open enrollment period or later cancelling their policy. They may assume MA-to-OM and OM-to-MA transitions are equally seamless, which is clearly not the case. This is particularly problematic when MA plans drop providers, leaving enrollees unable to access their doctors but unable to afford switching to OM, where they have greater choice. We ask CMS to share more information about access to supplemental coverage. This is an exceptionally high-stakes decision point; the risks must be clear.

More generally, as we answered in Question One under this section, if information about MA touts the potential for MA to decrease costs for beneficiaries, it must also alert the consumer to the potential that it will raise costs. If information includes references to supplemental benefits, it should also explain the limits of supplemental benefits, the potential that the consumer will not be eligible for the given benefits, and the option to get coverage for some supplemental

⁹³ Medicare Rights strongly supports the BENES 2.0 Act ([S. 3675](#)), which would effectuate this change. This commonsense, bipartisan bill would require the federal government to notify people approaching Medicare eligibility about basic enrollment rules, which would help prevent costly enrollment errors.

⁹⁴ Medicare Rights Center, “Comments on CAA/BENES Act Proposed Rule,” (June 27, 2022), <https://www.medicarerights.org/policy-documents/comments-on-cao-benes-act-proposed-rule>.

⁹⁵ Centers for Medicare & Medicaid Services, “Online Provider Directory Review Report,” (November 28, 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.

⁹⁶ Medicare Rights Center, “Notices that Medicare Advantage and Part D plans must send if they make changes during the year,” (last visited August 30, 2022), <https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/medicare-advantage-plan-overview/notices-that-medicare-advantage-and-part-d-plans-must-send-if-they-make-changes-during-the-year>.

⁹⁷ Cristina Boccuti, *et al.*, “Medigap Enrollment and Consumer Protections Vary Across States,” Kaiser Family Foundation (July 11, 2018), <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>.

benefits outside of MA. If the information includes the out-of-pocket cap for MA, it should include information showing that out-of-pocket costs may be lower with Medigap. Currently, even CMS materials such as Medicare & You fail to flag these issues, giving people an incomplete picture, on which they may base an incorrect conclusion. Namely, that MA is a better choice for their circumstances than it truly is.

We also note the importance of usable quality data in the decision-making process. As MedPAC documents, “[t]he ability to compare MA and FFS quality, and to compare quality across MA plans, [is] important for beneficiaries. Choosing between MA and FFS is a threshold choice.”⁹⁸

3. How well do MA plans’ marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

MA plans are businesses, and their marketing efforts, including the marketing activities of third-party marketing companies, are designed to attract new enrollees and maximize profits. From the beneficiary perspective, this can result in an overwhelming number of ads, calls, mailers, and other solicitations that make it hard to know who to trust. The evolution of digital marketing, search engine optimization, and algorithms is making it even more difficult for beneficiaries to find unbiased information about their Medicare choices. Plans, brokers, and firms paint rosy pictures of MA, like the potential for “extra” benefits and an out-of-pocket maximum; supplemental benefits in particular play a prominent role in television advertisements. This can and does mislead consumers to believe that all MA plans offer all such benefits to all enrollees, and that the benefits are more extensive and generous than they are. Plan marketing efforts also fail to disclose the very real tradeoffs with MA, such as networks that may not include chosen providers, delays or denials of medically necessary care through utilization management, and potentially higher costs than with Original Medicare plus a Medigap.

While not all MA advertisements are misleading, many are. Some seek to convey a false sense of urgency that leads beneficiaries to take action, even if they are satisfied with their current coverage. And others appear designed to confuse, by incorporating visual cues that suggest Medicare, and not a plan, is behind the ad. It is not uncommon for Helpline callers to report responding to such outreach, only to be enrolled in a plan unknowingly and without their consent.

We urge CMS to develop stronger, more prescriptive marketing rules—including rules specifically for supplemental benefits and third-party TV ads—and to rigorously enforce them, to prevent MA plans from misleading consumers about MA generally or about any given plan.

⁹⁸ Medicare Payment Advisory Commission, “The Medicare Advantage program: status report,” (March 2021), https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf.

We also ask for more transparency about marketing misconduct and more significant penalties for plan violations.

We also continue to ask CMS to correct materials that present an incomplete view of MA. Specifically, CMS cannot continue to claim that MA plans may have more benefits and lower costs than OM without explaining the potential tradeoffs, like narrow networks, limited benefits, or higher costs.⁹⁹ In some cases, prior authorization is presented as a benefit.¹⁰⁰

4. How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

We remain worried about barriers to mental health and substance use disorder (SUD) treatment for MA enrollees. For example, SUD providers report to us that many plans require prior authorization for inpatient detox/SUD treatment. When the facilities request expedited prior authorization in order to provide medically necessary services and prevent potentially life-threatening consequences, providers often must wait more than 48 hours to receive a response. We urge CMS to explore updating expedited prior authorization timelines so that enrollees with life-threatening conditions can receive the care they need when they need it.

