



May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-4207-NC–Medicare Program; Request for Information on Medicare Advantage Data

Submitted electronically via <https://www.regulations.gov>.

Dear Administrator Brooks-LaSure and Secretary Becerra,

Thank you for your commitment to strengthening CMS’s data capabilities with respect to Medicare Advantage (MA), and for providing the opportunity to respond to the MA Data request for information (RFI). This response is submitted on behalf of the Center for American Progress (CAP) with support from organizations and individuals listed below. CAP is an independent, nonpartisan policy institute based in Washington, D.C. dedicated to improving the lives of all Americans through bold, progressive ideas, strong leadership, and concerted action. CAP’s interconnected teams of policy experts and advocates have spearheaded and published research on Medicare and MA reform, as well as data transparency in government, health care, higher education, and the private sector. We welcome the opportunity to provide input on further

improving the MA program through the collection and handling of comprehensive, high-quality data and increased data transparency.

We applaud CMS’s ongoing efforts to strengthen beneficiary protections, promote healthy competition, and ensure MA plans meet the needs of enrollees, including through recent rules to address broker incentives, streamline and strengthen prior authorization requirements, and expand reporting requirements for the use of supplemental benefits. Further, we share CMS’s goal to “have, and make publicly available, MA data commensurate with data available for Traditional Medicare to advance transparency across the Medicare program, and to allow for analysis in the context of other health programs.”¹ Unfortunately, existing gaps in the reporting requirements for Medicare Advantage Organizations (MAOs) constrain researchers in their ability to fully assess MA plans, limit policymakers and regulators in their ability to conduct oversight of MAOs and MA plan performance, and prevent beneficiaries from making fully informed choices. These gaps also make it difficult to assess the degree to which MA plans are succeeding or lagging in efforts to address health disparities and advance health equity.

For publicly available MA data to be commensurate with Traditional Medicare (TM) data, CMS must require more – and more detailed – data from MAOs. In CMS’s final rule issued in February 2024, however, the agency opted against requiring an increased level of granularity in reporting from MA plans due to a concern that “reporting at the specialty level and service level could be overwhelming because of the volume of information presented.”² While we appreciate that large data sets could confound beneficiaries, there is no public benefit in limiting the volume of data made available to regulators, researchers, and policymakers. Further, it is incumbent upon CMS to ensure the relevant amount of useful data is presented to beneficiaries in plain language. It is possible that MA plans already collect and have easy access to this information.

¹ Centers for Medicare & Medicaid Services, “Medicare Program; Request for Information on Medicare Advantage Data,” January 30, 2024, available at <https://www.federalregister.gov/documents/2024/01/30/2024-01832/medicare-program-request-for-information-on-medicare-advantage-data>.

² Centers for Medicare & Medicaid Services, “Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children’s Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally- Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program: Final Rule,” Federal Register 89 (27) (2024): 8890, available at <https://www.govinfo.gov/content/pkg/FR-2024-02-08/pdf/2024-00895.pdf>.

We encourage CMS to update the agency’s reasoning on granularity and make comprehensive data transparency from MA plans the requirement.

In this letter, we outline several areas of concern regarding gaps in CMS’s collection and reporting of MA data: broker compensation, network adequacy, prior authorization (PA), supplemental benefits, disenrollment, and enrollee out-of-pocket (OOP) cost expenditures. Our comments are guided by CAP’s three goals for MA data collection: 1) to ensure that the MA program is providing beneficiaries with fair, reliable, and useful information that enables them to make informed enrollment choices; 2) to protect beneficiaries enrolled in MA plans from inadequate coverage and harmful practices; and 3) to ensure that the MA program is working optimally for contracted clinicians, enabling them to practice appropriate and high-quality care.

As advancing health equity is central to the missions of both CMS and CAP, each of these goals should be viewed through an equity lens, in an effort to safeguard and improve health care access for historically marginalized populations and enrollees with significant health care needs.³ MAOs, as well as the TM program, should be responsible for eliminating avoidable differences in quality of care and health outcomes and ensuring the provision of care and support that *all* Medicare beneficiaries need to thrive.

