MEDICARE RIGHTS CENTER
Getting Medicare right

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VIA ELECTRONIC SUBMISSION

Hon. Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Attention: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: RIN 0938-ZB84: Medicare Program; Request for Information on Medicare Advantage Data [CMS-4207-NC]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Request for Information on Medicare Advantage Data**. 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, including through our national consumer Helpline.

Based on this experience, we know that Medicare Advantage (MA) is increasingly affecting the lives and finances of many people with Medicare, and the program itself. Over 50% of eligible beneficiaries are now enrolled in MA, and MA organizations (MAOs) draw down billions of dollars from Medicare each year.[1] Despite this sizable and growing footprint, enrollees, families, advocates, researchers, and policymakers are often kept in the dark about important aspects of MA, including fundamentals like whether enrollees are getting the care they need and how MAOs are using Medicare, beneficiary, and taxpayer dollars.

These information gaps impact beneficiaries from the outset. Among the most frequent calls to Medicare Rights' Helpline are from or on behalf of people trying to understand their coverage options and navigate enrollment.[2] For many, including those who must actively enroll, this can be a confusing

[1] Meredith Freed, *et al*., "Medicare Advantage 2024 Spotlight: First Look" (November 15, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.
[2] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2022 Call Data from the Medicare Rights Center's National Helpline" (October 2023), https://www.medicarerights.org/pdf/2022-helpline-trends-report.pdf.

and daunting time as they attempt to understand specific timelines, intricate Medicare rules, and any existing coverage. People who choose MA face an additional hurdle: selecting a plan.

While plan selection has always been a complex task, it has become overwhelmingly so. Relaxed regulations, such as the elimination of meaningful difference and uniformity requirements,[3] and burgeoning profits[4] have allowed more, and more similar, plans to swiftly flood the MA marketplace. Beneficiaries now have more to wade through than ever before. In 2024, enrollees had access to an average of 43 MA plans, over twice as many as in 2018.[5] Plans can vary on everything from costs to coverage, sometimes in subtle but important ways. For many, this makes close analysis both critical and impossible.

Fundamentally, the number of MA plans and the variances across each can hinder sound decision-making.[6] Beneficiaries may become overwhelmed and select or continue with a plan that does not meet their needs or correspond with their preferences. This experience aligns with qualitative evidence[7] and is supported by behavioral economics research, which suggests individuals who face a wide range of choices may have more difficulty making decisions, make poorer choices, or fail to act at all.[8] Indeed, few people with Medicare evaluate their options annually or switch plans from one year to the next.[9] This inertia, and any underlying sub-optimal enrollments, can have detrimental impacts, like higher costs, care disruptions, and problems accessing preferred providers. 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.[10]

The need for oversight, transparency, and accountability will only grow as MA does. Enrollment has more than doubled in the last decade, and market gains are expected to continue.[11] The Congressional Budget Office projects the share of beneficiaries enrolled in MA, now just over 50%, will hit 60% by

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[3] 86 FR 16440, 16491.

[4] *See, e.g.*, Paige Minemyer, "2022 Forecast: Medicare Advantage is the Industry's Hottest Market. Don't Expect that to Change Next Year" (December 22, 2021), https://www.fiercehealthcare.com/payer/medicare-advantage-industry-s-hottest-market-2022-don-t-expect-to-change; Jared Ortaliza, *et al.*, "Health Insurer Financial Performance in 2021" (February 28, 2023), https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/ and Megan Houston, "Where the Bread is Really Buttered: Insurers' Q4 Earnings Reports Show Heavy Reliance on Government Business," (March 7, 2022), https://chirblog.org/bread-really-buttered-insurers-q4-earnings-reports-show-heavy-reliance-government-business/.

[5] Meredith Freed, *et al.*, "Medicare Advantage 2024 Spotlight: First Look" (November 15, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.

[6] Allison Rizer, "Is Too Much Choice a Bad Thing?" (July 26, 2021), https://www.arnoldventures.org/stories/is-too-much-choice-a-bad-thing.

[7] *See, e.g.*, KFF, "Chartpack: Seniors and the Medicare Prescription Drug Benefit" (November 2006), https://www.kff.org/medicare/poll-finding/chartpack-seniors-and-the-medicare-prescription-drug/; KFF, "Seniors' Knowledge and Experience With Medicare's Open Enrollment Period and Choosing a Plan: Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors" (October 2012), https://www.kff.org/medicare/issue-brief/seniors-knowledge-and-experience-with-medicares-open/.

[8] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch3_MedPAC_Report_To_Congress_SEC.pdf.

[9] *See, e.g.*, Meredith Freed, *et al.*, "More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually" (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/; Nancy Ochieng, *et al.*, "A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period" (November 01, 2022), https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/; and Jeannie Fuglesten Biniek, *et al.*, "Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment" (November 01, 2022), https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/.