We have also found that many plans lack an adequate network of mental health and SUD providers, and that many provider directories for mental health and SUD treatment are inaccurate. This is not limited to behavioral health providers, of course; the inaccuracy and unreliability of provider directories is well established. But in the case of mental health and substance use, delays or barriers to receiving care can put the life and well-being of beneficiaries in particular danger. We urge stronger network adequacy rules and more accurate provider information.

To further promote access, CMS should curb the use of default enrollment unless a beneficiary's current providers are in network. Where these enrollments are permitted, we urge continuation of care requirements of at least 12 months in default enrollment agreements between CMS, states, and plans.

5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

⁹⁹ See, e.g., Centers for Medicare & Medicaid Services, "Things to know about Medicare Advantage Plans" (last visited August, 20, 2022), <https://www.medicare.gov/types-of-medicare-health-plans/things-to-know-about-medicare-advantage-plans> ("4. Your out-of-pocket costs may be lower in a Medicare Advantage Plan. If so, this option may be more cost effective for you." "5. You can't buy and don't need Medigap.")

¹⁰⁰ *Id.* ("8. You can check with the plan before you get a service to find out if it's covered and what your costs may be.")

We support the recent rule change making audio-only telehealth permanently coverable for certain mental health and SUD treatment services.¹⁰¹

We ask that CMS collect outcome and quality data on telehealth, including audio-only telehealth, to make sure the proper balance is struck between access to care and quality of that care. We also encourage additional data on MA plan evaluation and benefit design.

6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

We again ask for attention to provider directory accuracy. Correct, up-to-date provider directories are critical to helping enrollees choose a plan that includes their providers, and to facilitating their access to care in a reasonable time and without the hassle of calling provider after provider, only to discover they are either out of network or not accepting new patients.

But even the best provider directory is only as effective as the network it captures. Here too, reforms are needed. MA networks are often far too narrow, which can make care harder to find, access, and afford. This is especially true for mental health and SUD treatment.¹⁰² On average, MA plan networks included only 23% of psychiatrists in a county—a smaller share than for any other physician specialty—and nearly 40% of plans included less than 10%.¹⁰³ By comparison, though psychiatry has the highest opt-out rate from OM of all medical specialties, only 7.5% of psychiatrists have done so.¹⁰⁴

Network adequacy standards must consider not only a provider's in-network status, but also their meaningful availability. Otherwise, if MA plans have adequate networks on paper but many of those providers are not accepting new patients, the network is not truly adequate for new enrollees. CMS could update plan reporting requirements to better capture both elements. We specifically support the adoption of two additional quantitative metrics: (1) the number of providers and facilities within a given specialty that have submitted a claim over a certain period, such as six months; and (2) the number of providers that are accepting new patients. Plan submission and CMS verification of these data points would better protect enrollee access to care.

¹⁰¹ 86 FR 64996, 65062.

¹⁰² Daria Pelech, *et al.*, "Medicare Advantage And Commercial Prices For Mental Health Services," Health Affairs (February 2019), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05226>.

¹⁰³ Gretchen Jacobson, *et al.*, "Medicare Advantage: How Robust Are Plans' Physician Networks?" Kaiser Family Foundation (October 5, 2017), <https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/>.

¹⁰⁴ Nancy Ochieng, "Most Office-Based Physicians Accept New Patients, Including Patients With Medicare and Private Insurance," Kaiser Family Foundation (May 12, 2022), <https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/>.

More broadly, a 2015 U.S. Government Accountability Office (GAO) report found “CMS’s oversight did not ensure that MAO networks were adequate to meet the care needs of MA enrollees. For example...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.”¹⁰⁵ In June 2022, in sworn testimony before Congress, GAO said its recommendations to address these issues “had not yet been fully implemented.”¹⁰⁶

It is concerning that instead of spending the intervening years strengthening network adequacy protections, CMS advanced policies to dilute them. For example, in a May 2020 final rule, CMS weakened network adequacy requirements by reducing the percentage of beneficiaries that must reside within the maximum time and distance standards in non-urban counties from 90% to 85%, along with an additional 10-percentage point credit when plans contract with telehealth providers in certain specialties, as well as an additional 10-percentage point credit for affected providers in states that have certificate of need laws or certain other restrictions.¹⁰⁷

We urge CMS to rescind these changes and to instead require MA plans to demonstrate they can meet enrollee care needs before they are permitted to offer plans in the area. If a plan does not have enough providers in network to realistically serve enrollees in a geographic area, then CMS should not allow the plan to operate in that region. The solution to inadequate plan networks is not for CMS to lower the bar.

