



Date: August 30, 2022

Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically to: <http://www.regulations.gov>

Re: CMS-4203-NC

Administrator Chiquita Brooks LaSure:

The Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR) is pleased to provide the Centers for Medicare & Medicaid Services (CMS) our comments relating to the request for information regarding various aspects of the Medicare Advantage program (CMS-4201-NC).

GWAAR is a nonprofit agency committed to supporting the successful delivery of aging programs and services in our service area consisting of 70 counties (all but Dane and Milwaukee) and 11 tribes in Wisconsin. We are one of three Area Agencies on Aging in Wisconsin. Our mission is to deliver innovative support to lead aging agencies as we work together to promote, protect, and enhance the well-being of older people in Wisconsin. There are estimated to be nearly 1.2 million adults aged 60 and older residing in our service area.¹

Nationwide enrollment in Medicare Advantage plans has increased steadily since 2006. In 2022 nearly half (48%) of all eligible Medicare beneficiaries (based upon those with both Part A and B coverage) are enrolled in Medicare Advantage plans. In Wisconsin, over half (51%) of Medicare beneficiaries are enrolled in Medicare Advantage plans. Medicare Advantage plan enrollment in some counties in central and east central Wisconsin represents approximately two-thirds (60-72%) of the eligible Medicare beneficiaries. Nationally and in Wisconsin, enrollment remains highly concentrated among a handful of firms, with UnitedHealthcare and Humana (that recently announced its plans to acquire a large Wisconsin Medicaid *long-term* care managed care organization (MCO) together accounting for 46 percent of enrollment in 2022.²

¹ Wisconsin Department of Health Services, Aging: Demographics in Wisconsin, [County Population Projections Through 2040, P00138A](https://www.dhs.wisconsin.gov/aging/demographics.htm); retrieved on Aug. 26, 2022 from <https://www.dhs.wisconsin.gov/aging/demographics.htm>.

² Meredith Freed, Jeannie Fuglesten Biniak, Anthony Damico, and Tricia Neuman; KFF, *Medicare Advantage in 2022: Enrollment Update and Key Trends*, Aug. 25, 2022, retrieved on Aug. 26, 2022 from <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>

As enrollment in Medicare Advantage plans continues to grow, it has become increasingly important for plans to provide transparent data about service utilization and out-of-pocket spending patterns to help Medicare beneficiaries compare their coverage options, as well as to assess how well the program is meeting its value and quality goals. Additionally, with the Medicare program facing growing fiscal pressures and with current plan and federal bonus payments to Medicare Advantage plans higher than for traditional Medicare (when comparing similar beneficiaries), it is essential to assess how well Medicare's current payment methodology for Medicare Advantage is working to enhance efficiency and hold down costs and to monitor how well beneficiaries are being served (costs, benefits, quality, patient outcomes, access to providers) in both Medicare Advantage and traditional Medicare.³

Advance health equity

Medicare beneficiaries, particularly those in Medicare Advantage (MA) plans and those in rural areas such as the Wisconsin counties and tribes served by GWAAR, face challenges to gaining access to care. This is especially true for those enrolled in MA plans with limited benefits and restrictive provider networks. According to an April 2021, CMS report, racial and ethnic disparities in health care also exist in MA plans and reveal higher rates of disenrollment from MA plans among those who are sicker (especially those in their last year of life).⁴

CMS must enhance oversight of MA plans to ensure that they are providing required, medically necessary care, including:

- Enforcement of current law - individuals with chronic conditions, must be ensured fair and appropriate, non-discriminatory coverage of home health in both MA and traditional Medicare and enforcement of the *Jimmo v. Sebelius* settlement must occur to ensure that Medicare coverage is determined by a beneficiary's *need* for skilled care, not on their potential for improvement which is so often cited as the reason for discontinuing services to older adults.
- Increase Oversight
 - While CMS has begun to analyze MA disenrollments in the last year of life (per GAO's recommendation), such effort should be expanded beyond the last year of life to monitor disproportionate disenrollment by those in poorer health more generally. Importantly, findings should carry consequences for plan sponsors, including carrying greater weight in quality assessments and corresponding bonus payments, public disclosure of findings and sanctions for plans that are outliers.
 - To maximize their Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores, MA plans have an incentive to discharge dissatisfied enrollees and

³ Jeannie Fuglesten Biniek, Meredith Freed , Anthony Damico , and Tricia Neuman; KFF, *Spending on Medicare Advantage Quality Bonus Program Payment Reached \$10 Billion in 2022*, Aug. 25, 2022, retrieved on Aug. 26, 2022 from <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-program-payment-reached-10-billion-in-2022/>.

