

August 31, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: Request for Information: Medicare Program, CMS-4203-NC

Dear Administrator Brooks-LaSure,

National Patient Advocate Foundation (NPAF) is pleased to submit feedback to the Centers for Medicare and Medicaid Services' Request for Information on the Medicare Advantage program. We appreciate the Administration's intention to strengthen Medicare Advantage and ensure all Medicare beneficiaries can equitably access high quality, person-centered and family-focused care.

NPAF advocates for inclusive policies that elevate and integrate patient and caregiver perspectives as central aspects of equity-focused healthcare reform. Advancing equitable and affordable healthcare forms the core of our person-centered agenda, which prioritizes financial and social stability as essential components of quality health care. Our direct patient services counterpart, Patient Advocate Foundation (PAF), has delivered skilled needs navigation services specifically supporting social and financial well-being for thousands of limited-resourced patients and families over its 26 years. Needs navigation, detailed in [this NPAF issue brief](#) (Appendix I), is a proven intervention that responds to specific social risks based on what patients and families report as their most pressing concerns that interfere with healthcare access and affordability. PAF's approach promotes health equity by linking individuals to the appropriate community and national resources and support programs based on their unique needs and circumstances.

A majority of over 2,800 patients surveyed by PAF in 2019 (63 percent) reported financial distress as a top concern surpassing even the possibility of dying.¹ Household material hardships such as food, energy and housing insecurity are frequent sources of concern contributing to dire circumstances and disparate health outcomes among people coping with complex chronic conditions. Needs navigation helps overcome health system shortfalls by identifying and striving to address the constellation of patients' unmet social and financial needs which are particularly prevalent in underserved populations and limited resourced communities. PAF's 2021 program evaluation data show that after navigation was provided, 77 percent of patients reported reduced distress and 100 percent reported a better understanding about health care costs and awareness of community resources that can help them.

PAF routinely provides enrollment assistance and education about Medicare coverage options and costs of care. Our navigators can attest that deciding between Medicare Fee-for-Service (FFS) and Medicare

¹ Internal Patient Advocate Foundation Data, 2019 survey of over 2,800 patients.

Advantage (MA) is challenging for most seniors and older adults. Simple enrollment tools can provide some decision-making support such as [NPAF's Medicare Plan Guide](#) (see Appendix II) which was developed with patient input responsive key questions about Medicare Parts A, B, C, D coverage and costs. While readily available guides are welcome, our patient and caregiver network has overwhelmingly and consistently expressed the need for a designated person to help them navigate the enrollment process, clarify the tradeoffs between covered benefits and associated costs, and flag potential penalties or important deadlines. Because hands-on guidance is so crucial in achieving enrollment efficiency and effectiveness, we routinely refer patients to PAF needs navigators and State Health Insurance Assistance Plans for personalized support.

With MA enrollment nearing 50 percent of all Medicare beneficiaries, we appreciate that CMS is seeking input from beneficiary advocates regarding ways to make the program more equitable, affordable, and transparent. We offer the following recommendations.

1. Strengthen provider network adequacy standards to maintain continuity of care

Our patients and caregivers, especially those in underserved and rural communities, have reported difficulties accessing their preferred providers when switching to a Medicare Advantage plan. These claims have been substantiated with one analysis finding that approximately one-third of MA beneficiaries are in narrow networks defined as having less than 30 percent of physicians in the county.² Anecdotally we have heard from health care professionals that it often falls on them to warn patients if they are not in an MA plan's network and foresee cost concerns with out-of-network charges. The unintended consequences may include delays and gaps in care while the patient finds an alternative provider that they can trust.

Because of the potential for care delays and concerns about care continuity, we were pleased to see that CMS is strengthening its oversight in the latest 2023 MA and Part D Final rule by requiring that MA plan applicants demonstrate compliance with network adequacy standards before approval of a new or expanded contract.³ However, current MA network adequacy standards requiring 90 percent of beneficiaries to have access to at least one provider of each specialty type⁴ are insufficient in practice. For example, a single provider may be within the time and distance standards for a given county but require the patient to take onerous modes of transportation making the provider effectively inaccessible. The patient may choose to forego the visit due to added stress or other negative impacts on their daily life or financial stability. Moreover, restricting meaningful choices for patients to find practitioners that align care with their needs, preferences, and values is disproportionately harmful and causes disparate experiences and outcomes among communities of color and the LGBTQ+ community.