We also recommend establishing network adequacy requirements for supplemental benefits. Without this basic guardrail, there is no way to measure plan capacity to deliver promised benefits.

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 CMS 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.

Finally, we encourage the adoption of wait time standards in MA similar to the recent decision to add such standards to Qualified Health Plans beginning in 2024.¹⁰⁸ The existing metrics for network adequacy in MA plans fail to capture whether timely care is actually available. Geographic criteria (travel time/distance standards) and minimum number of providers or provider-to-enrollee ratios are metrics for determining whether providers are reasonably

¹⁰⁵ U.S. Government Accountability Office, “Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy,” (August 31, 2015), <https://www.gao.gov/products/gao-15-710>.

¹⁰⁶ U.S. Government Accountability Office, “Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight,” (June 28, 2022), <https://www.gao.gov/products/gao-22-106026>.

¹⁰⁷ 85 FR 33796, 33855.

¹⁰⁸ 87 FR 27208, 27329.

accessible, while appointment wait times measure whether care is reasonably available.¹⁰⁹ This appointment wait time standard should apply to all appointments, not just to an initial “intake” appointment, to ensure that both initial and follow-up care are available.

Beyond network adequacy, we encourage CMS to adopt several policies from the ACA Marketplace. There, plan standardization and reporting requirements advance transparency, empower consumers, and streamline plan selection.¹¹⁰ We ask CMS to take a similar approach with MA. In particular, we urge attention to the ACA’s changes to Section 2715A of the Public Health Service Act regarding plan coverage disclosures; such information would similarly benefit decision-making among people with Medicare.¹¹¹ Offering standardized plans and more information may also help enrollees, advocates, and researchers identify instances of discriminatory plan behaviors, promoting equity alongside access and consumer choice.

We also recommend that CMS replicate the Biden-Harris administration’s consistent prioritization of Marketplace Navigators.¹¹² We fully support this funding. Helping people understand and choose appropriate coverage is vital to their physical and economic well-being. To that end, we urge comparable attention to—and therefore greater investments in—State Health Insurance Assistance Programs (SHIPs). While both Navigators and SHIPs provide enrollment assistance, only SHIPs are highly trained on Medicare’s complexities. They are often the only source of objective, one-on-one counseling available to help beneficiaries find the coverage that best meets their needs. Despite surging Medicare enrollment and an increasingly complex coverage landscape, the program remains woefully underfunded.

Marketplace outreach is also admirable and a good model for Medicare. We urge CMS to develop energetic, unbiased, and informed communications strategies to alert people who are approaching Medicare eligibility about important rules and deadlines. As mentioned earlier and documented by MedPAC, such notice could help prevent harmful enrollment errors, like lifetime penalties and gaps in coverage.¹¹³ But today, no such notice exists. We ask CMS and

¹⁰⁹ Legal Action Center, “Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services,” (May 2020), <https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services>.

¹¹⁰ See, e.g., Centers for Medicare & Medicaid Services, “HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet,” (April 28, 2022), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet>; Karen Pollitz, et al., “Health Insurance Transparency under the Affordable Care Act,” Kaiser Family Foundation (March 8, 2012), <https://www.kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/>.

¹¹¹ Karen Pollitz, et al., “Health Insurance Transparency under the Affordable Care Act,” Kaiser Family Foundation (March 8, 2012), <https://www.kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/>.

¹¹² See, e.g., Centers for Medicare & Medicaid Services, “Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of HealthCare.gov Open Enrollment Period,” (August 26, 2022), <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-makes-largest-investment-ever-navigators-ahead-healthcaregov-open>; Centers for Medicare & Medicaid Services, “HHS Announces the Largest Ever Funding Allocation for Navigators and Releases Final Numbers for 2021 Marketplace Open Enrollment,” (April 21, 2021), <https://www.cms.gov/newsroom/press-releases/hhs-announces-largest-ever-funding-allocation-navigators-and-releases-final-numbers-2021-marketplace>.

¹¹³ Medicare Payment Advisory Commission, “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.

SSA to correct this, using the BENES 2.0 Act as a guidepost.¹¹⁴ We also ask CMS to strengthen remedies for mistaken enrollment delays, including through increased use of equitable relief and maximum flexibility in the implementation of the BENES Act's special enrollment periods.¹¹⁵

8. How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?

Currently, we find beneficiaries are largely unaware of what supplemental benefits their or any other plan may offer. Insufficient data means it is unclear how many enrollees are in plans with supplemental benefits; who qualifies for them; how plans communicate such information; and how, if, and by whom they are delivered. These benefits are a mystery from outside a plan, and often to enrollees as well.

