August 30, 2022

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

Re: CMS-4203-NC Medicare Program; Request for Information on Medicare Advantage

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to submit comments on the Request for Information (RFI) on various aspects of the Medicare Advantage (MA) program.

Millions of older Americans rely on MA for their health coverage, and as noted in the RFI, MA enrollment will soon equal or exceed the number of beneficiaries in traditional Medicare. Throughout the current public health emergency, we have supported the expansion of supplemental benefits in MA to help alleviate the unprecedented health care crisis brought about by the COVID-19 pandemic.

In the last several years, we have also called for improvements in the program when appropriate, including support of the Centers for Medicare and Medicaid Services’ (CMS) work to address MA’s history of marketing abuses involving enrollment, calling for restoration of network adequacy reviews eliminated by the previous Administration, and urging more effective communication with beneficiaries on switching between MA and traditional Medicare and the penalties they may incur.

AARP offers the following input and recommendations regarding the MA program based around the categories set forth in the RFI:

**Advancing Health Equity**

Ensuring health equity for all Americans across racial, geographic, and other categories, is perhaps the most pressing challenge our health care system faces. In 2021, AARP’s Public Policy Institute analyzed rural-urban health disparities among adults age 50 and over. This analysis found that the approximately 20 million individuals age 50+ who are living in rural areas have less access to care and experience worse health outcomes than those in urban areas.
For example, older adults living in rural areas were more likely compared with those living in urban areas to report having been told by a health professional that they have heart disease, stroke, diabetes, cancer, or obesity. Racial and ethnic disparities also exist among both rural and urban older adults, but the gap is often especially pronounced between Black and White older adults living in rural areas.

We note that the Department of Health and Human Services (HHS) Equity Action Plan released in April 2022 calls for improving data and equity assessment capacity to be able to consistently identify and address inequities in health and human services. We strongly support the Department's plan to conduct an equity assessment in Medicare to ensure access to benefits for eligible populations and to develop strategies for addressing identified barriers.

With CMS’ capacity for oversight and data collection, ensuring that racial and geographic disparities are not exacerbated for MA beneficiaries must be prioritized. Identifying disparities and monitoring progress toward advancing health equity requires the collection and analysis of reliable demographic data. AARP applauds CMS’ recent steps to include race and ethnicity as optional questions as part of MA’s model enrollment form and urges continued efforts to encourage MA plans to collect reliable demographic and socio-economic data on MA enrollees. These data are critical to identify care gaps and inform future policy developments aimed at advancing health equity for MA enrollees. Across all categories of data, CMS should ensure that data collection approaches, screening tools, and measurement are validated, standardized and consistently applied across MA organizations.

CMS also needs more and better data on beneficiaries’ social needs (in particular, nutrition, housing, transportation, and social isolation), which are widely known to impact health outcomes. Such data would support efforts to improve access and care for all MA enrollees and particularly for those who have low income, are more frail, live in rural areas, and/or have complex medical conditions. Identifying social determinants of health needs among MA beneficiaries is a critical step to reducing health disparities. CMS recently proposed requiring Special Need Plans to screen for social needs as part of their Health Risk assessment. Similar efforts to identify MA beneficiaries with health-related social needs should be expanded to all MA plans. Moving beyond screening, CMS should consider policies to ensure appropriate follow-up when people screen positive for health-related social needs, including how to better support addressing those needs in partnership with community-based organizations and other partners. In addition, AARP supports public reporting of plans’ performance in screening for social needs measures and with follow-ups when people screen positive. And, eventually, incorporating these measures in star ratings as addressing these unmet social needs are important considerations for older adults and their families in assessing and selecting an MA plan that is right for them.