Of course, assessing progress toward these goals can only happen if there is adequate enforcement of data transparency requirements. Enforcement of existing data reporting and submission requirements is already inadequate. For that reason, CMS and Congress should take aggressive steps to ensure that MAOs are held accountable for existing reporting requirements as well as all new transparency requirements alike. CMS should also ensure the public is made aware of any failures of MAO data reporting compliance.

CMS must also ensure that MA data (in timing, format, and function) is commensurate with TM data to allow for apples-to-apples comparisons between the programs.

³ Centers for Medicare & Medicaid Services, “CMS Framework for Health Equity 2022–2032,” available at <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf> (last accessed May 2024).

Broker Compensation and Tradeoffs When Enrolling in MA

Agents and brokers, who can financially benefit from directing beneficiaries to enroll in specific MA plans, can be aggressive about reaching out to newly eligible beneficiaries and pushing them towards the MA plans with which they may have financial arrangements (which may not necessarily be the best plans for a beneficiary's needs).⁴ One third of all new beneficiaries receive guidance from brokers or agents compensated by MAOs.⁵ It is vital that beneficiaries receive unvarnished facts about the impacts of the choice they are making, which must include the financial incentives of the people steering them toward enrollment decisions.

Recent CMS rules now limit the compensation brokers receive from insurers, but insurers do not have to publicly disclose those compensation arrangements.⁶ MA marketing practice oversight is difficult to perform without this transparency. As a result, CMS has had to rely on using “secret shoppers” and other monitoring activities to understand the practices of the brokers and agents representing MA plans.⁷ A 2022 report by the majority staff of the U.S. Senate Committee on Finance, using research that tracked insurance company behaviors by looking at customer complaints, found instances of aggressive or deceptive MA marketing to be widespread.⁸ In each of the ten states reporting quantitative data to the report, beneficiaries complained of being switched to a new plan and discovering that their current doctors were not in their new network of providers.⁹

⁴ Jeannie Fuglesten Biniek and others, “How Health Insurers and Brokers Are Marketing Medicare,” KFF, September 20, 2023, available at <https://www.kff.org/report-section/how-health-insurers-and-brokers-are-marketing-medicare-report/>.

⁵ Faith Leonard and others, “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why,” Commonwealth Fund, October 17, 2022, available at <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

⁶ Centers for Medicare & Medicaid Services, “Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F),” Apr 04, 2024, available at <https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f>

⁷ Abby L. Block, “Final Marketing Provisions and CMS Marketing Surveillance,” Centers for Medicare & Medicaid Services, September 26, 2008, available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/agentbrokermemo_215.pdf.

⁸ Majority Staff of the U.S. Senate Committee on Finance, “Deceptive Marketing Practices Flourish in Medicare Advantage” (Washington: 2022), available at <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>.

⁹ Ibid.

Policymakers should not have to rely on secret shopping and Congressional investigative reports to regulate broker behavior. CMS should collect and publish complete data on paid broker compensation (including total amounts brokers are paid across different MAOs and how that proportion varies by type of plan enrolled), report when a broker is involved in a beneficiary's enrollment in an MA plan, and maintain a public database of broker IDs linked to MAO payments received.

To further protect prospective enrollees, brokers should be required to proactively disclose whether they are being compensated by MAOs, as well as which MAOs are paying them.

Finally, but no less critically, brokers should be required to proactively explain to beneficiaries in plain language what enrolling in an MA plan means when they are doing so for the first time. Currently, beneficiaries are not made sufficiently aware of the tradeoffs between TM and MA when they initially sign up for Medicare, or when they switch from TM to MA. For example, many beneficiaries are surprised to find out after being enrolled in an MA plan for over a year they can be denied Medigap plans due to pre-existing conditions if they want to switch back to TM, leaving them exposed to burdensome cost-sharing.¹⁰ This can effectively close the door on a switch over to TM. Some beneficiaries have described this as being “trapped” in MA.¹¹ We encourage CMS to strengthen and make even more prominent its plain-language guidance on the tradeoffs between TM and MA, require brokers and agents to proactively share that information with beneficiaries (including perhaps through requiring that first-time MA enrollees sign an acknowledgement—akin to a HIPAA notice—indicating that they have been made aware of those tradeoffs), and make those tradeoffs clearer in CMS's own guidance. Given how consequential that choice can be, CMS should impose significant penalties for a broker's failure to communicate that information.