[10] Nancy Ochieng, *et al.*, "A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period" (November 01, 2022), https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/.

[11] *Id.*

2030.[12] Payments to MA plans are also climbing. As a portion of total Medicare dollars, they increased from 26% in 2010 to 45% in 2020, and may reach 54% by 2030.[13] Per person, Medicare spending is higher and growing faster for MA beneficiaries than for those with Original Medicare (OM).[14] The Medicare Payment Advisory Commission (MedPAC) estimates Medicare pays MA plans 6% more than OM for similar enrollees, translating to an extra $27 billion in 2023.[15] Higher payments per MA enrollee are expected to cost Medicare $183 billion in the coming years.[16]

This system was not envisioned and is not sustainable. A driving premise behind MA was its potential to save Medicare dollars. But it never has. Instead, MA costs more, both per enrollee and in the aggregate, than OM.[17] MA enrollment growth disproportionately increases Medicare spending, raising taxpayer costs and Part B premiums for all beneficiaries while worsening Medicare sustainability.[18]

These trajectories are additionally concerning because the data are unclear when it comes to MA quality and the beneficiary experience.[19] Much of what we do know suggests room for improvement, and that plans are simply not being made to account for their use of public dollars.[20] There is also a lack of reported demographic information, which undermines transparency and stymies equity advancement. Without these and other data points, it is impossible to know how well MA works for people with Medicare, including those from underserved communities. This, in turn, makes it difficult 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 continuing unabated. For example, many MA plans inappropriately deny millions of medically necessary claims and services each year, leaving their

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[12] *See, e.g.*, Congressional Budget Office, "Baseline Projections" (May 2023), https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf and Tricia Neuman, *et al.*, "10 Reasons Why Medicare Advantage Enrollment is Growing and Why It Matters" (January 30, 2024), https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/.

[13] Jeannie Fuglesten Biniek, *et al.*, "The Growth in Share of Medicare Advantage Spending" (April 7, 2022), https://www.kff.org/medicare/slide/the-growth-in-share-of-medicare-advantage-spending/.

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

[15] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report" (January 12, 2023), https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf.

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

[17] 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.

[18] *Id.*

[19] *Id.*

[20] 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" (June 7, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793106.

[21] *See, e.g.*, Gretchen Jacobson, *et al.*, "Medicare Advantage Hospital Networks: How Much Do They Vary?" (June 2016), https://bit.ly/3PLw5bQ; Qijuan Li, *et al.*, "Medicare Advantage Ratings and Voluntary Disenrollment Among Patients With End-Stage Renal Disease" (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" (October 2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0272 and Meredith Freed, *et al.*, "Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings" (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/.

enrollees with high costs and care delays.[22] Some engage in misleading advertising to pull beneficiaries into plans that may not meet their needs.[23] Still others "cherry-pick" healthier enrollees through geographic targeting and discriminatory benefit designs.[24] Such conduct only worsens health care access, outcomes, and disparities.

For these reasons, we welcome this RFI. In our comments below, we outline opportunities to improve the system through data collection around **(I) Equity, (II) Provider Directories and Networks, (III) Marketing, (IV) Utilization Management and Appeals, (V) Supplemental Benefits, (VI) Dually Eligible Individuals and D-SNPs, and (VII) Favorable Selection and Risk Adjustment**. Our recommendations prioritize the beneficiary experience and are grounded in our work helping MA enrollees navigate coverage and access care.

While some of the data we request may be actionable for people with Medicare, CMS must neither expect the market alone to eradicate bad actors, nor overly rely on beneficiary reporting to ensure plan compliance. Instead, CMS-collected data must form the basis of enhanced enforcement of Medicare's statutes and regulations and be used to drive future policy improvements program-wide.

When contemplating data improvement strategies, we urge CMS to center the needs of beneficiaries and the goals of the program. A foundational principle of Medicare is its public financing. As private companies, MAOs are taking money from the federal government, taxpayers, and beneficiaries in exchange for providing necessary, and often legally required, care. CMS must hold plans accountable for the dollars they receive and the promises they make. Doing so will require additional data, transparency, and oversight. CMS must not allow MAOs to hide behind claims of proprietary operations or otherwise limit access to Medicare-related data. Instead plan responses to agency information requests must be timely, correct, and made freely and publicly available at the plan level. All data requirements must be rigorously enforced, with consequences for inaccurate and delayed reporting, including financial, enrollment, and contractual penalties.