We typically hear from beneficiaries who learned about the availability of a supplemental benefit through plan marketing or other outreach, some of which may be misleading. Problems can arise when beneficiaries choose a plan based on the promise of a supplemental benefit, only to later discover it was less generous or not available at all. For example, one Medicare Rights client selected her MA plan because it had a significant grocery benefit. However, once she enrolled, she was told she was not eligible. Another client changed plans in reliance on the sales agent's promise of more generous dental coverage; but the new plan did not actually offer this benefit. The lack of plan oversight and clear remedies, including an appeals structure, often leaves these enrollees with nowhere to turn for help.

We urge CMS to improve the information about and delivery of supplemental benefits through several changes: collecting and disseminating information about supplemental benefits, such as availability, access, limits, qualifications, expenditures, and other data that show what value may or may not be accruing to beneficiaries through supplemental benefits; developing standardized plans with standardized supplemental benefits; establishing network adequacy requirements for supplemental benefits; creating clear marketing rules so that enrollees are not lured into plans by supplemental benefits that they are not eligible for or that are too limited in scope to provide value; creating clear appeals processes for supplemental benefits; and providing greater information about supplemental benefits on Medicare Plan Finder and via other resources to help beneficiaries determine if MA is the right choice for their circumstances and, if so, what MA plan is the best fit. As ever, misleading, predatory, and otherwise problematic marketing tactics must not be tolerated.

¹¹⁴ S. 3675, <https://www.congress.gov/bill/117th-congress/senate-bill/3675?s=1&r=43>

¹¹⁵ Medicare Rights Center, "Comments on CAA/BENES Act Proposed Rule," (June 27, 2022), <https://www.medicarerights.org/policy-documents/comments-on-cao-benes-act-proposed-rule>.

As stated above, we were pleased to see the new requirement for MA organizations to separately report expenditures for supplemental benefits in Medical Loss Ratio reporting.¹¹⁶ This information can be helpful to determine if beneficiaries are truly getting value from MA supplemental benefits. We encourage CMS make this information publicly available, and to use it to hold plans accountable.

9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)?

We need more information about the scope, availability, and utilization of supplemental benefits, including demographic information about enrollees, MA benefit design, and marketing practices to meaningfully answer this question. Currently, as we note above, there is too little information reaching the public for beneficiaries, advocates, and researchers to judge the utility and value of supplemental benefits.

10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

Several studies, as well as our own experiences, raise concerns that MA plan use of prior authorization often prevents or delays medically necessary care, potentially worsening enrollee health and outcomes.¹¹⁷

- Most recently, an April 2022 OIG report found plans often used prior authorization to delay or deny beneficiary coverage or provider payment for Medicare-covered services. Thirteen percent of the service denials OIG examined met Medicare coverage rules and would have been approved if the beneficiary had been in OM.¹¹⁸ While MA plans are permitted to have their own coverage rules, they must be “no more restrictive than original Medicare.” But OIG’s experts determined that MA plans used additional medical criteria for their decisions and required more documentation than needed to demonstrate medical necessity.¹¹⁹
- A separate OIG investigation in September 2018 raised similar concerns with prior authorization, finding that while only 1% of denials were appealed, 75% were

¹¹⁶ 87 FR 27704

¹¹⁷ Julia C. Prentice, et al., “Delayed Access to Health Care and Mortality,” Health Services Research (April 2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955366/>.

¹¹⁸ U.S. Department of Health and Human Services Office of Inspector General, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

¹¹⁹ *Id.*

overturned at the first level of appeal.¹²⁰ That year, MA plans denied 1.5 million prior authorization requests.¹²¹ OIG's findings suggest very few of those denials were proper, but that almost all derailed access to care.

- CMS has also documented widespread and persistent problems with prior authorization. In 2015, the agency cited more than half of all audited MA contracts (56%) for inappropriate denials.¹²²

Such denials force beneficiaries to seek other care, pay out-of-pocket, go without, or get embroiled in burdensome appeals processes that create stress, expense, and extra work. Administrative burdens may contribute, deliberately or by chance, to people in MA leaving for OM if they are in poorer health or at the end of life. Better oversight and enforcement is needed to deter and prevent harmful denials.

OIG has proposed tightening audit standards on MA plans and establishing firmer guidance about MA coverage criteria. They also recommended that MA plans be directed to review their processes and systems to avoid many of the payment errors in the samples.¹²³ We agree with these reforms. We also ask CMS to notify beneficiaries about plan violations, offering enrollment relief where needed.

