Brown University Center for Advancing Health Policy Through Research (CAHPR) Public Comment on Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Plan Program (CMS–4205–P, RIN 0938–AV24)

This public comment represents the views of faculty members affiliated with the Center for Advancing Health Policy through Research (https://cahpr.sph.brown.edu/) at the Brown University School of Public Health. As a team of health economists, health services researchers, and lawyers, we hope that the comments we provide are useful in implementing improvements to the Medicare Advantage (MA) program.

In general, we support this rule as a step in the right direction on many fronts with potential to improve the functioning of the program, but we believe more can be done to address larger structural issues in MA such as in how data is collected, quality is measured, and payment rates are set. Our responses to each of the proposed rule's changes are as follows.

Brokers and Anti-competitive steering

In this rule, CMS is proposing to set a standardized payment rate to brokers for plan enrollments at $642 per enrollee. Under current rules, CMS pays brokers $611 for initial enrollment and $306 for renewals while plans can offer additional fees which can increase broker payments to more than $1,000 per enrolled beneficiary.

In general, setting a single standardized broker rate for all plans makes economic sense, as it would reduce incentives for brokers to differentially steer beneficiaries to higher paying plans, and instead encourage the broker to help the beneficiary make the best enrollment decision possible. That being said, we have several concerns and suggestions for additional steps to improve broker payment policy. First, by setting a fixed rate instead of a cap with variable rates under it, there is a potential that this could lead to an increase in wasteful spending on brokers from plans if this new fixed rate is higher than what plans were previously paying for broker services. Relatedly, if this is the only payment rate that can be set for brokers, smaller plans with fewer resources may be locked out of using broker services for attracting beneficiaries if they cannot afford the fixed $642 payment. CMS may wish to consider setting a lower broker payment rate or consider its impact on smaller plans.

Second, we have larger concerns about the current data being collected on broker enrollments or payments. To our knowledge, there is no required public reporting of which enrollees were referred to a plan by a broker and what the broker payments to plans currently are. We strongly urge that CMS require that plans submit this information to be incorporated into public report files, as well as research files so that we can better understand the types of enrollees that brokers are steering and if these lead to beneficial plan enrollment decisions. By making information on who was referred by a broker available to researchers, we can better understand if brokers are truly helping beneficiaries

make beneficial choices, which is currently completely unknown.

Network Adequacy Standards for Behavioral Health Providers.

CMS is proposing to add additional network adequacy standards to improve access to behavioral health care providers within MA. We agree that this is an important move, as work by our group[1] and others[2] has found that MA networks have notably limited access to these provider types. While we believe adding network adequacy standards for behavioral health providers would be beneficial, we have several comments about how the rule can be shaped.

First, in the proposed rule, CMS would combine marriage and family therapists, mental health counselors, opioid treatment program providers, community health centers, and addiction specialists into a single category. Yet, the clinical needs for a beneficiary experiencing conditions such as depression or anxiety are quite different from the needs of a beneficiary addicted to opioids. By combining these provider types into one group, plans may not actually be required to include adequate networks of different mental health providers in their network. We suggest that CMS consider disaggregating these categories in the final rule.

Second, requiring additional behavioral health providers to be included in-network may not adequately address low MA participation rates among these providers due to onerous prior authorization and documentation requirements.[3] To that end, CMS should consider implementing additional changes to make participation in MA plans easier for behavioral health providers, including through placing networks on the types of prior authorization requirements that could be required for standard mental health services.

Third, for behavioral health providers, and all provider types in general, there is a substantial need for more public information of what providers are included in plan networks that is readily accessible to beneficiaries at the time of enrollment. Beneficiaries often have to rely on inaccurate listings of doctors on individual plan websites, and when enrolling using the Medicare plan finder, there is little to no information on which providers are available. CMS should require plans to submit data on provider networks and make this information publicly and readily available to beneficiaries on the Medicare plan finder at the time of enrollment and on an ongoing basis. CMS should also increase scrutiny of provider availability (i.e., whether the provider is accepting new patients) when determining compliance with network adequacy requirements, as currently plans' lists of participating providers may reflect providers who are not accepting new patients and are functionality unavailable to beneficiaries.