⁴ Martino, SC, Elliott, MN, Dembosky, JW, Hambarsoomian, K, Klein, DJ, Gildner, J, and Haviland, AM. Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. Baltimore, MD: CMS Office of Minority Health. 2021.

encourage Special Enrollment Periods (SEPs) that can help people leave an unwanted plan. Data regarding disenrollments and SEPs should be collected and reported to CMS and factored into to CMS' oversight, including audits and quality ratings.

Expand access: coverage and care

Making choices regarding MA plans is complicated, confusing, and difficult for many consumers. While some beneficiaries are able to seek assistance in evaluating the plans from unbiased sources such as benefit specialists at their local Aging and Disability Resource Centers (ADRCs), due to limited resources, these benefit counselors (specialists) aren't available to everyone needing assistance. This leaves many consumers unable to make informed or active decisions. Instead, many choose plans based on advertising, word-of-mouth, or brand loyalty. To avoid the stress of having to assess the plans again, too often, consumers stay with those plans year after year even if another plan would better serve their needs.

To help promote informed and unbiased decision-making among Medicare beneficiaries, CMS should:

- Provide balanced and neutral information about both the advantages and disadvantages of MA plans.
- More actively promote and advocate for increased funding and capacity for State Health Insurance Assistance Programs (SHIPs) and Senior Medicare Patrol (SMP).
- Urge Congress to expand federal Medigap guarantee issue rights to make Medicare coverage options between MA and traditional Medicare more equal
- Overhaul MA Star Ratings, which are promoted as tool for consumer comparison of plans, but do not adequately do so. Star ratings must be strengthened to improve public reporting on plan quality and variation.
- Strengthen consumer protections surrounding plan marketing, including further oversight of plan advertising and addressing agent/broker compensation issues. Even though MA plans have proven to be more costly than traditional Medicare, MA payment plans, agent and broker compensation structures, and MA plan advertising are all geared to favor MA enrollment over other options. As the Advocacy and Public Policy Coordinator at GWAAR, I hear **frequent complaints from beneficiaries and aging network professionals serving beneficiaries, about the marketing practices** of organizations who sell MA and Part D products. A more aggressive regulatory response by CMS is needed and should include:
 - Further strengthening of consumer protections regarding plan marketing.
 - Rescinding changes made in 2019 to the Medicare Communications & Marketing Guidelines (MCMG), that blurred the lines between marketing and educational events provided by those selling MA and Part D products.
 - Increase oversight of agents and brokers, including:
 - ❖ Overhauling agent/broker compensation to counteract the significant pecuniary advantage in selling MA plans vs. products in traditional Medicare. Impose stronger standards for enforcement, discipline and punishment relating to the sale of Medicare products – this should include more transparency surrounding

how complaints against agents, brokers, or TPMO's are received and processed, what enforcement process exists, or what actions if any are taken by a MA plan or by CMS as the result of a complaint.

- ❖ Exploring requiring signed attestations that whatever product is sold by an agent/broker (MA, Part D) is appropriate for that beneficiary; such an attestation is currently required for the sale of a Medigap.
- ❖ Tightening oversight of MA plans and their downstream marketing and sales entities, including a clear administrative process for complaints, and a process that includes coordination with state regulators and the National Association of Insurance Commissioners (NAIC)

MA plans generally limit the providers available to enrollees by using a contracted provider network. As we are currently experiencing in our state's long-term care system, CMS' current oversight has been unable to ensure provider networks are adequate to meet the care needs of MA enrollees. CMS' May 2020 funding rule further weakened network adequacy requirements by reducing the percentage of beneficiaries that must reside within the maximum time and distance standards in non-urban counties from 90 percent to 85 percent, along with an additional 10-percentage point credit when plans contract with telehealth providers in certain specialties, as well as an additional 10-percentage point credit for affected providers in states that have certificate of need laws or certain other restrictions. To ensure that MA networks are adequate to meet the needs of plan participants, CMS should:

- Fully Implement the 2015 recommendations from the Government Accountability Office (GAO) recommending CMS increase their oversight of MA networks to address provider availability, verify provider information submitted, conduct additional reviews of network information, and set minimum information requirements for enrollee notification letters.
- Rescind their May 2020 network adequacy changes and strengthen the requirements – If a plan does not have enough providers to realistically serve enrollees in an area, the plan should not be permitted to operate in that area.
- Strengthen protections for beneficiaries re: mid-year provider network terminations, including prohibit MA plans from terminating providers mid-year without cause, and strengthening the currently limited Special Enrollment Period (SEP) only for “significant” network terminations.
- Adequately enforce requirements concerning plan provider directories – there have been long-standing problems regarding the accuracy of these directories, which can present significant challenges for enrollees (this is even more critical as CMS plans to make provider directories available through the Medicare Plan Finder in the coming years).