MA plans that inappropriately deny care must not be permitted to benefit from it. Capitation provides a motive to deny or delay access to care, but rigorous oversight and penalties for bad actors can help curb this impulse. Or, if the decisions are simply mistakes, corrective actions from CMS can spur plans to take more care in their process design and decision-making.

We additionally urge CMS to revise regulations, manual provisions, and other guidance to require plans to disclose to providers and enrollees the Medicare criteria upon which coverage denials or terminations are made, along with relevant citations.

To enhance data collection and reporting efforts, we ask CMS to monitor MA 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

¹²⁰ U.S. Department of Health and Human Services Office of 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>.

¹²¹ U.S. Department of Health and Human Services Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

¹²² U.S. Department of Health and Human Services Office of 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>.

¹²³ U.S. Department of Health and Human Services Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

and publicly documented. Offending plans should remain subject to higher levels of review going forward and all captured data should be made publicly available. Finally, to best obtain the full range of data about pre- and post-service denials, we ask the agency to rescind the September 2020 guidance improperly limiting reported elements.¹²⁴

We continue to urge CMS to simplify the unnecessarily complicated MA appeals system.¹²⁵ This includes making sure plan denial letters 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. In addition, 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.

11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

Beneficiaries need to know if MA plans are denying access to Medicare-covered treatment. While there can be some tradeoffs when choosing managed care, it should not require beneficiaries to sacrifice access to needed, and promised, services.

Under current rules, when a plan issues a denial, they are required to notify the affected enrollee in a timely manner. This notification should contain everything the enrollee needs to determine next steps, which may involve pursuing an appeal. Without such notice, beneficiaries may not understand their rights, how to appeal, or even that they have been denied coverage. Despite the importance of this obligation, an OIG report found that many plans fail to comply. In 2015, 45% of MA plans sent denial letters with incomplete or incorrect information.¹²⁶

From 2014 to 2016, as noted above, beneficiaries and providers appealed only 1% of service and coverage denials. Of the decisions that were appealed, a stunningly high number—75%—

¹²⁴ Centers for Medicare & Medicaid Services, “Revised Appeal and Grievance Data Form, Form CMS-R-0282,” (September 24, 2020), <https://www.hhs.gov/guidance/document/revised-appeal-and-grievance-data-form-form-cms-r-0282>. (Removed the following data elements from the standardized Appeal and Grievance Data Form [Form CMS-R-0282] Expedited appeals; Disposition of expedited appeals, IRE (level 2) appeals, Disposition of IRE (level 2) appeals, Withdrawals).

¹²⁵ Medicare Rights Center, “Policy Recommendations for the Biden Administration,” (January 18, 2021), <https://www.medicarerights.org/pdf/012021-biden-harris-transition-memo.pdf>.

¹²⁶ U.S. Department of Health and Human Services Office of Inspector General, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

were overturned by the plan, with independent reviewers at higher levels issuing additional reversals.¹²⁷

These findings strongly suggest a pattern that warrants attention and correction. We again urge CMS to enhance plan reporting requirements regarding appeals, to make such information publicly available, and to increase oversight and penalties.

As noted above, CMS should also make the appeals process more manageable and accessible. In particular, plan denial notices should be prompt, accurate, and actionable, and the first level of appeal should be handled by an independent entity, rather than the plan itself. These changes would simplify the system, promote timely access to care, and, along with the reforms outlined above, encourage plans to make accurate initial coverage determinations.

We also urge CMS to require accurate provider directories, so beneficiaries can make informed enrollment decisions and obtain care in a timely manner. This need is pronounced in the mental health and SUD treatment space, where the access to services can be unusually time-sensitive.

C. Drive Innovation to Promote Person-Centered Care

8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

In our experience, beneficiaries use the MA Star Ratings as a barometer of general quality, but very rarely base their enrollment decisions on the rating alone. For example, Star Ratings may break ties when beneficiaries are comparing one plan to another, and some beneficiaries may limit their Medicare Plan Finder searches to plans with a Star Rating of four or above. But we see these effects largely on the margins. Beneficiaries are typically much more interested in other factors, such as finding plans that contract with their chosen providers, premium and cost sharing rates, and certain supplemental benefits. We are also concerned that plan gaming, combined with ineffective oversight and time delays, make the Star Ratings even less useful.