I. EQUITY

Discrimination deeply affects people in their daily lives. In the health care context, it persists across a variety of demographics and care settings and can disrupt treatment, derail care plans, and ultimately lead to worse health and well-being.[25] Currently, the lack of public information from MA plans may conceal health equity issues. We request greater collection and careful consideration of demographics, including intersectional data that may reveal inequitable treatment for certain communities within MA

[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" (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" (August 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.
[25] Samantha Artiga, *et al.*, "Survey on Racism, Discrimination and Health: Experiences and Impacts Across Racial and Ethnic Groups" (December 5, 2023), https://www.kff.org/report-section/survey-on-racism-discrimination-and-health-findings/.

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.

Additional data and oversight are needed to ensure that MAOs and plan designs do not perpetuate the harms of discrimination by denying, limiting, dissuading, or conditioning coverage or provision of appropriate benefits on any discriminatory basis. Such bases may include demographics such as age, sex, gender, race or ethnicity, religion, disability status, dual eligibility status, income, the receipt of financial assistance, LGBTQ+ status, limited English proficiency, rural status, poverty, former incarceration, mental health or substance use disorder diagnoses, end-stage renal disease (ESRD), long-term care facility residence, and homelessness.

Recommendations and Data Requests

- Determining disparities and identifying discriminatory effects cannot be done without broad data collection and stratification by the demographics described above, at a minimum.
- We request all data about enrollment, disenrollment, utilization management, interpreter utilization, provider access, prior authorization requests, denials, appeals, and overturn rates to identify disparities in access to care.

II. PROVIDER DIRECTORIES AND NETWORKS

Choice of provider is a key consideration for many beneficiaries, both when deciding between OM and MA and when selecting an MA plan. In 2022, 40% of new OM enrollees said they were primarily driven by provider choice.[26] MA enrollees who value provider choice may try to select a plan that reflects this preference. But unreliable provider directories and shifting networks can leave them at risk of losing—or never even having—the provider access and affordable care they seek. Typically, there is little recourse. Impacted enrollees may be stuck until the next open enrollment window. Since provider directory errors are likely to persist in the interim, finding care may remain a challenge.

Over the years, many independent studies have examined provider directory inaccuracies. Nearly all have identified errors with provider contact and location information, network status, and availability.[27] For example, a 2018 CMS report found that 52% of physician listings in MA provider directories contained at least one inaccuracy.[28] Similarly, a May 2023 review by the Senate Finance Committee found "secret shoppers" could successfully use provider directories to make mental health appointments only 18% of the time.[29] More than 80% of the listed providers "were either unreachable,

[26] Faith Leonard, *et al.*, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (October 17, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.
[27] U.S. Senate Committee on Finance, "Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.
[28] Michael S. Adelberg, *et al.*, "Improving the Accuracy of Health Plan Provider Directories" (June 7, 2019), https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories.
[29] *See, e.g.*, U.S. Senate Committee on Finance, "Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf and Robert Trestman, "Statement to the U.S. Senate Committee on Finance Re: Barriers to

not accepting new patients, or not in-network."[30] The effects are often profound for beneficiaries, leading to higher bills, additional burdens, and worse care.

In addition to direct beneficiary complications, provider directory errors can prevent CMS from conducting proper oversight. Without this accurate information, there is no evidence plans are meeting their network adequacy obligations. No potential enrollee should be at risk of joining a plan with an insufficient network, and no plan must be allowed to use provider directories to obscure their non-compliance with these or any other requirements.

To advance provider directory accuracy, network stability, informed decision-making, and access to care, we urge additional data collection and significant penalties for directory errors and non-compliance. We also support allowing directory users to flag incorrect information for review and correction, and the monitoring of such instances.

In addition to these and the data requests below, we recommend further policy and practice changes, including holding beneficiaries harmless with respect to any enrollment decisions they may make in reliance on provider directory misinformation. To further ensure MA enrollees can count on stability in their plan networks and the knowledge that their doctors will be there when they need them, we ask 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.

Recommendations and Data Requests

- We request all provider contact and location information, network participation, availability for new patients, specialties, specific office accessibility features for patients with disabilities and/or limited mobility, accessible examination or medical diagnostic equipment, languages spoken, plan participation, accreditation, and quality information.
- Network information should include networks for supplemental benefits and data on mid-year network changes.
- Accurate directory and network information should be integrated with Medicare Plan Finder.

III. Marketing

The cluttered MA plan landscape, a lack of usable information, inadequate decision-making tools, and chronic underfunding of State Health Insurance Assistance Programs (SHIPs) 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

Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks" (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/Robert%20Trestman%20APA%20testimony%20050123%20FINAL.pdf.

