

May 29, 2024

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-8013

Re: MA Data RFI

Dear Administrator Brooks-LaSure:

The Center for Medicare Advocacy (Center) appreciates this opportunity to comment on ways the Centers for Medicare & Medicaid Services (CMS) can collect, publish, and act on Medicare Advantage (MA) data to better ensure private insurance companies are serving their enrollees properly and in order to guide CMS oversight of these private plans accepting federal funds.

The Center is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality health care. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with longer-term conditions. The Center's policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues annually. Additionally, the Center provides individual legal representation and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care.

### Introduction

MA now enrolls over 50% of eligible beneficiaries, and MA organizations (MAOs) draw down billions of dollars from Medicare each year. While CMS has made recent improvements in data collection and transparency requirements for MAOs, much of the essential plan data remains concealed.

But while some of the data allow beneficiaries to make more informed choices about plans, the burden of assessing plan noncompliance cannot rest on the shoulders of beneficiaries. Instead, this data and other information must form the basis for vigorous oversight and enforcement of Medicare's statutes and regulations. To protect prospective and current enrollees from an overwhelming and confusing amount of data, CMS (or a third party) should provide selected, useful, plain language data to beneficiaries directly, rather than relying on MA plans to do so. Transparency and ease of use of the data is key to the release of data being meaningful for beneficiaries, advocates and policy makers. In addition, the more granular the data the more we are able to determine trends and identify access issues. Therefore, we ask CMS to collect and standardize data that are disaggregated by race and ethnicity, income, sex, age, disability status of the MA enrollee population, and full-benefit dually eligible status and partial-benefit dually eligible status where applicable.

As the agency is aware, HHS has certain **statutory obligations** to disseminate information about MA plans, including the following information outlined at **42 U.S.C. 1395w-21(d)(4)(D)**:

(D) Quality and performance.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original Medicare fee-for-service program under parts A and B in the area involved), including—

- (i) disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan’s service area),
- (ii) information on Medicare enrollee satisfaction,
- (iii) information on health outcomes, and
- (iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

Similarly, **42 C.F.R. §422.111(f)(8)** requires MA plans to furnish some of the same “quality and performance indicators” information outlined in the statute, upon request by an “individual eligible to elect an MA plan” and “to the extent they are available”.

For purposes of collecting information from plan sponsors and reporting it publicly, CMS should close any gaps in transparency provided by the “to the extent available” language by mandating that these (and other data) be collected and reported. Further, CMS should revise the regulatory language limiting plan obligations to individuals eligible to elect the plan and instead make it publicly available to everyone.

While CMS does post some comparative information on its website, much of the data is aggregated so it is more difficult to review particular plans in a geographic area in relation to traditional Medicare. Thus, CMS should not only collect all information contemplated by the statutory language, but report it in a manner that fosters informed decision-making by Medicare beneficiaries.

Further, the **MA Quality Bonus Program (QBP)** is in dire need of an overhaul. Meant, in part, to serve as a means for consumers to differentiate between MA plans offered in their area, the current measures do not allow for the public to assess meaningful distinctions between plan sponsors. Instead, the QBP has largely served as an additional funding stream for plan sponsors with little public utility.

As noted in *Politico Pulse* (Aug. 10, 2023)<sup>1</sup>, an August 2023 KFF report<sup>2</sup> highlighted that MA bonus payments have “skyrocketed” despite such bonuses being “based on the star rating system,

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<sup>1</sup> <https://www.politico.com/newsletters/politico-pulse/2023/08/10/anti-abortion-activists-rethink-state-approach-00110560>

<sup>2</sup> <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>

a system that the Medicare Payment Advisory Commission [MedPAC] recommended overhauling in 2020, arguing that the system doesn't adequately measure plan quality.”<sup>3</sup>

As the Center has repeatedly highlighted (see, e.g., *Special Report* (Oct. 2021)<sup>4</sup>, *Special Report* (Oct. 2022)<sup>5</sup>), independent analysts in addition to MedPAC have raised concerns about the star rating and bonus payment system. For example, in December 2021, *Health Affairs* published an article titled “The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality” by Adam A. Markovitz, John Z. Ayanian, Devraj Sukul, and Andrew M. Ryan (Vol. 40, No. 12), which found that “the quality bonus program did not produce the intended improvement in overall quality performance of MA plans.”<sup>6</sup>