¹⁰ Cristina Boccuti and others, “Medigap Enrollment and Consumer Protections Vary Across States,” KFF, July 11, 2018, available at <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>.

¹¹ Matthew Cunningham-Cook, “The Medicare Advantage Trap,” American Prospect, November 29, 2023, available at <https://prospect.org/health/2023-11-29-medicare-advantage-trap/>.

Network Adequacy and Accurate Provider Directories

Adequate provider networks and accurate, up-to-date provider directories are essential to prospective enrollees' ability to make informed choices. When deciding whether to enroll in a particular MA plan, a beneficiary should know with certainty whether a particular doctor is in a plan's network, and whether they will have access to a range of providers they deem sufficient for their needs.

CMS requires MAOs to maintain networks of appropriate providers that are sufficient to provide adequate access to covered services to meet the needs of the population served and consistent with the pattern of care in the network service area.¹² Yet, a 2018 CMS review found inaccuracies in nearly half of listed provider directory locations including incorrect addresses and providers being listed as accepting new patients or MA plans when they in fact were not.¹³ The previously mentioned report by the majority staff of the U.S. Senate Committee on Finance also found instances of brokers and agents falsely claiming that networks included preferred providers when they in fact did not.¹⁴ It is impossible for prospective enrollees to make informed choices when the information they are being provided is inaccurate.

CMS regulations effective June 2022 and June 2023 partially addressed this issue by strengthening restrictions on MA plans and third-party marketing organizations,¹⁵ but 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

¹² Centers for Medicare & Medicaid Services, "Network Adequacy," available at <https://www.cms.gov/medicare/health-drug-plans/network-adequacy> (last accessed May 2024).

¹³ Centers for Medicare & Medicaid Services, "Online Provider Directory Review Report" (Washington: 2018), available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.

¹⁴ Majority Staff of the U.S. Senate Committee on Finance, "Deceptive Marketing Practices Flourish in Medicare Advantage."

¹⁵ Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," Federal Register 87 (8) (2022): 27707-27902, available at <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>; Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," Federal Register 88 (70) (2023): 22122-22341, available at <https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf>.

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.¹⁶ 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.

Given the serious consequences an enrollee might face if they select an MA plan only to discover they will not have access to a doctor they need, enforcement of network directory accuracy rules must be robust. Additionally, CMS should ensure there are explicit protections that would allow for an enrollee to change MA plans or return to TM without being subject to medical underwriting for supplemental Medigap policies if their MA plan directory was inaccurate at their time of enrollment. For example, CMS can clarify that if an enrollee makes such a discovery, it should be considered a misleading MA practice and accordingly trigger a Special Enrollment Period (SEP) for supplemental benefits.¹⁷

Prior Authorization

Prior authorization (PA) is a utilization management tool through which insurance companies require advance approval for certain medical care or medications as a condition for payment. While TM uses PA for very few services, nearly all MA enrollees (99 percent) are in plans that require PA for some services.¹⁸ The argument in favor of PA when first introduced was that by determining medical necessity and limiting unnecessary procedures and services, insurers

¹⁶ U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, "No Surprises Act: Overview of Key Consumer Protections," November 2023, available at <https://www.cms.gov/files/document/nsa-keyprotections.pdf>.

¹⁷ Centers for Medicare & Medicaid Services, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," 2024, available at <https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf>.

¹⁸ Center for Medicare Advocacy, "Medicare Prior Authorization," available at <https://medicareadvocacy.org/prior-authorization/> (last accessed May 2024); Nancy Ochieng and others, "Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings," KFF, August 09, 2023, available at <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>.

could lower costs by reducing wasteful spending.¹⁹ In practice, however, PA now mostly complicates the decision-making process for doctors and patients who must not only determine the best course of treatment for a diagnosis, but also consider what an insurance company will approve. Waiting for PA approvals, going through the process of appealing denials, and ultimately being denied care can lead to stress and anxiety for beneficiaries. Of course, delays and denials of care caused by PA processes can also result in actual harm to patients' health.