[30] *Id.*

information. Others may overly value information from sources that have more loyalty to the plan than to its enrollees, such as plan brokers and agents.[31]

Indeed, in 2022, most people who received help choosing between their coverage options turned to professional brokers and agents.[32] But these representatives are not always objective. They receive commissions, which may financially incentivize them to push a coverage pathway or product that is in their best interest rather than the beneficiary's.[33] While recent rule changes will begin to address this, further reforms are needed.[34]

The marketing of supplemental benefits is another core area of concern. We welcome the recent modernizations to plan-enrollee communications about Special Supplemental Benefits for the Chronically Ill (SSBCI) but note that a significant regulatory hole remains. Although many who opt for MA are drawn in by supplemental benefits,[35] CMS has not yet established clear rules about how MAOs may market these "extras" to current and potential enrollees.[36] We urge CMS to rectify this and reinforce that supplemental benefits should not merely be a sales tool or used to persuade beneficiaries to enroll in a plan. We also ask the agency to be vigilant in its enforcement of existing rules, including by watching for unusual spikes in enrollment and other patterns that might indicate inappropriate behavior. When identified, such practices must be corrected, including through plan and broker penalties and enrollment remedies such as Special Enrollment Periods.

Similarly, despite CMS efforts of late to curb unwanted outreach and advertisements, many beneficiaries continue to report being bombarded with MA plan ads, phone calls, mail, and other solicitations.[37] While MA marketing tactics, including the activities of third-party marketing companies, are designed to attract new enrollees and maximize profits, there must be a balance. In our experience, inadequate—and absent—marketing guardrails expose beneficiaries to an overwhelming amount of propaganda that can further muddle decision-making. Ultimately, inaccurate and aggressive marketing makes coverage decisions harder and negative outcomes more likely.

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[31] Martha Hostetter, *et al.*, "Taking Stock of Medicare Advantage: Choice" (March 3, 2022), https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice.
[32] *Id.*
[33] For example, commissions that are higher for MA plans than for supplemental coverage like Medigap may incentivize agents and brokers to steer consumers into MA. Riaz Ali & Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice" (October 12, 2021), https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice.
[34] *See, e.g.,* Centers for Medicare & Medicaid Services, "2024 Medicare Advantage and Part D Final Rule" (April 5, 2023), https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f and "Contract Year 2025 Medicare Advantage and Part D Final Rule" (April 4, 2024), https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f.
[35] Faith Leonard, *et al*., "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (October 17, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.
[36] Centers for Medicare & Medicaid Services, "Contract Year 2025 Medicare Advantage and Part D Final Rule" (April 4, 2024), https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f.
[37] *See, e.g.,* KFF, "Marketing Private Medicare Plans" (last visited January 4, 2024), https://www.kff.org/marketing-medicare/; Gretchen Jacobson, *et al.*, "The Private Plan Pitch: Seniors' Experiences with Medicare Marketing and Advertising" (September 12, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising and U.S. Senate Committee on Finance, "Hearing: Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences" (October 18, 2023), https://www.finance.senate.gov/hearings/medicare-advantage-annual-enrollment-cracking-down-on-deceptive-practices-and-improving-senior-experiences.

For marketing improvements to be effective, CMS must also promote informed beneficiary decision-making, so that more enrollees are empowered to evaluate their options and able to choose wisely. As discussed above, these decisions are difficult and carry serious consequences. If an enrollee makes a mistake, they may be stuck in a MA 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.

Plan 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, and CMS is beginning to address plan overload in Marketplace coverage, including by offering standardized plans and increased discussion of meaningful differences between plans.[38] We urge similar consideration in the MA space.

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.

Recommendations and Data Requests

- We recommend capturing and more timely reporting of all information around consumer complaints and reported experiences with brokers, agents, and marketers.
- We also request data regarding plan marketing tactics and efficacy rate, such as the mechanism that was most responsible for generating MA sales (e.g., brokers or marketing); what kind of marketing is most likely to impact enrollment decisions (e.g., in-person events, television ads, phone calls, or mailers); how much plans spend on marketing per year and the number of outputs (e.g., how many mailings are sent per year).
- Payments, commissions, commission residual schedules, bonuses, and other financial incentives brokers and other plan agents receive for any given enrollment should also be publicly available in usable formats.

IV. UTILIZATION MANAGEMENT AND APPEALS

Plan use of utilization management (UM) is becoming more prevalent. For example, in 2018, 80% of MA enrollees were in plans that used prior authorization.[39] By 2022, this number had jumped to 99%.[40] Today, millions of MA enrollees are subject to UM requirements each year, often to detrimental effect.[41]

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[38] Centers for Medicare & Medicaid Services, "HHS Notice of Benefit and Payment Parameters for 2024 Proposed Rule" (December 12, 2022), https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-proposed-rule.

[39] Gretchen Jacobson & Tricia Neuman, "Prior Authorization in Medicare Advantage Plans: How Often Is It Used?" (October 24, 2018), https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used.

[40] Meredith Freed, *et al.*, "Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings" (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/.

[41] Jeannie Fuglesten Biniek & Nolan Sroczynski, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare advantage Plans in 2021" (February 2, 2023), https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.