With respect to beneficiaries using the quality ratings as a means to meaningfully compare plans, an October 2022 article in *JAMA Forum* titled “The Lake Wobegon Effect—Where Every Medicare Advantage Plan Is ‘Above Average’” by Joan M. Teno and Claire Ankuda (Oct. 20, 2022)<sup>7</sup>, states that

The current system for rating the quality of MA plans does not allow consumers to make meaningful comparisons. The millions of US seniors faced with choosing an MA plan deserve to know if a given plan is truly above average—or if a favorable rating might be a fictional entity, not unlike Lake Wobegon's ubiquitously above-average children.

Similarly, the Urban Institute published a report titled “The Medicare Advantage Quality Bonus Program – High Cost for Uncertain Gain” by Laura Skopec and Robert A. Berenson (June 26, 2023)<sup>8</sup>. Among the report's findings are that: “measures of beneficiary experience do not permit meaningful distinctions across MA contracts” and “administrative effectiveness measures do not target important deficiencies regulators have identified within MA organizations.”

Further, “The star rating system and the QBP suffer from many problems, including the following:

- score inflation, which results in overly generous bonuses
- limitations in underlying data sets, which lead to measures focused on the needs of younger and healthier beneficiaries rather than beneficiaries facing serious illnesses
- performance is not measured at the plan or local level, limiting the usefulness of star ratings for beneficiaries' choice”

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<sup>3</sup> See, e.g., MedPAC June 2020 Report to Congress: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun20\\_ch3\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf)

<sup>4</sup> <https://medicareadvocacy.org/wp-content/uploads/2021/10/Report-AEP-and-MA.pdf>

<sup>5</sup> <https://medicareadvocacy.org/special-report-recent-articles-and-reports-shed-light-on-medicare-advantage-issues/>

<sup>6</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00606>

<sup>7</sup> <http://jamanetwork.com/article.aspx?doi=10.1001/jamahealthforum.2022.4320>

<sup>8</sup> <https://www.urban.org/research/publication/medicare-advantage-quality-bonus-program>

Most damning, perhaps, is the finding that: “Despite the 10-year commitment to paying MA plans substantial bonuses to support successful quality improvement, **the preponderance of research does not demonstrate that beneficiaries, on average, receive higher quality care in MA than they would in the traditional Medicare program**” [emphasis added].

The authors of the report state: “Although policymakers’ attention to overpayments has focused mostly on gaming of the risk adjustment system, the [quality bonus program] contributes substantially to overpayment and needs reform.”

Thus, we urge CMS, with the assistance of Congress and legislative action if need be, to significantly revise or replace the QBP, including suggestions made by MedPAC such as requiring measures that evaluate quality at the local market level. Further, the program should be budget-neutral, not merely another revenue stream that most plans can count on qualifying for. Most importantly from a consumer standpoint, any plan comparison tool or measure should allow beneficiaries to actually make meaningful comparisons between plans.

Other measures that CMS could take to foster informed decision-making by beneficiaries include **reinstating MA uniformity standards and meaningful difference requirements**.<sup>9</sup> CMS should also explore **standardizing plan benefit packages** and imposing **limitations on how many plans an individual issuer can offer** similar to current Marketplace rules.

### Beneficiary Access

- Prior Authorization

Currently there are gaps in data collection from MA plans regarding beneficiary access to care. This includes detailed data on prior authorizations, a common obstacle to care for beneficiaries. While we know that almost all MA enrollees are in plans that utilize prior authorizations, much of the detailed data is not currently available.

We appreciate the Advancing Interoperability and Improving Prior Authorization Processes final rule that requires MA plans to publicly report certain prior authorization metrics annually by posting them on the plan website starting in 2026. However, we know that much more data is needed. Average timeframes will also be reported only at the MAO contract level, not the plan level.<sup>10</sup> The timeframes requirements are not broken down by type of service or specific condition. Plans are also not required to report appeals decisions, and overturn rates. This type of limited, aggregate data makes it difficult for policy-makers, regulators and consumers to tease out plan compliance and beneficiary access to services.