Currently, nine out of 10 MA enrollees are in plans with four or five stars.¹²⁸ While this might appropriately represent the proportion of plans CMS believes should be earning bonus payments, this consolidation undermines the usefulness of the rating as a decision tool. Moreover, as OIG observed, audit violations are no longer reflected in Star Ratings, which diminishes the utility of the rating for people for whom the plan abiding by all rules is an important measure.¹²⁹ Further, MedPAC has documented the “continuing erosion of the

¹²⁷ *Id.*

¹²⁸ Bob Herman, “The Lake Wobegon effect in Medicare Advantage,” Axios (October 11, 2021), <https://www.axios.com/2021/10/11/medicare-advantage-star-ratings-2022>.

¹²⁹ U.S. Department of Health and Human Services 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.asp>.

reliability of data on the quality of MA plans” and in March declared “[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.”¹³⁰ In other words, MA plans earn quality bonuses that do not appear to be tethered to anything at all.

Even if the ratings were more reliable, however, they would still not necessarily be good tools for plan selection for any particular individual. The measures, metrics, and differences between plans that are important on a policy or population level such as process measures are not necessarily the ones that do, or should, drive an individual’s plan selection. Even among the factors that might affect beneficiary preferences between plans, the same elements are not likely to be uniform across beneficiaries.

That is, the quality measures that capture the percentage of enrollees with diabetes with certain A1C results, or the percentage of enrollees who are up-to-date on their colorectal cancer screening tests, are undoubtedly important indicators of plan and care quality from a policy and payor perspective. It is reasonable for CMS to reward plans that do things to make it easier for people to manage their chronic conditions and utilize preventive services. However, the fact that a plan has scored highly on these measures is unlikely to be important enough to influence plan choice for a 65-year-old non-diabetic with no family history of cancer whose mental health diagnosis makes conflict and change exceedingly difficult to manage. That person is more likely to care about the plan’s performance on measures, such as denial rates and people’s satisfaction with their customer service interactions.

Especially in light of the myriad factors beneficiaries must already consider when choosing a plan—and the overwhelming number of plans available in the MA landscape—it is unreasonable to expect them to heavily weight generic and generalized Star Ratings. Few beneficiaries will choose a plan with higher premiums,¹³¹ with a formulary that does not include their regular medications, and where their current doctor is out of network just because it has a high Star Rating. Indeed, after considering and comparing those and other factors, many people have such decision fatigue that even considering Star Ratings is too daunting. Increased standardization, simplified plan options, and more uniform formulary options would ease other selection pressures and allow room for beneficiaries to use this information in their decision making more readily. In addition, and in line with our recommendation to increase Medicare Plan Finder personalization and customization options, adding plan quality information that could reflect a particular beneficiary's priorities while seeking care in the community would make the ratings more relevant.

¹³⁰ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” (March 2021), <https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/>.

¹³¹ However, some beneficiaries do associate higher premiums with greater quality. *See, e.g.,* Amelia Haviland, *et al.*, “Association of Medicare Advantage Premiums With Measures of Quality and Patient Experience,” *JAMA* (August 26, 2022), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795747>.

9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

We suggest studying the effect of providing supplemental benefits in Original Medicare to provide a basis for determining 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 research questions.

10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity?

As in Question Nine, we suggest studying the effect of providing supplemental benefits in Original Medicare to provide a basis for determining 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 research questions.

D. Support Affordability and Sustainability

Medicare beneficiaries need the program to be affordable and sustainable, and the current trajectory for MA spending puts that at risk. There is consistent, mounting evidence that MA is paid more than OM would be for the same beneficiary, and that such per person spending is growing, as is MA enrollment, with significant implications for Medicare's future.¹³² While reaping these rewards, MA plans are also restricting care through utilization management techniques that delay or deny services—often incorrectly—and in ways that force beneficiaries to pay out-of-pocket or engage with the cumbersome, intimidating, time-consuming appeals process. Last year, erroneous denials accounted for nearly one-third of all calls to our Helpline. Of those, 65% were about how to appeal a plan's decision.¹³³

MA overpayments are also a major concern, as they increase program, beneficiary, and taxpayer costs.¹³⁴ They are largely attributed to plan manipulation of current systems and

¹³² Jeannie Fuglesten Biniak, *et al.*, "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges," Kaiser Family Foundation (August 17, 2021), <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges/>.

¹³³ Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2020-2021 Call Data from the Medicare Rights Center's National Helpline," (May 2022), <https://www.medicarerights.org/pdf/2020-2021-helpline-trends-report.pdf>.

¹³⁴ Medicare Payment Advisory Commission, "The Medicare Advantage program: Status Report" (March 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch13_sec.pdf.

payments.¹³⁵ And these additional expenses are significant. 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 “upcoding”—could raise Medicare expenditures by \$600 billion over the next decade.¹³⁶ Another report found that Medicare overpaid MA plans by \$70 billion from 2008 through 2013,¹³⁷ and GAO estimates that in 2013 alone, MA plans received an extra \$14.1 billion.¹³⁸

We strongly urge CMS to use the tools at its disposal to rein in excessive MA payments—primarily its discretion to increase the statutory minimum coding intensity adjustment, meant to account for differences in patterns of coding between MA and OM. We also support better monitoring and auditing of risk-adjusted payments, and other efforts to deter upcoding.