Expert analysis, as well as our own experience, raises concerns that these practices can interfere with medically necessary treatments, lead to worse health outcomes and higher costs, and contribute to provider burn-out—burdening beneficiaries, providers, and the system.[42] The coverage denials that often result can further impede access to care by forcing beneficiaries to choose between seeking other treatments, paying out-of-pocket, going without, or getting embroiled in the daunting MA appeals system.[43] In 2022, as in previous years, plan denials accounted for nearly one-third of all calls to the Medicare Rights Helpline. Most (65%) were about what to do next.[44] Too often, there is not a simple solution. Multiple watchdog reports indicate prior authorization denials are too often inappropriate, unnecessarily forcing millions of beneficiaries into these choices.[45]

Although new CMS rules introduce greater accountability into plan use of prior authorization, more must be done to sufficiently curtail the use and misuse of UM strategies.[46] These policies require constant and thorough attention. They are necessarily designed to create barriers to care for MA enrollees, and without rigorous oversight allow plans to delay or deny even the most urgent and life-saving care.

Outstanding reforms include tightening audit standards on MA plans, establishing firmer guidance about MA coverage criteria, and requiring MA plans to review their processes and systems to avoid payment errors. We also continue to ask CMS to notify beneficiaries about plan violations—offering enrollment relief where needed—and to explore updating expedited prior authorization timelines so that enrollees can receive timely care.

Attention is also needed to address the aftermath of UM-related coverage denials. Appealing these decisions is an arduous process. We frequently hear from beneficiaries who don't know how to begin. We also hear from those who simply can't; they don't have time to wait for treatment or to wade through what might be a thicket of denials across their care.

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[42] *See, e.g.,* U.S. Department of Health and Human Services Office of Inspector General, "HHS OIG Impact Brief: Medicare Advantage Prior Authorization" (March 2024), https://oig.hhs.gov/documents/impact-briefs/9820/Medicare%20Advantage%20Prior%20Authorization%20Impact%20Brief.pdf; 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; 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 and Julia C. Prentice, *et al.,* "Delayed Access to Health Care and Mortality" (April 2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955366/.

[43] 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.

[44] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2022 Call Data from the Medicare Rights Center's National Helpline" (October 2023), https://www.medicarerights.org/pdf/2022-helpline-trends-report.pdf.

[45] *See, e.g.*, 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.

[46] Centers for Medicare & Medicaid Services, "Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4201-P)" (December 14, 2022), https://www.cms.gov/newsroom/fact-sheets/contract-year-2024-policy-and-technical-changes-medicare-advantage-and-medicare-prescription-drug.

Those who do appeal are typically successful. In 2021, 11% of denials were appealed and more than 80% were overturned.[47] A 2018 investigation similarly found that of the 1% of prior authorization denials that were appealed, 75% were overturned at the first level of review.[48] But even reversals come at a cost, including care delays and adverse health outcomes.[49] These remarkably high overturn rates signal systemic deficiencies with plan determinations and countless beneficiary harms.

The full impact of plan denials is unknown, in part because the MA appeals process is hampered by limited data and transparency. Beneficiaries and advocates alike can struggle to track not only an individual's specific claim, but also improper denial patterns that may be widespread or intentional.

For example, the very limited information that Medicare publishes with the Office of Medicare Hearings and Appeals fails to provide a complete picture of the process and the enrollee experience.[50] CMS does not routinely release publicly accessible appeals information by level of appeal or disposition, nor does the agency share information that could aid beneficiary decisions and CMS oversight, such as whether certain plans have disproportionately high appeal rates.

Better data could lead to better policy, as a more transparent system would lend itself to targeted and evidence-based solutions. Using the data described below, CMS should conduct a comprehensive, in-depth analysis of the MA appeals process and release that information publicly. Similarly, we urge CMS to revise regulations, manual provisions, and other guidance to strengthen other reporting requirements as needed, including to direct plans to disclose to providers, enrollees, and the public the Medicare criteria upon which coverage denials are made, along with relevant citations.

We urge 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. Medicare could also likely review currently collected information to determine whether there are geographic variations on appeals filed and whether beneficiaries with certain diseases or conditions are subject to more denials and appeals. Any trends that emerge should trigger a more comprehensive review to determine the underlying cause, and to obligate the plan to resolve any errors or issues.

This information should also be used to drive compliance. Plans that regularly engage in harmful denial practices should lose the ability to enroll new members or, if the violations are severe, to contract with CMS until corrections are made and publicly documented. Offending plans should remain subject to higher levels of review going forward, and all data captured therein should be made publicly available.

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[47] Jeannie Fuglesten Biniek & Nolan Sroczynski, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021" (February 2, 2023), https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.

[48] 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.