We therefore ask that CMS require MA plans to make available detailed data on:

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<sup>9</sup> See, e.g., discussion in CMA Comments to CMS’ RFI re: MA (August 31, 2022), available at: <https://medicareadvocacy.org/wp-content/uploads/2022/09/MA-RFI-Comments-2022.pdf>

<sup>10</sup> [Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency | KFF](#)

- Detailed data on prior authorization denials and appeals in all care settings, including percent of claims for services approved by prior authorization
- The percent of denials that were appealed and to what level of review, as well as the percent of appeals that were overturned, and at what level of review, and denial rates by plan
- Percentage of denials of prior authorization requests made based on medical necessity when compared to other reasons for denial
- Percentage of providers exempt from prior authorization requirements, types of providers and services
- Detailed data regarding if Medicare Advantage enrollees with certain health conditions are more likely to have a prior authorization request denied because of medical necessity than other Medicare Advantage enrollees
- Percentage of prior authorization denials attributed to medical necessity compared to other reasons, such as insufficient documentation or requiring a more basic service first

We also seek data underscoring the impacts of denials of prior authorization, such as the number of beneficiaries who died while waiting for prior authorization. We recognize that data sets seeking the above information might not be complete at the time they are reported; for example, the administrative appeals process might not be exhausted yet, so plans should be required to indicate when appeals are ongoing and complete the data sets the next time they report data.

At the Center, beneficiaries we represent have experienced repeated denials for services that have had successful appeals, particularly in regarding post-acute care. Therefore, we reiterate our request to urge CMS to finalize a provision in the proposed 2024 rule (CMS-4201-P) to impose a minimum time period during which MA plans cannot issue a termination notice after their prior termination decision has been reversed by a Medicare contractor (e.g., the QIO). For example, an MA plan should have to meet a higher burden of proof demonstrating a significant change in beneficiary condition or need warranting a termination of coverage/services, particularly if the provider disagrees with the termination. CMS should consider a grace period of 14 days, at minimum, before a plan can issue another termination notice. This time period would allow a reasonable amount of time to reassess a beneficiary's condition.

We are grateful that CMS will require MAOs to have their utilization management (UM) committees conduct and then make publicly available an annual health equity analysis of the use of prior authorizations for certain populations. Under the provision, the plan-level metrics analysis will highlight the effect of prior authorizations on populations with one or more social risk factors (SRFs): 1) individuals with disabilities and 2) Part D Extra Help enrollees or individuals dually eligible for Medicare and Medicaid. We believe this information will be valuable since there currently is not a data source that compares data for enrollees with the SRFs to populations without them. The 2025 Parts C and D final rule requires plans to make this information easily accessible to the public free of charge. We ask CMS to devote resources to ensuring that plans are compliant with these requirements.

While research indicates that MA plans deny Medicare-covered services that beneficiaries would have access to in traditional Medicare, the full scope of this problem cannot be fully determined

without requiring plans to release this data. We therefore request that CMS require MA plans to release data on denials for Medicare-covered services, including the rate of denials by clinical condition. We also seek data on appeals of such denials, and the rate of subsequent denials of Medicare-covered services that have been successfully appealed.

- Algorithmic and artificial intelligence (AI)-driven decision-making tools

While CMS does not explicitly prohibit use of AI or algorithmic-driven tools, but states that “MA organizations must ensure that they are making medical necessity determinations based on the circumstances of the specific individual, as outlined at § 422.101(c), as opposed to using an algorithm or software that doesn’t account for an individual’s circumstances” and plans “will need to understand the external clinical evidence relied upon in these products and how that evidence supports the coverage criteria applied by these tools” and “must make the evidence that supports the internal criteria used by (or used in developing) these tools publicly available, along with the internal coverage policies themselves” (88 Fed Reg 22195). Despite this requirement, reporting has indicated that plans utilizing such software make decisions in such a short time period that it appears to be an automated formulaic determination, not an individualized assessment, as required.<sup>11</sup>

Since there is limited information and data regarding MA plans’ use of algorithmic and artificial intelligence (AI)-driven decision-making tools and the rate of denials and appeals using those tools, there is no way for CMS to provide vigorous oversight of such tools. Despite plan protests that this is proprietary data, this data is crucially important and must be made publicly available. CMS has a responsibility to provide oversight of the MA program. Unless plans wish to forgo federal funds, plans that are outsourcing their decision making to these tools must provide information to CMS in order for oversight to extend to these tools.