For these reasons, we urge CMS to reconsider maximum time and distance standards among other network adequacy requirements given their limitations in promoting person-centered care. This

² Kaiser Family Foundation. Medicare Advantage: How Robust Are Plans' Physician Networks? October 5, 2017. Available at: <https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/>

³ Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. April 4, 2022. Available at: <https://www.cms.gov/files/document/2023-announcement.pdf>

⁴ [Medicare Advantage Network Adequacy Criteria Guidance](#). Last Updated January 10, 2017.

examination of MA plans is an ideal opportunity for CMS to more integrally involve diverse patient and caregiver lived experience expertise throughout the development of revised standards. NPAF will be happy to support CMS processes for garnering such “experts by experience” via patient and caregiver input.

2. Ensure MA plans support patient access to services that meet Medicare’s clinical criteria

Concerning OIG findings recently reported instances where MA plans have delayed or denied approvals for service requests that met Medicare coverage rules.⁵ Prescribed treatments, medications, diagnostic tests, or other services should be the result of evidence-based and personalized shared decision making between patients and their physicians based on what best meets the patient’s needs and circumstances. While utilization management strategies such as prior authorization may be a useful tool within a plan’s benefit design to reduce health care costs, it’s imperative to apply these policies so they improve quality care rather than impede it.

We support OIG’s recommendations to ensure MA beneficiaries have timely access to care. Responding to the real-world data documenting access interference, CMS can take steps regulating application of utilization management to avoid adversely affecting enrollees’ access to medically necessary care. NPAF urges CMS to consider issuing new guidance on the appropriate use of MA organization clinical criteria and holding MA plans accountable for complying with Medicare program requirements.

3. Mitigate misleading marketing and advertising

Insurance brokers and agents can significantly influence a person’s enrollment decision-making. We have heard anecdotally from patients and caregivers that seniors in their community were visited at home unsolicited by sales representatives who encouraged MA enrollment. As a result, some people with complex chronic conditions did sign up for an MA plan during open enrollment not realizing the difference or impact it would have on access to care and costs compared to Medicare FFS. In fact, the Federal Trade Commission released a consumer alert on October 15, 2021, advising consumers about their rights and some of the limits on marketing for MA and Part D plans.⁶

We are concerned that agents and brokers for MA plans may not disclose important penalty information having substantial financial consequences for the beneficiary in the long term. While it is true that a beneficiary can switch back to FFS, they should be warned that if they want to purchase a Medigap supplemental plan to help cover out-of-pocket costs but are outside of their 6-month window, they are subject to medical underwriting and may be denied or the plan may cost more. Even with an exception to the underwriting process when a consumer is misled, it is reasonable to assume that not every person has the persistence and know-how to pursue that process. Additionally, MA beneficiaries who remain in MA as they age into end of life could drive up costs for Medicare since MedPAC analysis shows that

⁵ U.S. Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 27, 2022. Available at: <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>

⁶ Federal Trade Commission. Consumer Alert. Avoid marketing scams during 2022 Medicare open enrollment. October 15, 2021. Available at: <https://consumer.ftc.gov/consumer-alerts/2021/10/avoid-marketing-scams-during-2022-medicare-open-enrollment>

Medicare pays more for enrollees in MA compared to FFS.⁷ Given that MA enrollment is steadily increasing, we urge CMS to increase oversight of MA plan marketing practices that may mislead beneficiaries and result in preventable costs for beneficiaries and Medicare.

We appreciate the availability of State Health Insurance Assistance Programs to guide people in this regard. Yet NPAF also acknowledges the broader need for neutral third parties to be embedded in the enrollment process, like insurance navigators are now, to independently help beneficiaries weigh plan choices based on individual needs. This is particularly important for Medigap plan selection. We applaud the Biden-Harris Administration for its continued investment in the Marketplace Navigator program and ask that CMS consider building upon existing navigator infrastructure to ensure that all people enrolling in a Medicare plan receive the same level of impartial and person-centered support.

Conclusion

NPAF greatly appreciates CMS' intent to meaningfully engage beneficiaries throughout rulemaking processes to understand and address continuing challenges for patients with Medicare FFS and MA plans. Patient and caregiver insights can ensure CMS is evaluating quality by measuring outcomes that reflect what matters most to people, including utilization and preferences for supplemental benefits. Providing needs navigation services directly to patients and caregivers is a hallmark of PAF's two and a half decades of organizational experience, expertise, and history. We are happy to share lessons learned and welcome the opportunity to meet directly with Administration staff to discuss our input in these comments and opportunities to scale needs navigation as part of efforts to achieve equitable and affordable healthcare reform. Please contact Nicole Braccio, Policy Director, at Nicole.Braccio@npaf.org if we can provide further details.

Respectfully submitted,



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EVP Policy and Programs

⁷ MedPAC. For the record: MedPAC's response to AHIP's recent "Correcting the Record" blog post. March 3, 2021. Available at: <https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/>