[49] Julia C. Prentice, *et al.*, "Delayed Access to Health Care and Mortality" (April 2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955366/.

[50] U.S. Department of Health and Human Services, "HHS Primer: The Medicare Appeals Process" (last accessed May 29, 2024), https://www.hhs.gov/about/agencies/omha/about/index.html.

It should also be used to bolster informed decision-making. Appeals data should be available to beneficiaries, advocates, enrollment assisters, and researchers. This includes incorporating it into consumer-facing tools like Medicare Plan Finder in a way that indicates rates of denials, appeals, and reversals. Adequate enrollment tools and SHIP capacity would further bolster the utility of this information.

More generally, we continue to urge CMS to simplify the unnecessarily complicated MA appeals system.[51] 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. And, to make the MA appeals process more fair and more manageable, we recommend the first level of appeal be handled by an independent entity, rather than the plan itself. This would simplify the system, promote timely access to care, and encourage plans to make accurate initial coverage determinations.[52]

Recommendations and Data Requests

- We request data on all prior authorization requirements, requests, authorizations, denials and rates of denial, reasons for denials, appeals and rates of appeal, overturn rates, reasons for overturns, and level of appeal reached at resolution.
- Reporting should include instances of abandoned appeals, including stage of and reason for appeal, available detail on the reason for abandonment and subsequent beneficiary response, setting, provider and provider type, service and service type, enrollee diagnoses, and enrollee demographics as described in Section I, above.
- Reporting should also include any use of algorithms, artificial intelligence, machine learning, or decision heuristics and documentation of the utility, fairness, and non-discriminatory design of such.
- Utilization management and appeals data should be integrated into Medicare Plan Finder.

V. SUPPLEMENTAL BENEFITS

According to the Commonwealth Fund, in 2022, supplemental benefits were the most common reason Medicare enrollees cited for choosing MA over Original Medicare.[53] Despite their popularity, there is an alarming lack of data on their utilization, quality, and value.[54]

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[51] *See, e.g.,* Medicare Rights Center, "Policy Recommendations for the Biden Administration" (January 18, 2021), https://www.medicarerights.org/pdf/012021-biden-harris-transition-memo.pdf.

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

[53] Faith Leonard, *et al.*, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (October 17, 2022), https://www.commonwealthfund.org/publications/issuebriefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.

[54] 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.

We often hear from enrollees about these benefits, and about dental coverage in particular. In 2022, 71% of all Helpline calls about MA supplemental benefits were related to dental care.[55] Some were general inquiries about Medicare coverage, but many were regarding plan denials, including instances where providers were out of network or the dental services in question were not covered. More broadly, callers often express frustration about finding information on and accessing supplemental benefits because the services can vary from plan to plan, change every year, have different eligibility requirements, and are not well captured in Medicare Plan Finder.

The lack of transparency and oversight around supplemental benefit offerings is a key reason for this confusion and frustration. For instance, consumers may believe that all MA plans offer all supplemental benefits to all enrollees, or that a given benefit is more generous than it later proves to be. Coverage decisions that overly weight or rely on inaccurate information about supplemental benefits can lead to enrollment choices that undermine beneficiary health and financial security.

We urge CMS to closely examine the value and usage of supplemental 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,[56] Home Health care,[57] and discharge services. We also ask CMS to review the extent to which these benefits are meaningfully available in historically disadvantaged communities, the level of uptake among different population groups, and the extent of program adherence by plan members. Such analysis may reveal plan practices that yield important health improvements, as well as those that function as deliberate barriers to care for sicker enrollees.

We appreciate that "CMS has taken multiple actions that will ensure that, by 2025, CMS has data needed to answer key policy questions related to supplemental benefits, including what is being offered, what plans are spending, which enrollees use which services, the cost to enrollees, and plan-level utilization."[58] We urge the agency to consider capturing additional missing information. For example, it is unclear what beneficiaries are being promised vs. what they have access to, if the benefits meet their expectations, how the benefits are marketed (as discussed above), how easy or difficult the services are to obtain, what beneficiary satisfaction rates are, and what the appeal processes are. As a result, 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 experiences these are not isolated instances. But the dearth of national, systemically collected data makes it impossible to evaluate the extent of any complications and efficacies. Whether or not the benefits are even delivered, much less if they improve enrollees' health or well-being, should not be unanswerable questions. We

[55] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2022 Call Data from the Medicare Rights Center's National Helpline" (October 2023), https://www.medicarerights.org/pdf/2022-helpline-trends-report.pdf.
[56] 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/.
[57] 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.
[58] U.S. Department of Health and Human Services, "Biden-Harris Administration Launches Effort to Increase Medicare Advantage Transparency" (January 25, 2024), https://www.hhs.gov/about/news/2024/01/25/biden-harris-administration-launches-effort-increase-medicare-advantage-transparency.html.

recommend data collection on these issues to better evaluate supplemental benefit access, delivery, and impact as well as the beneficiary experience.