For example, we ask CMS to more closely oversee plan use of at-home risk assessments, to verify they lead to services that are actually needed, provided, and effective to treat beneficiaries’ clinical needs.¹³⁹ As we and others have long cautioned, there is a continued risk that such assessments serve as a vehicle for plans to collect diagnoses and increase payments without providing meaningful care.¹⁴⁰ In recent congressional testimony, OIG discussed the widespread consensus across watchdog organizations:

OIG’s work builds on concerns raised by other oversight entities. In 2016, the Government Accountability Office (GAO) raised concern that diagnoses collected from MAOs’ chart reviews may be less likely to be supported by medical records than diagnoses submitted to MAOs by providers. CMS and the Medicare Payment Advisory Commission (MedPAC) have questioned whether MAOs use health risk assessments primarily as a strategy to submit more diagnoses to increase payments rather than to improve the care provided to their beneficiaries. Since 2016, MedPAC has recommended that HHS eliminate health risk assessments as a source of diagnoses for risk-adjustment payments.¹⁴¹

¹³⁵ Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress,” (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

¹³⁶ Richard Kronick, “Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By \$200 Billion Over Ten Years,” Health Affairs (February 2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0768>.

¹³⁷ 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/>.

¹³⁸ 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>.

¹³⁹ U.S. Department of Health and Human Services 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>.

¹⁴⁰ 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>.

¹⁴¹ U.S. Department of Health and Human Services Office of Inspector General, “Testimony Before the United States House Committee on Energy and Commerce Subcommittee on Oversight and Investigations” (June 28, 2022), https://oig.hhs.gov/documents/testimony/1039/E_Bliss_Medicare_Advantage_Testimony.pdf

1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

As already mentioned, the changes made in the recent C & D rule (CMS-4192-F) to restart detailed Medical Loss Ratio reporting and to include supplemental benefits in that reporting is a positive step toward documenting the money Medicare pays MA, and ensuring it increases value for enrollees.¹⁴²

We urge CMS to build on this transparency, and not to allow plan claims of “proprietary information” to deny public reporting of how taxpayer and beneficiary money is being spent. These are public dollars; what happens to the must be too.

Again, we ask CMS to halt MA overpayments. MedPAC conservatively estimates “that payments to MA plans are about 104 percent of what FFS Medicare would have spent to cover the same enrollees.”¹⁴³ This inflation is from a combination of CMS policies regarding benchmarks and rebate dollars, quality bonus payments, and anemic coding intensity adjustments. It is exacerbated by expanded supplemental benefit availability, without accompanying data collection; as well as by egregious upcoding that allows plans to benefit from paper-only diagnoses without providing care. It is unethical, unhelpful, and unsustainable.

We agree with many of MedPAC’s perennial calls for MA payment reform,¹⁴⁴ and specifically encourage CMS to more aggressively adjust coding intensity, change benchmarking policy by requiring MA plans to compete with each other rather than with OM, audit plans and penalize for upcoding, eliminate health risk assessments as a source of diagnoses for risk-adjusted payments, establish thresholds for the completeness and accuracy of MA encounter data, rethink quality bonus payments, and aggressively recoup overpayments made to MA plans.¹⁴⁵

Likewise, we recommend CMS implement GAO’s recommendations around the validity of encounter data, audits, and recovery of improper payments to MA plans; and to improve the timeliness of MA Audits and Appeals to Recover Improper Payments, including through risk adjustment data validation (RADV) audits.¹⁴⁶

¹⁴² 87 FR 27704, 27824.

¹⁴³ Medicare Payment Advisory Commission, “Medicare and the Health Care Delivery System: Report to the Congress,” (June 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf.

¹⁴⁴ Medicare Payment Advisory Commission, “Testimony: Improving the Medicare Advantage Program (Energy and Commerce),” (June 28, 2022), <https://www.medpac.gov/document/testimony-improving-the-medicare-advantage-program-energy-and-commerce/>.

¹⁴⁵ Medicare Payment Advisory Commission, “Comments on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled “Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies,” (March 3, 2022), https://www.medpac.gov/wp-content/uploads/2022/03/03032022_MA_Coding_MedPAC_COMMENT_SEC.pdf.

¹⁴⁶ U.S. Government Accountability Office, “Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight,” (June 28, 2022), <https://www.gao.gov/products/gao-22-106026>.