We seek the following data on:

- Rate of prior authorization denials using these tools
  - Rate of coverage denials using these tools
  - Overturn rate of denials using these tools
  - Patient data points used to fill in algorithmic formulas
  - Process of review of these tools to demonstrate that a plan is conducting individualized assessments of their enrollees as required under Medicare rules
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- Provider Networks and Directories

There is pervasive failure on the part of MA plans to provide adequate, stable, and high-quality provider networks for their enrollees. Adding to this problem, MA provider directories are often out of date and misleading. As a result, individuals enrolled in MA plans are at grave risk of not

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<sup>11</sup> [How Medicare Advantage plans use AI to cut off care for seniors \(statnews.com\)](https://www.statnews.com/2019/07/11/medicare-advantage-plans-use-ai-to-cut-off-care-for-seniors/)

receiving the medically necessary care and coverage they need - and to which they are entitled - when they become ill or injured.

Doctors and hospitals are cancelling their contracts with MA Plans. In the last year, several large hospital systems and physician groups in California, Arizona, Florida, Oregon, Oklahoma, South Dakota, Kentucky, Ohio, and Missouri have stopped accepting MA coverage.<sup>12</sup> Some providers have said they have stopped participating in MA because the MA insurers are denying payment to them inappropriately – as often as 20 to 30 percent of the time.

People enrolled in MA plans are discovering that their doctors and hospitals are no longer in-network, forcing them to find new ones. In rural areas and other health care deserts, people covered by MA plans are often forced to travel long distances to get the health care they need.

MA enrollees are at serious loss, as their MA plan provider directories can be completely inaccurate, leading people to enroll in plans that prevent them from using the providers they want to use.<sup>13</sup> Reports of ghost networks and networks that are inadequate abound. A recent Senate Finance Committee investigation resulted in only an “18 percent success rate” in making an appointment with a Medicare Advantage plan mental health provider, even though the MA plans’ directories listed mental health providers as in-network.<sup>14</sup> Networks must be correct for the contract year as they are presented at the time of enrollment. Beneficiaries must not be left with out-of-pocket costs because of deceptive plan actions.

For example, beneficiaries who enroll in a plan because of doctors who are listed as in-network, but are not in the plan for the duration of the plan year should have a special enrollment period in order to switch plans to be able to see their doctor or to go back to traditional Medicare.

CMS could also consider requiring the plan to consider the doctors as in-network for the duration of the contract year. CMS could do this through an existing regulation, recently strengthened by CMS requiring an MA plan to cover care outside of the plan’s network in certain scenarios (in addition to urgent or emergency services):

**\*Title 42, Code of Federal Regulations, Section 422.112(a)(1)(iii) states that an MA plan must:**

“Arrange for and cover any medically necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee’s medical needs.”

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<sup>12</sup> <https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html>; <https://www.medpagetoday.com/special-reports/exclusives/106483?trw=no>

<sup>13</sup> <https://healthpayerintelligence.com/news/medicare-advantage-provider-directories-are-inaccurate-study-finds>

<sup>14</sup> <https://healthpayerintelligence.com/news/medicare-advantage-provider-directories-are-inaccurate-study-finds>

Also see the Medicare Managed Care Manual, [Chapter 4](#), §110.1.1, which states that an MA plan must:

“Regardless of the MA plan type being offered, arrange for medically necessary care outside of the network, but at in-network cost-sharing, in order to provide all Medicare Part A and Part B benefits. That is, if an enrollee requires a medically necessary covered service that is not provided by the providers in the network, the plan must arrange for that service to be provided by a qualified non-contracted provider;”

CMS revised §422.112 in a final rule issued in April 2023 (88 Fed Reg 22120, April 12, 2023). The previous language at §422.112 required that an MA organization provide or arrange for necessary *specialty* care and arrange for specialty care outside of the plan’s provider network when network providers are unavailable or inadequate to meet an enrollee’s medical needs (emphasis added).