Similarly, we appreciate the updated requirement for MA organizations to separately submit expenditures for supplemental benefits in Medical Loss Ratio reporting.[59] This reporting should be helpful in determining if beneficiaries are truly deriving 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 recommend incorporating it into Medicare Plan Finder to help people compare and understand the scope and availability of each benefit, as well as using it to strengthen Medical Loss Ratio data to ensure vertically integrated companies are not simply masking profits as costs.[60]

We recognize the promise of supplemental benefits, and the inequity in their availability being limited to MA enrollees. We support leveling the MA-OM playing field, including by equalizing coverage. Accordingly, we suggest studying the provision of supplemental benefits in Original Medicare, to provide a basis for expanding access to any that, for example, help prevent hospitalization, improve outcomes, strengthen well-being, lower out-of-pocket costs, or save program dollars.

Recommendations and Data Requests

- We request data on all costs, utilization, denials and reasons for denial, appeals and rates of appeal, out-of-pocket beneficiary spending, and demographic comparisons of those who use, are denied, or who voluntarily do not utilize supplemental benefits, to include demographic information as described in Section I, above.
- Reporting should include all facets of supplemental benefit development and design, eligibility information, and evidence justifying benefit design.
- Accurate and complete supplemental benefit information should be integrated into Medicare Plan Finder.

VI. DUALLY ELIGIBLE INDIVIDUALS AND DUAL ELIGIBLE SPECIAL NEEDS PLANS (D-SNPS)

The diverse, rapidly growing segment of MA enrollees who are dually eligible for Medicare and Medicaid must navigate uniquely complex program considerations, daunting care coordination rules, and complicated plan choices. Some may have access to a Dual Eligible Special Needs Plan (D-SNP) which is an MA plan exclusive to Medicare-Medicaid enrollees. While CMS has taken important steps to increase

[59] 87 FR 27704, 27832.
[60] Richard G Frank & Conrad Milhaupt, "Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation" (2023), https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/ and Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

the level of integrated care within D-SNPs,[61] our experiences reveal that opportunities remain to streamline these systems and empower beneficiaries.[62]

We urge CMS to collect and publish data regarding D-SNP program design, coordination efforts, and enrollee outcomes. Although such information is needed to properly hold plans responsible for delivering coordinated, high-quality care, much of it is not standardized or required. For example, every D-SNP must sign a contract with the state, known as the State Medicaid Agency Contract (SMAC). In these contracts, states typically include care coordination and reporting requirements to promote D-SNP and Medicaid coverage integration. However, these contracts are not publicly available.

Improvements are also needed to enhance the utility of existing public-facing resources in ways that promote informed beneficiary decision-making. Medicare Plan Finder, for instance, is not maximally responsive to the needs of dually eligible enrollees, undercutting their efforts to understand their coverage and navigate their care.

Recommendations and Data Requests

- We request all data around D-SNPs, including data on care coordination, networks, service availability, prior authorization, supplemental benefits, enrollee advisory committee recommendations and representation, denials and appeals, and plan integration level and practical efforts toward integration.
- Collect SMACs and post them publicly.
- Reporting should include data about partial vs. full benefit status.
- Improve the information aimed at people who are dually eligible, including by integrating D-SNP data on integration level into Medicare Plan Finder.

VII. FAVORABLE SELECTION AND RISK ADJUSTMENT

Favorable selection—in which lower-cost beneficiaries enroll in MA, while higher-cost beneficiaries choose OM—has been a feature of MA since its inception.[63] Research suggests that insurers continue to be financially rewarded for attracting healthier and younger enrollees while leaving more expensive beneficiaries behind.

A 2019 KFF analysis found beneficiaries who choose MA have lower pre-enrollment spending than similar people in OM.[64] Similarly, a 2023 MedPAC review of 2019 spending data concluded OM enrollees cost 11% more than their MA counterparts.[65] That same year, a University of Southern California study

[61] *See, e.g.*, Centers for Medicare & Medicaid Services, "FY 2022 Medicare-Medicaid Coordination Office Report to Congress" https://www.cms.gov/files/document/mmco-report-congress.pdf-0.
[62] Medicare Rights Center, "Improving Integrated Care for the Dually Eligible: Policy Recommendations for New York" (May 16, 2024), https://www.medicarerights.org/policy-documents/improving-integrated-care-for-the-dually-eligible-policy-recommendations-for-new-york.
[63] Medicare Rights Center, "Medicare Advantage History: Legislative Milestones" (July 17, 2023), https://www.medicarerights.org/policy-documents/medicare-advantage-history-legislative-milestones.
[64] Gretchen Jacobson, *et al.*, "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" (May 07, 2019), https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/.
[65] Medicare Payment Advisory Commission, "Chapter 4: Favorable selection and future directions for Medicare Advantage payment policy" (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

found that between 2006 and 2019, OM enrollees in relatively good health were more likely to switch to MA than their peers with more costly and complex needs.[66]