Midyear Notification of Available Supplemental Benefits

Under the new proposed rule, plans would be required to notify beneficiaries half-way through the year if the beneficiary has any unused supplemental benefits. In principle, we are supportive of this change as more transparency of benefits to beneficiaries would be a good thing.

Nevertheless, we have broader, first-order concerns about the current role of supplemental benefits in MA. Namely, there is currently no research evidence that most supplemental benefits offered by plans offer tangible benefits to beneficiaries. Rather, many supplemental benefits such as dental and vision tend to be very low-quality products (e.g., they are difficult to use, functionally inaccessible, or have very low actuarial values), and there is currently no data collected on the utilization or detailed characteristics of these benefits.

We propose that CMS require plans to include more detail on what is included in these supplemental benefits in public reported data, and on the plan finder tool so that beneficiaries can better understand what these benefits entail, and what their limitations might be, at the time of enrollment. We also propose that CMS require the use of supplemental benefits to be a required element to be reported in the MA encounter data, so that CMS, policymakers, and researchers can begin to understand the extent, value, and usefulness of supplemental benefits in MA.

Updated Rules for Special Supplemental Benefits for the Chronically Ill (SSBCI)

In the proposed rule, MA plans will be required to report to CMS evidence that the SSBCI benefits they would like to offer will improve beneficiary outcomes. Plans would also be required to report detailed policies for when a beneficiary is eligible for a SSBCI benefit and to document denials of these services. The rules will also require plans to document more explicitly which beneficiaries are eligible for SSBCI benefits in any marketing materials.

In principle, we support all of these changes. Requiring evidence-based benefits would help to ensure that these benefits are not being used primarily for advertising purposes without providing value to beneficiaries. More transparency about which beneficiaries are eligible for SSBCI benefits would also help enrollees avoid enrolling in a plan on the lure of benefits they cannot actually access.

While these changes are positive, a larger issue here is that there is very little data available on the nature of SSBCI benefits and their utilization. Without requiring that plans report to CMS full utilization information for these benefits, it will not be possible for CMS, policymakers, and researchers to understand the true impact of these benefits. This rule change would also require an increase in scientific evidence about which benefits might improve beneficiary outcomes. Given that there may be a dearth of evidence for some benefit types, this requirement could restrict the offering of many benefits. We would suggest that CMS work with AHRQ and/or NIH to make more research funding available so that evidence can be better generated around offering supplemental benefits in the MA program.

Equity Analysis of Utilization Management

In the proposed rule, plans will be required to include someone with health equity experience on their utilization management committee and to produce an annual report on the equity impacts of their policies, with a focus on low-income and disabled beneficiaries.

While we support this change, we are doubtful that these changes alone will make a substantial difference in ensuring equity. Instead, we believe that the first order concern is that plan-specific information on utilization control is not currently publicly available. It would make a more substantial impact if plans were to be required to report all denials of care, including beneficiary demographics that may pose equity concerns. In addition, MA plans should be required to report prior authorizations as a part of the encounter data so that CMS and independent researchers can conduct unbiased analyses of the equity impacts of utilization control. We are not optimistic that an internal plan process would be sufficient to lead to change. The CMS Office of Minority Health would also be in a better position to conduct such an analysis than plans.

Our second concern with the proposed rule is that it does not require this analysis to be conducted along other dimensions of equity, most notably by race/ethnicity, which is related to the largest disparities in outcomes in the healthcare system. Further, understanding utilization management by gender identity and sexual orientation would also be important to truly ensure plans are delivering on equitable care.

Appeals Process Changes

Under the new rule, beneficiaries in MA will have the right to appeal a plan's decision to terminate coverage for non-hospital provider services using the same tools that are available to appeal in Traditional Medicare. We believe that this is a positive change and would help to bring more equity between the two programs.

