

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:

Our organizations welcome 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 these private companies are benefiting enrollees, acting in good faith, and appropriately stewarding federal funds. Our comments are grounded in our organizations' history of advocacy as well as experiences working with Medicare beneficiaries as they attempt to decipher Medicare and MA rules, choose the appropriate coverage for their circumstances, understand governmental and plan communications, and access the care they need.

MA now enrolls over 50% of eligible beneficiaries, and MA organizations (MAOs) draw down billions of dollars from Medicare each year. Despite MA's massive scope, beneficiaries, advocates, researchers, policymakers, and taxpayers are often kept in the dark about many aspects of MAOs, including fundamentals like whether enrollees are getting the care they need.

Such information is vital. Companies taking money from the federal government must be accountable for it and must not be permitted to deny access to data or hide behind claims of proprietary secrets or processes. And beneficiaries making choices often need more information to ensure they find the right fit.

But while some of the data may be actionable for people with Medicare who are choosing their coverage pathway, we must not expect the market to eradicate bad actors. Instead, this data and other information must form the basis for vigorous oversight and enforcement of Medicare's statutes and regulations.

Our comments will focus largely on equity and will encompass three major areas: 1. the need for data on beneficiary access, including networks, prior authorization, and denials; 2. data issues around dually eligible individuals; and 3. the need for additional enrollment data, including data on enrollee demographics and Medicare Savings Program status.

Need for data on beneficiary access

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,¹ much of the detailed data is not currently available.² We ask that CMS require MA plans to make available detailed data on what services prior authorization requests are made most often, the timelines for prior authorization, as well as detailed data on prior authorization denials and appeals in all care settings. This includes data on the percent of claims for services approved by prior authorization; those denied because of lack of prior authorization and by service; the percent of denials that were appealed; and the percent of appeals that were overturned. 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 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.³ 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,⁴ the full scope 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. There is also 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. This data must be made publicly available.

Need for data on the dually-eligible Medicare-Medicaid population:

¹ Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits, KFF (June 21, 2021) <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-costsharing-out-of-pocket-limits-and-supplemental-benefits/>. (“Nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services, which is generally not used in traditional Medicare.”)

² This is still the case even with the Interoperability and Prior Authorization Final Rule issued in January 2024 (CMS-0057-F) making additional prior authorization data available in 2026.

³ “Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025.” 89 FR 30448. Page 30783.

⁴ “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” a 2022 HHS Office of Inspector General (OIG) report focusing on Medicare Advantage plan denials. Based on a sample of cases from 2019, OIG found that 13% of prior authorization requests denied by MA plans met Medicare coverage rules, and would have likely been approved for coverage under traditional Medicare. Similarly, among payment requests that MA plans denied, OIG found that 18% met Medicare coverage rules.

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 duals 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.

D-SNP plans are also often subject to enhanced federal requirements - including the establishment of enrollee advisory committees, integrated communications, and integrated appeals processes. Data on these additional requirements - for instance, the representation on enrollee advisory councils and information on how well integrated appeals are working - would help greatly in shaping policy for this key population.

Need for improved enrollment data

We believe it would be helpful to provide enrollees with information that may help with their enrollment decision making. To make this data more useful and accessible, the data would need to be simplified in a way that would not overwhelm the user; the beneficiary user’s experience should be a primary consideration.

Since Star Ratings data may not always be a meaningful resource for the beneficiary to use when comparing MA plans, MA data ought to serve the purpose of driving more informed beneficiary decision making. CMS may want to consider providing, for instance, data around the size and scope of the plan’s provider network or the amount of utilization management requests and denials per plan.⁵

We would also like to ask CMS to provide the public with data around the demographic characteristics (data disaggregated by race and ethnicity, sex, age, disability status - to name a

⁵ In 2021, there were 2.9 prior authorization requests per Anthem enrollee and .8 requests per UnitedHealthcare enrollee. The denial rate ranged from 12 percent for CVS to 3 percent for Anthem and Humana. The range of this data would be helpful for enrollees to know. Jeannie Fuglesten Biniek and Nolan Sroczyński. “Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021.” KFF. 02 February 2023. 01 May 2024.
<https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/>.

few) of the MA enrollee population. We recommend this so we can better understand how health disparities and health-related social needs interact with the MA program. Knowing more about how the design of MA or the approach of plans (utilization management, provider access, etc.) affects certain demographic groups would help CMS and advocates better address health disparities among demographic groups through targeted interventions.

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 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.

Thank you for the opportunity to provide additional input into the Medicare Advantage data needed to ensure these plans are meeting the needs of their enrollees. We appreciate CMS's efforts to expand the collection and public sharing of this important information as ever growing numbers of Medicare beneficiaries are covered through MA plans.

Please feel free to contact us with any questions or concerns.

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National Council on Aging (Matthew Hubbard at Matthew.Hubbard@NCOA.org).

The undersigned organizations thank you for the opportunity to provide recommendations on this RFI.

Access Center for Independent Living, Inc. - Dayton Ohio
Access Ready Inc.
Addiction Professionals of North Carolina
ALS Association
American Academy Of Addiction Psychiatry
American Association on Health and Disability
American Geriatrics Society
American Mental Health Counselors Association
American Physical Therapy Association
American Psychiatric Association
Arizona Center for Law in the Public Interest

Asian Resources, Inc.
Be A Hero
California Health Advocates
Caring Across Generations
Center for Advocacy for the Rights and Interests of Elders (CARIE)
Center for Elder Law & Justice
Center for Health Progress
Center for Health Care Rights
Center for Independence of the Disabled, New York
Center for Medicare Advocacy
Citizen Action of NY
Community Catalyst
Community Service Society of New York
CT Citizen Action Group
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Disability Policy Consortium
Disability Rights Connecticut
Disability Rights Education and Defense Fund (DREDF)
Diverse Elders Coalition
Families USA
Frederick County Progressives
Healthy California Now
Health Care Voices
Healthcare NOW
Illinois Association for Behavioral Health
Independent Living Center of the Hudson Valley Inc.
Institute for Exceptional Care
Iowa Citizens for Community Improvement
Just Care USA
Justice in Aging
Labor Campaign for Single Payer
Lakeshore Foundation
Legal Action Center
Legal Council for Health Justice
Long Term Care Community Coalition
Lymphedema Advocacy Group
Maine People's Alliance
Medical Home Development Group
Medicare Advocacy Project, Greater Boston Legal Services
Medicare Rights Center
Metro New York Health Care for All
Michigan United
Missouri SHIP
NAADAC, the Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Behavioral Healthcare
National Association of Addiction Treatment Providers
National Association of Social Workers (NASW)
National Committee to Preserve Social Security and Medicare
National Council on Aging

National Health Law Program
National Indian Council on Aging, Inc.
National Disability Rights Network (NDRN)
National Rural Health Association
New Disabled South
New Jersey Association of Mental Health and Addiction Agencies, Inc.
ONE Northside
Partners for Dignity & Rights
Pennsylvania Stands Up
People's Action
People's Lobby, The
People Power Untied
Physicians for a National Health Program
ProgresPublic Citizensive Maryland
Progressive Harford County
Public Citizen
REDC Consortium
RespectAbility
RN Beside You, LLC
Social Security Works
Tennessee Health Care Campaign
Tennessee Justice Center
The Moorings at Lewes
Triage Cancer
Unity Fellowship of Christ Church-NYC
VOCAL-NY