PA requirements can create an immense administrative burden on health care providers. An AMA survey found that physicians completed an average of 45 PA requests per week in 2021, which required an average of 14 hours of work for physicians and their staff.²⁰ A third of physicians now have staff members *assigned exclusively to PA*, and nearly 9 in 10 physicians describe the burden associated with PAs as high.²¹

Over 35 million PA requests were submitted to MA insurers in 2021—an average of 1.5 per enrollee.²² PA request frequency and volume varied meaningfully across MAOs in 2021, ranging from 0.3 to 2.9 PA requests per enrollee on average that year.²³ When making enrollment decisions, beneficiaries should know how heavily individual plans use PA in making care or reimbursement decisions.

CMS rules finalized in 2024 will require MAOs to: 1) streamline prior authorization processes, send notices to providers when they make a prior authorization decision, and include specific reasons for denials; and 2) publicly report aggregated data on prior authorization approvals, denials, and appeals; and improve transparency on prior authorizations, enrollment, and

¹⁹ Jeff Madrick, "Economic Scene; Does Medicare or private insurance do a better job of controlling health care costs?", *New York Times*, November 27, 2003, available at <https://www.nytimes.com/2003/11/27/business/economic-scene-does-medicare-private-insurance-better-job-controlling-health.html?searchResultPosition=3>.

²⁰ Tanya Albert Henry, "Fixing prior auth: 40-plus prior authorizations a week is way too many," *JAMA Network*, April 29, 2024, available at <https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-40-plus-prior-authorizations-week-way-too#:~:text=On%20average%2C%20practices%20complete%2045,work%20exclusively%20on%20prior%20authorizations>.

²¹ *Ibid.*

²² Jeannie Fuglesten Biniek and Nolan Sroczyński, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021, February 02, 2023, available at <https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/>.

²³ *Ibid.*

financial relationships between brokers and plans.²⁴ These rules do not, however, require a level of data granularity that would be sufficiently meaningful to beneficiaries, researchers, regulators, and policymakers.²⁵ Meaningful data on PA would include information at the MA plan level, as well as PA data by type of service and enrollee characteristic.

CMS rules require MA plans to inform enrollees and providers of the reasons for denials of PA requests, but CMS itself does not receive or collect this data. New CMS rules will also require that MAOs publish (aggregate) denial reasons on their websites, but this should not be a substitute for CMS data collection and monitoring.²⁶

Starting in 2026, MAOs will be required to publish the average timeframe for prior authorization decisions aggregated across request types on their company websites, but that data will not be made available to researchers in a single file.²⁷ Instead, interested parties will be able to access that data only by visiting each individual website, which places an unreasonable burden on the public. Average timeframes will also be reported only at the MAO contract level,²⁸ not the plan level, and MAOs are not required to include timeframes by type of service or specific conditions, making it impossible for researchers and regulators to ensure that all plans are comporting with CMS rules, or for prospective enrollees to gauge how difficult it might be to access the types of services that may matter most to them. There are also no requirements for MA plans to report timeframes for appeals decisions.²⁹

²⁴ Centers for Medicare & Medicaid Services "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program," Federal Register 89 (27) (2024): 8758-8988, available at <https://www.govinfo.gov/content/pkg/FR-2024-02-08/pdf/2024-00895.pdf>.

²⁵ Jeannie Fuglesten Biniek, Meredith Freed, and Tricia Neuman, "Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency," KFF, April 10, 2024, available at <https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/>.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

Some MA plans have started exempting certain providers from PA requirements through a process called “gold carding.”³⁰ CMS should require that MA plans report the number or percentage of exempted providers to provide the agency and researchers with data on how frequently that is occurring, and how the proportion is changing over time.