RADV Appeal Process

Risk Adjustment Data Validation (RADV) audits are CMS's primary mechanism to recoup overpayments to MA organizations based on unsupported risk coding. However, the RADV audit process is currently underutilized, which means that expanding and improving the RADV program presents a significant opportunity to recoup billions more in MA overpayments. The lengthy appeals process and resulting backlog of appeals pose significant barriers to expanding the recovery of MA overpayments through RADV audits.[4,5]

The proposed rule includes changes to streamline the RADV appeals process. Specifically, the proposed rule would require MA organizations to complete appeals of medical record reviews before beginning payment calculation error appeals, because the outcome of medical record appeals could affect or moot payment calculation appeals. We agree that this sequencing change will help streamline the appeals process.

While we support the proposed rule's efforts to improve the RADV appeals process, more could be done. In particular, CMS could allocate more resources for processing appeals and further streamline the appeals process by establishing time limits for resolution.[6,7] The lack of time limits for appeals and delays in the audit process have created barriers to expanded recoveries through the RADV audits and limited the willingness of Recovery Audit Contractors to participate in RADV and help expand its scope. We support efforts to improve RADV audits and urge CMS to take further steps to expand the scope, improve timeliness, and devote additional resources to RADV audits to recoup billions more in overpayments.

Changes for Dual Eligibles

The proposed rule has several changes that are relevant to dual eligible beneficiaries. First, it would allow duals to change their plan selection on a monthly basis rather than on a quarterly basis under the current system. Second, it would allow for a special enrollment period for duals to enroll in plans that are integrated with their Medicaid care organization. Third, it would move the threshold for DSNP lookalike terminations down to 60 percent by 2026.

In general, we are supportive of these changes, however it is important to note that there is currently limited to no published research that actually finds that enrollment in integrated care for

dual eligibles actually leads to improved outcomes. While care integration may help beneficiaries to navigate through both their Medicaid and Medicare benefits, it is not clear if these integrations are actually living up to their current potential. Our second concern is over any disruptions in care that may occur as a result of the termination of additional lookalike plans. It will be important for CMS and researchers to ensure that these terminations don't lead to gaps in continuity of care for duals affected by those terminations.

First Order Issues Not Yet Addressed

While we are supportive of many of these proposed changes in the new rule and believe that they will contribute to small improvements in the functioning of the program, our research and experience indicates that there are currently several other substantial issues with the MA program that this proposed rule does not address. We urge CMS to consider these issues in this rule and in further proposed changes to the program:

Data Availability Including on Supplemental Benefits, Utilization Control, and the Quality of Encounter Data: There is a critical lack of high-quality data available on the Medicare Advantage program which limits the ability of researchers and policymakers to evaluate it's success. Namely, the MA encounter data still have substantial issues, with wide variation in the quality of data reported across contracts. There is no published information on denied care and other utilization control efforts that plans take. There is also currently no available information on the actual utilization of supplemental benefits in the MA program. CMS should continue to ensure that the quality of the encounter records are adequate, and consider penalizing plans that don't report complete information.

Concerns with MA Benchmarks: Recent evidence suggests that the Medicare Advantage benchmarks are inflated by favorable selection and do not reflect the cost of providing care to MA beneficiaries.[8,9] Adjustments to MA benchmarks from the quartile payment system[10] and Quality Bonus Program[11] add billions more to plan payments. Congress and CMS should work to reform these payment distortions.

Concerns with Coding Intensity: In addition to challenges with the setting of MA benchmarks, it is well established that there is inflation of risk coding that leads to wasted increased payments to plans.[12–15] CMS should monitor this risk coding inflation more closely, and consider increasing the minimum adjustment factor used when calculating payments to plans.

The Usefulness of Star Ratings. Beneficiaries are attracted to MA by the low premiums, cost sharing protections, and supplemental benefits. Beneficiaries have little to no knowledge about prior authorization and network restrictions in MA. Prior work finds that the current star ratings may not be highly predictive of beneficiary outcomes, and hide important inequities in care.[16,17] The star ratings should be re-specified to provide critical information to beneficiaries about supplemental benefits, cost sharing, prior authorization, and network breadth that beneficiaries want.

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