Most, if not all, Medicare Advantage enrollees are in plans that require prior authorization for some services (especially relatively expensive ones). Far too often, MA plans inappropriately deny care and payments only to later overturn their own denials after an appeal is filed. Unfortunately, most consumers and local providers do not know this and often do not file an appeal. To ensure that MA enrollees have adequate access to medically necessary care, CMS should:

- Implement prior recommendations made by the Office of Inspector General (OIG) to better protect beneficiaries and providers from inappropriate denials.
- Revise regulations, manual provisions and other CMS guidance to require plans to provide both providers and enrollees with the Medicare criteria upon which coverage denials/terminations are made, along with relevant citations.
- To address frequent and repeated denials/terminations following reversals by external reviewers, revise guidelines to require a minimum number of days between notices of termination/discharge and/or some type of presumption of coverage.
- Ensure that CMS-created materials, and MA plan materials, fully explain prior authorization, including the scope of its use (how widespread it is) and the limitations on access to services it imposes.

Drive innovation to promote person-centered care

There is a trend in Wisconsin (and across the nation) for employers and unions that offer retirement health benefits to increasingly contracting with private insurance carriers to provide group Medicare Advantage benefits instead of traditional retiree health benefits, with little or no other options provided to such individuals. To ensure adequate consumer protections, CMS should enhance oversight of such plans, including a review of how employers and unions effectuate enrollment, as well as a review of waivers currently given to such plans. Further, CMS should monitor the practical ability of retirees to choose traditional Medicare and ensure that option is fully available.

Support affordability and sustainability

There is consistent and growing evidence that the MA program is paid more than traditional Medicare would spend on the same beneficiary. Despite concerns about the future solvency of the Medicare program, spending differences in the program are further increasing in MA plans. According to a recent report by MedPAC, Medicare spends 4 percent more on MA than it would spend on traditional Medicare (an estimated \$12 billion in excess payments this year alone) and “private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.”⁵ Among other things, these overpayments allow MA plans to offer supplemental benefits unavailable under traditional Medicare and therefore incentivizing beneficiaries to select an MA plan. CMS is encouraged to rein in excessive MA payment; increase attention to true cost-savings measures for those in traditional Medicare by covering dental, hearing, and vision services that positively impact the overall health of beneficiaries (and reduce current disparities that exist for people of color and people in low-income communities); and create a risk-adjusted payment system that improves MA plan enrollee care instead of encouraging MA plans to submit more

⁵ Medicare Payment Advisory Commission, Report to the Congress – Medicare Payment Policy; March 2022, retrieved on Aug. 30, 2022 from <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>

diagnoses to increase payment. Additionally, to further support affordability and sustainability, CMS should:

- Use all tools at its disposal to achieve payment parity between MA and traditional Medicare; in other words, ensure that MA plans are paid no more per enrollee than is spent on average for traditional Medicare beneficiaries.
- Implement the GAO's recommendations regarding the validity of encounter data, audits, and recovery of improper payments to MA plans.
- Implement the OIG's recommendations regarding chart reviews and health risk assessments (HRAs).
- Implement MedPAC's June 2022 recommendations regarding increasing coding pattern adjustment above the statutory minimum, eliminating health risk assessments as a source of diagnoses for risk-adjusted payments, and establishing thresholds for completeness and accuracy of MA encounter data.

Engage partners

Partnerships and ongoing dialogue with beneficiaries and advocates will be necessary to truly achieve the vision for Medicare - putting the person at the center of care and driving towards a future where people with Medicare receive more equitable, high quality, and whole-person care that is affordable and sustainable.

Robust data regarding service utilization and out-of-pocket spending patterns must be made more readily available for Medicare beneficiaries to truly be able to compare coverage options. Improved quality and cost-efficiency will come from thorough reviews of appeals, reducing incentives for MA plans to submit more diagnoses to increase payment, and ongoing communication (via phone/virtual interviews, stakeholder advisory councils, etc.) with beneficiaries and advocacy groups to better understand the consumer experience.

To date, privatization of the Medicare program has not lived up to its promise of delivering better care at lower cost. Thank you for your consideration of these comments regarding various aspects of the Medicare Advantage program (CMS-4201-NC).

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