In the final rule, CMS explained that “[h]istorically, CMS has interpreted these statutory and regulatory requirements to mean that in the event an in-network provider or service is unavailable or inadequate to meet an enrollee’s medical needs, the MA organization must arrange for any medically necessary covered benefit outside of the plan provider network at in-network cost sharing for the enrollee” (p. 22175). The rule said “[e]nrollees should not bear a financial burden because of the inadequacy of the MA plan’s network” (p. 22175). In order to ensure that regulatory language is consistent with “current, longstanding sub-regulatory policy” and implementation of the Medicare Act (p. 22176), CMS has revised §422.112 accordingly to “ensure adequate access to medically necessary covered benefits for enrollees when the plan network is not sufficient by both arranging or covering the out-of-network benefits and only charging in-network cost sharing for those out-of-network benefits.” (p. 22175) As CMS appropriately broadened the interpretation of this in the above referenced final rule, so it could be expanded in the case of misleading and incorrect directory information. Additionally, CMS should collect and report data on how often MA enrollees request this option and how often plans grant or deny it.

As the Center for American Progress recommends, “CMS must take further action to ensure that the agency has all necessary data for network adequacy enforcement to ensure that beneficiaries can feel confident they are getting what they sign up for. CMS should require plans to report MA network data that is accurate and timely for more than the week after the opening of an enrollment period. For example, CMS could consider requiring MA plans to attest network data accuracy every 90 days, which would comport with the standards Qualified Health Plans are held to as a result of the No Surprises Act. Reporting compliance should also be made public, so that prospective enrollees can see clearly each MA plan’s level of compliance with network accuracy reporting requirements. Considering how important accurate network information is to beneficiaries, CMS should consider that compliance with attestation be part of the agency’s MA star rating methodology.”

#### Dually-Eligible Medicare-Medicaid Population



Individuals enrolled in both Medicare and Medicaid warrant special data attention. This diverse, rapidly growing segment of Medicare Advantage enrollees face heightened care needs compared to other Medicare enrollees. At the same time, their enrollment status in two complex programs means that clear data describing the whole picture can be difficult to obtain. This impacts our ability to access information essential to designing policy that ensures care access. It also impacts the ability for dually eligible individuals to access clear information about their plan choices.

We ask that data about the dually eligible population be made available in a manner that is useful for the dually eligible population. For example, we seek data broken out by type of dually eligible individual (e.g. partial versus full benefit), data on how well plans are fulfilling their obligations to coordinate Medicaid and Medicare, and data on networks, service availability, prior authorization, supplemental benefits, and care coordination. Where possible, data should be available that follows the individual across Medicare and Medicaid payers to give a fuller picture.

We also ask that information about dually eligible special needs plans (D-SNPs) be made public. Currently, the “source of truth” for many D-SNP policies - including who is eligible for D-SNP enrollment and what care coordination requirements a plan must follow - are contained in State Medicaid Agency Contracts (SMACs). SMACs are not uniformly public, hindering the ability of Medicare counselors to help individuals navigate their choices and the ability of policy makers to understand state by state differences in D-SNP policy.

As our colleagues at Justice in Aging noted, “We ask CMS to publish data on how well D-SNPs are complying with integration requirements, including level of care coordination, integrated communications, integrated appeals, enrollee assistance with Medicaid appeals, and establishment and use enrollment advisory committees (including the proportion of committees that are DE individuals and minutes from those meetings). As CMS tests new approaches to integrating Medicare and Medicaid, part of understanding how well these approaches are working includes understanding of how well MA plans comply with new requirements.”

### I-SNPs

There is very little public information about I-SNPs. The Medicare Payment Advisory Commission’s (MedPAC’s) March 2024 [Report to the Congress: Medicare Payment Policy](#) had a single paragraph about I-SNPs (p. 476), which said that there were about 110,000 beneficiaries in I-SNPs in 2023 and about 90% of them are full-benefit dual eligibles. MedPAC wrote: “Most I-SNPs appear to focus on beneficiaries in nursing homes, although there is relatively little data available.”<sup>15</sup>

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<sup>15</sup> [medpac.gov/wp-content/uploads/2024/03/Mar24\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf)

The lack of information about I-SNPs is of special concern for two reasons: first, because I-SNPs are increasingly led and controlled by long-term care facilities and second, because there are concerns about the quality of care received by nursing home residents who are in I-SNPs.