Furthermore, CMS does not require MAOs to report the share of MA claims that are denied after service has already been provided.³¹ This tactic appears to be growing. According to research from the American Hospital Association (AHA) and Syntellis, revenue reductions related to Medicare Advantage denials increased 55.7 percent for the median hospital over the 18 months preceding July 2023.³² It is important for CMS to have information on all payments denied for services (including whether those denials were for in or out-of-network services) to ensure that MAOs are abiding by program rules. This information should also be publicly reported. Providers in particular should have information about how frequently specific MA plans deny payments to help them assess whether to enter into a contract with an MAO. Prospective MA enrollees considering a plan with out-of-network coverage (who would thus be expected to foot the bill for denied claims) also have a vested interest in knowing how frequently claims for out-of-network services are denied.

Remaining PA data gaps also prevent researchers from determining whether PA is applied more often for certain services or groups of enrollees.³³ CMS must closely monitor data for disparities in care delivery to ensure that no one group is disproportionately experiencing denials of PA requests or claims denials. Disaggregated data, which would also allow for researchers to examine specific trends within sub-groups of enrollees, such as people of color or those with chronic conditions, will be reported only at the contract level, not at the plan or encounter level, leaving many disadvantaged populations without a potentially valuable tool for

³⁰ Kaye Pestaina and others, “CMS Prior Authorization Proposal Aims to Streamline the Process and Improve Transparency,” KFF, February 21, 2023, available at <https://www.kff.org/affordable-care-act/issue-brief/cms-prior-authorization-proposal-aims-to-streamline-the-process-and-improve-transparency/>.

³¹ Biniek, Freed, and Neuman, “Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency.”

³² Jakob Emerson, “American Hospital Association: Medicare Advantage denials jump 56%,” Becker’s Hospital CFO Report, November 21st, 2023, available at <https://www.beckershospitalreview.com/finance/american-hospital-association-medicare-advantage-denials-jump-56.html>.

³³ Biniek, Freed, and Neuman, “Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency.”

comparing MA plans.³⁴ CMS should require this degree of plan-level reporting through future rulemaking.

MA plans' use of Artificial Intelligence (AI) during the PA process is also of growing concern. For example, journalistic investigations have uncovered situations where algorithmic determinations seemingly overruled the judgements of doctors in discharging nursing home patients.³⁵ Beyond denying access to needed care, algorithm-assisted denials of PA requests can also burden beneficiaries, caretakers, and providers with arduous appeals processes. Policymakers and researchers currently do not have sufficient access to the algorithms insurers use in the PA process. Accordingly, there is no way to be certain what the determinations are based on, how much influence humans (and beyond that, professionals with appropriate credentials) have on decisions, or whether AI is involved in the appeals process.

CMS rules dictate that MA plans must comply with TM standards for denials of care, and we appreciate the recent clarification from CMS that any algorithm or AI must comply with all of the rules at § 422.101(c) for making a determination of medical necessity, but without a clear understanding of the processes MA plans use to assist with decision-making—including access to underlying algorithms and AI tools—compliance is very hard to enforce.³⁶ We recommend that CMS require MAOs to report the standards used for all electronic PA requests and appeals determinations, including those made with assistance from algorithms and AI.

We also recommend that MAOs be required to report to CMS the reasons for all PA and PA appeals denials, as well as the timeliness of responses to PA requests and appeals, at the plan level and by type of service. Those data, disaggregated to monitor for patterns of inequities, should be made accessible to researchers along with all the other data CMS collects and makes available. To the extent possible, this information should also be included in MA encounter data.

³⁴ Ibid.

³⁵ Zahida Siddiqi, "AI Use by Medicare Advantage Blamed for Increased Denial of Nursing Home Services," Skilled Nursing News, March 13, 2023, available at <https://skillednursingnews.com/2023/03/ai-use-by-medicare-advantage-blamed-for-increased-denial-of-nursing-home-services/>.

³⁶ Centers for Medicare & Medicaid Services, "Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)," February 6, 2024, available at <https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf>.