The MA payment formula, which bases MA payments on OM costs, is a key reason why favorable selection remains embedded in the MA system. Because MA enrollees are healthier and less expensive than their OM counterparts, the formula overpays MA plans and therefore motivates them to perpetuate the favorable selection cycle.[67] Plans can do so in several ways, such as benefit designs that appeal to healthier enrollees and through more active means, like steering.[68]

The MA risk adjustment model allows for similar payments and behaviors. Currently, Medicare boosts payments to MA plans to cover enrollees that are projected to have relatively high expenses, as indicated by their risk score. MAOs can exploit this by making their enrollees appear sicker than they are, generating higher risk scores and payments without providing additional care. Common strategies include using MAO-controlled entities to conduct health risk assessments and chart reviews that capture "paper only" diagnoses.[69]

While the MA payment methodology incentivizes these practices, lack of data and oversight allows them to flourish. CMS must monitor these practices and intervene as necessary to halt and prevent them, and to ensure beneficiary access to high-quality coverage and care.

Just as favorable selection drives healthy people into MA, it drives those in worse health out. Research from the U.S. Government Accountability Office shows MA enrollees disproportionately switch to OM when their health needs and expenses grow. These can be times of acute stress and illness, when enrollees need reliable coverage the most.[70] Here too, additional data and safeguards are urgently needed.

Recommendations and Data Requests

- We request all data around benefit design decisions; claims, including supplemental and core benefits access; comparisons between MA enrollees and those remaining in OM, with and without supplemental coverage; and any services, supplies, treatments, or diagnoses that are disproportionately found in MA or OM claims.

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[66] Steven Lieberman, *et al.*, "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments" (June 13, 2023), https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments/.

[67] *See, e.g.*, Medicare Payment Advisory Commission, "Chapter 4: Favorable selection and future directions for Medicare Advantage payment policy" (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch4_MedPAC_Report_To_Congress_SEC.pdf; Steven Lieberman, *et al.*, "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments" (June 13, 2023), https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments/ and Gretchen Jacobson, *et al.*, "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" (May 07, 2019), https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/.

[68] Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care" (April 2024), https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf.

[69] *Id.*

[70] *See, e.g.*, U.S. Government Accountability Office, "Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight: GAO-17-393" (April 28, 2017), https://www.gao.gov/products/gao-17-393 and Medicare Rights Center, "Medicare Advantage Disenrollment in Final Year of Life Continues Troubling Pattern" (August 5, 2021), https://www.medicarerights.org/medicare-watch/2021/08/05/medicare-advantage-disenrollment-in-final-year-of-life-continues-troubling-pattern.

- Data on self-reported health status of enrollees and their plan-reported risk scores is needed to determine whether these measures correlate, and to guide corrective and preventive actions.
- We also request information on all instances of plan changes and disenrollments, data on the characteristics of enrollees who switch MA plans or who disenroll to get coverage under OM, including reasons for switching or disenrolling, diagnoses, and demographics as described in Section I, above.
- All prior authorization and other utilization management data as described in Section IV, above.
- All data on home health risk assessments and chart review, including diagnoses based exclusively on such sources and the entities used to conduct these reviews, including any AI or other generative means.
- All data on touchpoints between enrollees and MA affiliates, including providers, pharmacies, brokers and agents, or other organizations, to determine if MAOs are using such affiliates to find and steer healthier or otherwise more profitable enrollees into their plans or to steer sicker enrollees out.
- Reporting should include information on ownership, affiliation, or financial incentives for all companies, provider groups, or organizations performing health risk assessments, chart reviews, or that otherwise drive up risk scores.

Conclusion

Thank you again for the opportunity to provide comment. It is evident MA enrollment and costs are growing, that access issues abound, and that transparency is long overdue. To ensure MA works well for those it is supposed to serve, we urge the immediate and thorough collection and publication of additional data on enrollee demographics; network adequacy, provider availability, and directory accuracy; the use and potential abuse of utilization management strategies and all aspects of MA appeals; on the marketing, access, utilization, spending, and denial of all services, including supplemental benefits; on beneficiary experiences with D-SNPs and plan coordination efforts; and on plan and enrollee interactions with favorable selection and risk adjustment. This information should be granular, regularly reported, and used to guide MA and program-wide improvements. CMS must finally hold plans accountable for the public dollars they use and the promises they make.

For additional information, please contact Lindsey Copeland, Director for Federal Policy 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

Fred Riccardi
President
Medicare Rights Center