ATI Advisory reported the number of I-SNPs increased from 57 in 2015 (with only two led by long-term care providers) to 174 in 2021 (with 110 led by long-term care providers).<sup>16</sup> The American Health Care Association (AHCA), the largest trade association of nursing facilities, formed a Population Health Management (PHM) Council in 2019 in order “to convene and support long LTC providers who are leading in PHM initiatives through advocacy, education, and quality improvement data.”<sup>17</sup> AHCA identified four organizations – AllyAlign Health, American Health Plans, Longevity Health Plan, and PHHP – “whose sole or primary purpose is to partner with LTC providers to support LTC provider ownership interests in PHM models.”

On AHCA’s website, American Health Plans wrote<sup>18</sup>:

American Health Plans’ provider-owned I-SNPs allow nursing home owners and operators to take control of the LTC residents and realize 100 percent of the shared savings associated with execution of the model of care.

### **Facility level financial returns: 100 percent shared savings**

For too long, the concept of risk-based reimbursement meant an upside to other providers and a downside for nursing home owners and operators. American Health Plans has changed that dynamic. Their members are your residents and 100 percent of the shared savings generated through great clinical results is paid to the nursing facilities. These are savings your facility has earned. American Health Plans ensures you keep them within the facility.

The piece concludes:

### **American Health Plans: control your future by controlling the Medicare premium**

As nursing home owners themselves, American Health Partners appreciates the challenges of clinical resources and cash flow. However, their experience owning and

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<sup>16</sup> [LTC Provider-Led I-SNPs Increase by 38% in Plan Year 2021 | Resources for Innovations in Care | ATI Advisory](#)

<sup>17</sup> <https://www.ahcancal.org/Reimbursement/Pages/Population-Health-Management.aspx>

<sup>18</sup> <https://www.ahcancal.org/Reimbursement/Documents/PHM/American%20Health%20Plans%20Overview.pdf#sea%20rch=I%20DSNP>

operating Medicare Advantage Plans since the inception of the program in 2004 has allowed them to realize the clinical and financial power of controlling the Medicare premium for their nursing home residents. They want to partner with you to bring the clinical program and financial upside to your facilities as well.

In March 2019, MedPAC reported that I-SNPs in 2017 had average margins of 9.4% (14.1% in 2016), compared to Medicare Advantage plans' average margins of 2.7%.<sup>19</sup>

Quality of care for residents is a second major concern about I-SNPs. In 2013, MedPAC supported permanent reauthorization of I-SNPs, but made two disturbing comments about the care provided by I-SNPs – that I-SNPs “have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions” and “fewer hospital readmissions than would be expected given the clinical severity of their enrollees.”<sup>20</sup>

### Enrollment

More data must be collected and made public about agents and brokers, who can financially benefit from enrolling beneficiaries in specific MA plans. Each MA and Part D enrollment should capture data regarding who, if anyone, assisted the enrollee (e.g. agent/brokers, SHIP, 1-800-MEDICARE), where the enrollment took place. If an agent/broker assisted, then data must be collected that includes name, license number, and affiliated TPMP or other employer. CMS should maintain a public database of broker IDs linked to MAO payments received, which includes how brokers are paid across different MAOs and how that proportion varies by type of plan enrolled. CMS should also collect data on the number of brokers working directly for an insurer, number of beneficiary complaints about individual brokers and brokerage firms/TPMPs, by broker and license number and employer/contracting entity. Brokers should be required to report all provider groups with whom they have a financial relationship.

In an effort to ensure that consumers understand what product they are enrolling in, and the corresponding consequences, including any changes to their current coverage, CMS should explore requiring agents/brokers to sign attestations that whatever product is being sold by said agent/broker (MA, Part D) is appropriate for that beneficiary; such an attestation is currently required for the sale of a Medigap.

While the insurance industry often touts MA products as being more affordable and comprehensive than traditional Medicare options, oftentimes agents/brokers selling MA plans also cross-sell ancillary or other supplemental products alongside MA plans.<sup>21</sup> Under current Medicare marketing rules, MA organizations may not “Market non-health care related products

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<sup>19</sup> [mar19\\_medpac\\_ch13\\_sec.pdf](#)

<sup>20</sup> [chapter-14-medicare-advantage-special-needs-plans-march-2013-report-.pdf \(medpac.gov\)](#)

<sup>21</sup> See, e.g., CMA Alert: <https://medicareadvocacy.org/ma-and-selling-extra-products/>

to prospective enrollees during any MA sales activity or presentation. This is considered cross-selling and is prohibited.”<sup>22</sup> This regulation has such a limited definition of “cross-selling” that it allows a broad range of exploitative behavior, including the sale of ancillary health products during MA sales. We urge CMS to revise these rules to expand the prohibition to include “health related products.” Absent prohibition of such sales, the agency should require agents/brokers and others to report if any ancillary products are sold corresponding to each MA sale in order to gauge the extent to which agents/brokers are maximizing their commissions.