Supplemental Benefits

We share CMS's concern that supplemental benefits, which are extensively marketed by MA plans, may attract beneficiaries only to be un- or under-utilized, nullifying any potential health value.³⁷ The little research that is available suggests that MA plan coverage for dental, vision, and hearing services has not resulted in improved access for beneficiaries.³⁸ CMS must collect more granular information on supplemental benefit use in order to ensure that feature of the MA program is working as intended.

To that end, CMS has recently required MAOs to report utilization and cost data for all supplemental benefit offerings.³⁹ However, CMS does not require that data be reported at the beneficiary level, making it impossible to determine how spending varies amongst beneficiaries or how much different groups are actually spending out-of-pocket (OOP) on supplemental benefits that should be covered by their MA plans.⁴⁰ Plans are also required to report spending by category of supplemental benefit (such as dental or hearing), and some levels of spending by transaction type (such as dental x-ray or hearing aids), but that information is also not reported at the beneficiary level.⁴¹ Further, there is no public data on how often prior authorization requests for supplemental benefits are denied, or why they are denied.⁴²

³⁷ Centers for Medicare & Medicaid Services, "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024—Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE)," Federal Register 89 (79) (2024): 30561-30562, available at <https://www.govinfo.gov/content/pkg/FR-2024-04-23/pdf/2024-07105.pdf>.

³⁸ Meredith Freed and others, "Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage," KFF, September 21, 2021, available at <https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/>; Rahul Aggarwal, Suhas Gondi, and Rishi K. Wadhwa, "Comparison of Medicare Advantage vs Traditional Medicare for Health Care Access, Affordability, and Use of Preventive Services Among Adults With Low Income," *JAMA Network Open* 5 (6) (2022): e2215227, available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793106>.

³⁹ Centers for Medicare & Medicaid Services, "Medicare Part C Technical Specifications Document Contract Year 2024," available at <https://www.cms.gov/files/document/cy2024-part-c-technical-specifications-01092024.pdf> (last accessed May 2024).

⁴⁰ Biniek, Freed, and Neuman, "Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency."

⁴¹ *Ibid.*

⁴² *Ibid.*

We recommend that CMS collect and publish utilization and OOP spending data for all supplemental benefits, disaggregated by enrollee race, ethnicity, gender, income level, and other important demographic characteristics, at both the plan and beneficiary level. This information should be stratifiable by benefit transaction/service type. We also recommend that complete data on the use of prior authorization for supplemental benefits, including rates of denials on PA requests, be reported to CMS and made publicly available.

Disenrollment Rates

Understanding the demographic and health characteristics of MA enrollees who switch between MA plans or disenroll from MA plans in favor of TM coverage is important for both researchers and regulators in spotting alarming patterns and ensuring that MA plans are operating consistent with CMS's commitment to equity.⁴³ This information may also be helpful for prospective enrollees to know when choosing whether to enroll in MA or when comparing MA plans. Currently, this data is collected and reported in aggregate, at the contract level, by CMS. We recommend that CMS require more granular reporting from MAOs such that this information is disaggregated and stratified across demographic and health characteristics of dis-enrollees. CMS should also make this data publicly available—to both researchers and prospective enrollees—at the plan level.

Out-of-Pocket Costs

Annual OOP costs are capped for MA plan enrollees. When beneficiaries compare plans, they can see what the upper limits of their OOP costs are and can estimate what their costs might be. However, *actual* OOP spending can vary significantly across MA plans. That information is collected by CMS but is not published.⁴⁴ Prospective enrollees should be able to compare plans based on what the typical range of actual OOP spending is, not only what the potential upper limits of OOP spending might be, for a plan's beneficiaries. Prospective enrollees should also be able to see what proportion of an MA plan's beneficiaries actually hit their OOP max each year.

Additionally, researchers should have the ability to study what OOP spending looks like for both MA and TM beneficiaries so that the true actuarial value of MA plans can be compared to the

⁴³ Ibid.

⁴⁴ Ibid.

TM program. To that end, CMS should publish actual OOP spending information as part of MA encounter data.