We also ask that CMS investigate potential steering, and revise MA payment incentives accordingly. Recent KFF analysis indicates that people who choose MA plans have lower spending and use fewer services relative to their peers with OM—even before they enroll. While additional data collection and study is needed, these initial findings suggest the current basis for MA payments, which assumes MA enrollees have the same overall health costs as people with OM, may be flawed, and contributing to the problem of overpayments.¹⁴⁷ As the authors note, given the increases and projected growth in MA enrollment and expenditures, “the stakes are high for making payments to plans as accurate as possible.”¹⁴⁸ We implore CMS to heed this call: to step up enforcement of existing safeguards and identify ways to improve the current payment system to promote accuracy, sustainability, and equity.

2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

We support more aggressive coding intensity adjustments as well as audits to deter and prevent egregious upcoding that allows plans to benefit from paper-only diagnoses without providing care. Health risk assessments and chart reviews must not count as a source of diagnoses for risk-adjusted payments.

3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

We suggest CMS focus on the following areas: (1) Making MA plan selection easier and less risky, including by leveling the Medicare playing field; (2) Curbing bad plan behaviors, like misleading marketing and misapplied utilization management; and (3) Reforming MA payment calculations in ways that promote equity and sustainability.

We frequently hear from beneficiaries who need help understanding their Medicare coverage options and making enrollment decisions. Regardless of the coverage pathway they choose, people may then need help paying for and accessing that care. However, these challenges are often more pronounced for MA enrollees. The plan landscape is cluttered, complex, and confusing. Other MA-specific features, like utilization management, narrow provider networks, and predatory plan marketing, can add to decision-making, access, and affordability problems. CMS must address both the structural and behavioral drivers to ensure beneficiaries are able to rely on their earned Medicare coverage.

And as MA enrollment increases, ensuring financial incentives are properly aligned becomes ever-more important. At its inception, the MA program was touted as a way to reduce

¹⁴⁷ Gretchen Jacobsen, *et al.*, “Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?,” Kaiser Family Foundation (May 2019), <https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/>.

¹⁴⁸ *Id.*

Medicare spending. Instead, the opposite is true: MA plans in the aggregate have never produced savings for Medicare due to flawed MA payment policies.¹⁴⁹

Not only does overpaying MA plans increase outlays in the short-term, but it also sets up a vicious circle of increasing costs. Higher benchmarks lead to more rebate dollars. More rebate dollars lead to more supplemental benefits. More supplemental benefits make MA plans appear more attractive, leading to greater enrollment. Greater enrollment increases program spending on MA. The more policies favor MA, the more MA costs. The more MA costs, the more people in Original Medicare bear the burden of paying for benefits not available to them, including through higher premiums and as taxpayers, all of which serves to undermine Medicare's financial outlook. We strongly recommend revisiting, and right-sizing, these payment methodologies.

E. Engage Partners

1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?

We need more information on demographics and the relationship, if any, between those demographics and denials, delays, appeals, benefit designs, enrollment, disenrollment, and outcomes.

We urge the elimination of proprietary information loopholes that keep valuable information from the public.

The finalized proposals in the C & D rule (CMS-4192-F) to restart detailed Medical Loss Ratio reporting, and to include supplemental benefits that that reporting, will begin to fill some of the current information gaps.¹⁵⁰

2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

¹⁴⁹ See, e.g., Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=401; Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf; Medicare Payment Access Commission, "For the Record: MedPAC's Response to AHIP's Recent "Correcting the Record" Blog Post," (March 3, 2021), <https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/>.

¹⁵⁰ 87 FR 27704, 27824.

In our experience, CMS often oversamples from MA plans and providers and under samples from enrollees and beneficiary advocacy groups. We encourage CMS to bring beneficiary and advocacy voices into any conversation and decision regarding new or changing rules, guidance, oversight, marketing materials, and outreach.

3. What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

CMS requires all MA organizations offering one or more D-SNPs in a state to establish and maintain one or more enrollee advisory committees to solicit direct input on enrollee experiences. We ask CMS to consider whether such a structure would be of benefit for all MA enrollees. Plans that listen to the voices of people with Medicare would better understand their needs, wants, frustrations, and fears. We also support the creation of well-structured Consumer Advisory Councils, focus groups, and smaller information sessions with beneficiaries. It is critical that different voices are heard, including the voices of those with limited English proficiency and disabilities.

4. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

We hope CMS will pay particular attention to responses to this RFI that come directly from beneficiaries and beneficiary advocates, especially those who are members of or represent underserved communities.

Conclusion

Thank you again for the opportunity to comment on the important topic of Medicare Advantage. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,



Fred Riccardi
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