Information regarding enrollee disenrollment is also essential in determining underlying access to care issues (and, as discussed above, is statutorily required). CMS should collect and make public disenrollment data/rates by plan, including plan switching and returning to Traditional Medicare, as well as the percentage of enrollees who disenrolled from the contract-plan who had a claim denied, and those rapidly disenrolled. Data on reasons Medicare Advantage enrollees switch plans or disenroll for reasons that differ from reasons other groups of Medicare Advantage enrollees disenroll or switch, broken down by demographic data is key to understanding barriers to care. CMS should also collect data on subsequent Medigap enrollment, by state, as well as the number of providers departing the plan network, per plan year.

MA plans extensively advertise supplemental benefits to drive enrollment in their plans. Despite this, the extent to which beneficiaries access and utilize these benefits is unclear. It is essential for data on utilization of these benefits and detailed payment and spending data, including out-of-pocket beneficiary spending on extra benefits, to be made publicly available. Therefore, we seek data on beneficiary liability by Medicare ID number by type of benefit, as well as average per capita liability by contract-plan. We also seek more detailed information on networks used for supplemental benefits, in addition to encounter data for claims. We also believe data on beneficiary liability for supplemental benefits, among beneficiaries who used the benefit, by type of supplemental benefit, including average liability among users per contract-plan ID, and liability for users by Medicare ID number would be helpful in understanding plan enrollees’ use of such benefits.

We also ask that CMS make it easier for the public to obtain information around Medicare Savings Program (MSP) enrollment. Currently, one must request from CMS the various relevant data sources. It would also be useful to see state-by-state data on LIS enrollees who are not also enrolled in the MSPs as this group might represent individuals who are eligible for the MSPs, but not enrolled. Understanding them better could make it easier for states and enrollment counselors to engage in more targeted outreach. Additionally, since MA plans are able to provide screening and application assistance for SNAP and MSP, we ask that CMS collect data on the proportion of each MA plan’s population that are likely eligible, but not enrolled in MSP and other public benefits.

### Home Health

As the Center has written in comments submitted to CMS on numerous occasions, home health services as authorized by Medicare law, regulation and policies are increasingly unavailable in

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<sup>22</sup> 42 CFR §[422.2263](#) (b)(4).

practice. For patients who meet qualifying criteria, Medicare law authorizes up to 28-35 hours a week of home health aide and nursing services combined, as well as therapies and medical social services.<sup>23</sup> While this coverage law has not changed, home health aides services, as a percentage of total home health visits, has declined from 48% of total services in 1997 to 5% in 2021.<sup>24</sup> According to federal regulations, home health aides must provide “hands on personal care services,” such as bathing, dressing, grooming, feeding, toileting, transferring and numerous other services that are needed to help maintain the individual’s health or to facilitate treatment.<sup>25</sup> Unfortunately, in practice, patients can rarely access even a fraction of these Medicare-covered aide services. Patients may contact every Medicare-certified home health agency (HHA) that serves their home zip code<sup>26</sup>, seeking Medicare-covered services, only to find no HHAs willing to provide aide services. As reflected in a recent study of 217 HHAs by the Center, aide access problems are especially difficult for homebound beneficiaries with chronic, longer-term, and disabling conditions who need both skilled and aide services to effectively maintain or slow decline of their condition and stay safe and healthy at home.<sup>27</sup>