Equity

To advance the commitment to equity outlined in CMS Framework for Health Equity 2022–2032, CMS must protect Medicare’s most vulnerable beneficiaries from disparate practices that could lead to higher OOP costs, worse health outcomes, and unequal access to care for historically-marginalized beneficiaries.⁴⁵ Granular, disaggregated, and timely data from MA plans is necessary to achieve this goal.

In 2021, Black and Hispanic people made up 25 percent of the Medicare Advantage population, compared to only 13 percent of TM enrollees.⁴⁶ A 2023 KKF review of 20 studies using publicly-accessible data, found Black MA enrollees had worse outcomes than white enrollees on more than half of examined measures.⁴⁷ There is very little data available, however, on disparities amongst other groups.

CMS, researchers, regulators, policymakers, and the public must have more visibility into whether particular groups of people enrolled in MA (and TM) are systematically worse off than others as a result. In addition to correcting for disparate health care quality outcomes, CMS and other policymakers should be able to monitor and correct for whether network adequacy, the use of prior authorization supplemental benefit uptake, disenrollment rates, and OOP spending vary among people of color, residents of rural areas, people with chronic health conditions, LGBTQI+ people, women, people living with disabilities, and other historically marginalized groups. This is not possible without access to disaggregated data.

⁴⁵ Centers for Medicare & Medicaid Services, “CMS Framework for Health Equity 2022–2032;” Biniek, Freed, and Neuman, “Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency.”

⁴⁶ Nancy Ochieng and others, “A Snapshot of Sources of Coverage Among Medicare Beneficiaries,” KFF, December 13, 2023, available at <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.

⁴⁷ Nancy Ochieng and others, “Disparities in Health Measures by Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature,” KFF, December 13, 2023, available at <https://www.kff.org/medicare/report/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-a-review-of-the-literature/>.

To go one step further, CMS should consider including some dimension of equity as part of the MA star ratings program, which at the very least could be a reflection of whether MA plans are collecting adequate and stratifiable data.

Finally, researchers have raised concerns about the accuracy and utility of the race and ethnicity variables CMS currently collects.⁴⁸ CMS should prioritize making any necessary adjustments to its race and ethnicity data collection processes given how central accurate underlying data is to the validity of monitoring for inequities.

Enforcement of Data Transparency Requirements

Recent CMS rules have included an intention to initiate program audits to assess compliance across multiple dimensions, including national coverage determinations, applicable local coverage determinations, and the general TM equivalent coverage requirements.⁴⁹

We strongly urge that there must be real penalties for noncompliance with reporting and auditing requirements. CMS has the authority to take enforcement or contract actions when CMS determines that an MA plan sponsor fails to comply with certain requirements, including imposing civil money penalties; applying intermediate sanctions such as suspension of marketing, enrollment, or payments; and the authority to go as far as to terminate contracts.⁵⁰ CMS should exercise the full scope of these penalties with respect to MA data reporting and transparency. As indicated throughout these comments, the severity of the penalties should be commensurate with the potential impacts associated with the compliance failure. To that end, we encourage CMS to develop a systematic enforcement apparatus that can trigger the full range of penalties and responses as appropriate. For example, an MAO's failure to report

⁴⁸ Andrew W Huang and David J Meyers, "Assessing the validity of race and ethnicity coding in administrative Medicare data for reporting outcomes among Medicare advantage beneficiaries from 2015 to 2017," *Health Services Research* 58 (5) (2023):1045-1055, available at <https://pubmed.ncbi.nlm.nih.gov/37356821/>.

⁴⁹ David Kopans, "CMS warns Medicare Advantage organizations of upcoming utilization management compliance audits," DLA Piper, October 31, 2023, available at <https://www.dlapiper.com/en/insights/publications/2023/10/cms-warns-medicare-advantage-organizations>.

⁵⁰ Centers for Medicare & Medicaid Services, "Part C and Part D Enforcement Actions," available at <https://www.cms.gov/medicare/audits-compliance/part-c-d/part-c-and-part-d-enforcement-actions> (last accessed May 2024).

disaggregated information might trigger outreach and technical assistance while failure to regularly report network accuracy might result in a temporary enrollment suspension.

Apart from compliance with transparency requirements, the extent to which MA plans are compliant with CMS audits would be useful information for prospective MA enrollees. To that end, we recommend CMS publish data on MAO compliance with audits, perhaps grading plans accordingly, for beneficiaries to see during enrollment periods.

Finally, wherever possible CMS should make robust data available using Research Identifiable Files (RIFs) to enable researchers to uncover and study patterns of potential inequities within MA. For example, RIFs that link broker IDs with their enrolled beneficiaries can help researchers spot any targeted beneficiary steerage. Researchers could also use RIFs containing enrollee-level supplemental benefit data to surface who actually has access to benefits and any equity concerns therein. Further, researchers could study and demonstrate the degree to which supplemental benefit access (and use) actually has an effect on beneficiary health outcomes.

Presenting Data to Medicare Beneficiaries

How data is presented—especially when it is presented to beneficiaries—is vitally important. As we learned when hospitals were required to publicly post their charges and pricing, entities can be technically transparent, but in practice present data in a manner that is so dense, complex, and confusing that it is of limited use to the public.⁵¹ 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.

Finally, we underscore that the desired end of providing data to beneficiaries is not to place the role of programmatic enforcement onto them (or to assume that enrollees will correct for shortcomings across MA plans or MAOs by voting with their feet), but to ensure that they have the information they want and need to make informed choices. The role of assuring

⁵¹ Sarah Volpenhein, “Study: Medical costs remain murky: Despite federal rule requiring price transparency, report finds only 2 in 5 Wisconsin hospitals comply,” Oshkosh Northwestern, March 26, 2024, available at <https://www.proquest.com/newspapers/study-medical-costs-remain-murky/docview/2985433100/se-2>

performance accountability on the part of plans—through reporting, auditing, and enforcement—is the responsibility of CMS and Congress.

Conclusion

The MA program has grown dramatically in recent years and now accounts for more than half of all Medicare enrollment.⁵² Moreover, CAP estimates that CMS overpays MA plans by 22 to 39 percent, with overpayments in 2024 alone estimated to total between \$83 billion and \$127 billion.⁵³ Yet there is no clear evidence that the MA program leads to improved health care quality nor is there evidence that it advances health equity for enrollees. With this in mind, CMS must exercise a high degree of oversight over the program—which necessitates more and better information about how MAOs and MA plans are operating.

We applaud CMS’s ongoing efforts to advance MA data transparency to both ensure the program is complying with regulations and that it is meeting the needs of enrollees. We share CMS’s goal of making MA data available at a level that is commensurate with TM data.

To achieve a level of MA data transparency that is meaningful to researchers, regulators, and policymakers—which will, in turn, protect beneficiaries—CMS must collect more robust MA data and at a much more granular level. As we have outlined, this is especially true for data on broker compensation, network adequacy, prior authorization, supplemental benefits, disenrollment, and enrollee out-of-pocket cost expenditures. We urge CMS to use that data to: 1) ensure that the MA program is providing beneficiaries with fair, reliable, and useful information that enables them to make informed enrollment choices; 2) protect beneficiaries enrolled in MA plans from inadequate coverage and harmful practices; and 3) ensure that the MA program is working optimally for contracted clinicians, enabling them to practice appropriate and high-quality care.

⁵² Victoria Bailey, “The History of Medicare Advantage: From Inception to Growing Popularity,” Health Payer Intelligence, May 22, 2023, available at <https://healthpayerintelligence.com/features/the-history-of-medicare-advantage-from-inception-to-growing-popularity>; Nancy Ochieng and others, “Medicare Advantage in 2023: Enrollment Update and Key Trends,” KFF, August 9, 2023, available at <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>.

⁵³ Micah Johnson and others, “Ending Overpayment in Medicare Advantage” (Washington: Center for American Progress, 2024), available at <https://www.americanprogress.org/article/ending-overpayment-in-medicare-advantage/>.

Thank you for the opportunity to comment on this RFI, and we appreciate your consideration of our comments. For any questions regarding this comment letter, please contact Andrea Ducas at aducas@americanprogress.org.

Sincerely,

Center for American Progress, *with support from:*

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