The Center hears regularly from MA enrollees who meet Medicare criteria for home health services, but who are denied prior authorization, or who are granted approval for a limited number of services, inadequate to meet their care needs. Appealing denials may yield additional services, but MA plans know that less than 1% of Medicare beneficiaries in MA plans appeal denials, although 75% of beneficiaries who appeal have their appeals approved, according to the HHS OIG<sup>28</sup>. Beneficiaries should not be forced to deal with overly aggressive denials by MA plans for covered services. Given all the red flags about Medicare Advantage identified by OIG and others, CMS should take a more active role in ensuring that MA plans follow the law and rules under which they contract with Medicare to provide services to beneficiaries. Specifically, regarding home health care, the following data points would be essential to proper oversight:

- Number of requests made for home health services, and how many are approved versus denied
- Number of orders altered and services not delivered
- Number of enrollees who are not pre-approved for any/or reduced services and why

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<sup>23</sup> 42 U.S.C. §1395x(m)(1)-(4). Receipt of skilled therapy can also trigger coverage for home health aides.

<sup>24</sup> MedPAC March 2023 Report to Congress, page 250 [MedPAC March 2023 Report to the Congress: Medicare Payment Policy](#); MedPAC March 2021 Report to Congress, page 245 [http://medpac.gov/docs/default-source/reports/mar21\\_medpac\\_report\\_to\\_the\\_congress\\_sec.pdf](http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf); MedPAC March 2019 Report to Congress, page 234 [mar19\\_medpac\\_entirereport\\_sec\\_rev.pdf](#)

<sup>25</sup> 42 CFR §409.45(b)(1)(i)-(v). See also, Medicare Benefits Policy Manual, Chapter 7, §§50.1 and 50.2.

<sup>26</sup> [Find Healthcare Providers: Compare Care Near You | Medicare](#)

<sup>27</sup> <https://medicareadvocacy.org/wp-content/uploads/2020/06/Medicare-and-Family-Caregivers-June-2020.pdf>

<sup>28</sup> [Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials \(OEI-09-16-00410; 09/18\) \(hhs.gov\)](#)

- Early discharges by agencies before orders are fulfilled

### Dental Services

At the Center we understand that enrollees often find MA plans appealing because of the extra benefits, particularly dental services. While we know that most MA plans offer some kind of dental benefit, these services and the out-of-pocket costs associated with them can vary widely among plans. Because dental services are so important to over health and quality of life and because they are a large driver in enrollment in plans, more data on this benefit must be collected and shared publicly. We request the following of MA plans that offer dental coverage:

- Number or percent of enrollees that have used dental benefits
  - Number of dental claims submitted
  - Average amount paid on dental claims
  - Total amount paid on dental claims
  - Claims breakdown based on type of dental service (e.g., exam, cleaning, filling, periodontal, extraction, etc.)
  - The number of in-network dentists per county or zip code, the number of dental claims submitted per county or zip code
  - Total out-of-network dental claims paid by the plan
  - Number of out-of-network dental claims submitted per county or zip code
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- Dental services that are “inextricably linked” to a covered medical procedure

As an advocacy organization, the Center receives calls and emails on a daily basis from Medicare beneficiaries across the country. For decades now, the absence of coverage for medically related dental care has been one of the pressing problems that we most frequently hear about. The individuals who contact us experience high risks to their health and health care treatment, as well as very compromised quality of life because they cannot readily afford this dental care.

The Center reiterates its praise of the current Administration and the team at CMS for their diligent efforts to improve treatment outcomes for Medicare beneficiaries who require medically essential dental care. We appreciate the clarifications by CMS in the Physician Fee Schedule the last few years that Medicare payment may be made for dental services that are inextricably linked to, and substantially related and integral to the clinical success of a covered medical service for certain conditions.

The Center understands that several pieces must align in order for Medicare patients to actually access the dental services that are inextricably linked to their covered medical treatments. We also understand that while CMS may be able to guide or influence some of those pieces, the

agency does not control all of the pieces. That said, we urge CMS to utilize all available vehicles within its means to educate relevant providers about the payment policy, address concerns and uncertainties they may have about the policy, and encourage dentists to enroll in Medicare. We are particularly concerned that MA plans are not meeting their obligations regarding this type of dental care. In order to improve implementation of this clarification, more data is needed.

We are seeking the following:

- The number of calls that the plan received concerning how to access covered services
- The number of claims submitted to the plan for coverage of these services
- The number of claims processed by the plan for these services
- The number of denials and the number of appeals of denials for services
- Total amount paid on “inextricably linked” dental services

## **Conclusion**

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

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