More generally, it is critical for CMS to monitor the effects of current MA payment policies on disparities in access to and quality of care and to address any unintended harmful consequences. For example, recent evidence suggests that the current design of MA payments may incentivize insurers to offer fewer high-quality plans in areas with many racial and ethnic minority group
residents. AARP supports CMS’ ongoing efforts as part of its broader strategy to use quality measurements as a tool to focus plans and clinicians on improving equity in MA; as part of that effort, AARP supports the use of stratified reporting of performance measures to allow plans and clinicians to monitor and address differences by race/ethnicity and other relevant domains. We encourage CMS to leverage MA’s quality ratings and quality bonus systems to identify and incentivize the reduction of health disparities among MA enrollees and to reward MA plans that deliver high quality care to underserved populations.

CMS could consider requiring MA organizations to develop and report progress on equity impact plans for addressing disparities at the beginning of each plan year. The equity impact plan would describe internal operational and cultural changes required to advance health equity among MA enrollees. In addition, CMS could require MA plans to describe how they will identify and address beneficiaries’ social determinants of health.

Given the range of approaches to advancing health equity among MA beneficiaries, technical assistance that includes learning collaboratives, information sharing, and structured trainings could help participants identify and apply promising approaches. This includes best practices for collecting and using data on patients’ demographic and social determinants of health, developing partnerships with community-based organizations to address social needs, and implementing interventions. Given the returns that investing in services targeting health disparities can yield for health and social organizations, CMS could share this evidence with MA insurers to support their efforts.

**Expanding Access: Coverage & Care**

**Coverage Information and Enrollee Choice**

MA’s utilization of private health plans creates both opportunities and challenges for the whole of the Medicare program and its beneficiaries. The wide array of private health plan options gives beneficiaries greater opportunity to find plans that meet their needs and preferences. But giving beneficiaries more choices also makes the task of selecting coverage more complicated and may be so confusing for some that it leads to poor decisions. Given the broad array and complexity of choices involving traditional Medicare versus MA, beneficiaries need timely, accurate, concise, and understandable information about the availability, quality, and cost of services under each option.

Consumers would greatly benefit from better information to understand the differences between MA and traditional fee-for-service Medicare, not just a focus on shopping between private plans as the Plan Finder tool does now. Information on MA and traditional Medicare coverage options should be transparent and balanced, and consumers should have access to complete and unbiased information on the tradeoffs between both coverage options.

Beneficiaries should also be better informed of certain aspects of MA plans, including that plans may terminate their relationship with Medicare in any given year; that plans may change the premiums, cost-sharing charges, or benefits from year to year, including drug coverage; and that plans may drop physicians from their networks during the year. Beneficiaries may also be
unaware that if they voluntarily leave an MA plan and return to traditional Medicare, they may be subject to medical underwriting for a Medicare supplement (Medigap) policy. This underwriting may result in their being refused a policy or required to pay higher rates.

Given the potential for high out-of-pocket expenses under traditional Medicare, a key consideration for beneficiaries choosing between traditional Medicare and MA is their ability to access Medigap coverage. Though federal law requires guaranteed issue periods when a Medicare beneficiary first enrolls in Part B after turning 65 (and for a limited set of other scenarios), some states have policies that expand beneficiaries’ access to Medigap while others do not. Consumers should have easy access to clear information on the implications of enrolling in an MA plan should they later choose to switch to traditional Medicare.

Some beneficiaries may choose MA, at least in part, to gain coverage of newly available supplemental benefits that MA plans can offer only to certain enrollees. Easily accessible information on whether a beneficiary would be covered by a given supplemental benefit would allow consumers to make better informed choices.

A beneficiary’s choice of coverage option is highly personalized, complex and nuanced, and likely to evolve over time. For example, beneficiaries may try to align their selection with their medical needs—for less healthy individuals that may mean opting for more comprehensive coverage or choosing a coverage option that allows them to continue seeing a particular specialist. In addition to beneficiaries’ personal health care needs, other factors such as their financial situation, plan availability where they live, and access to employer coverage may influence their Medicare coverage choice.

Too many choices can also make it very hard for consumers to focus on what is important to them. To help simplify this decision for consumers, we recommend not allowing insurers to offer multiple very similar MA plans. In addition, it can be very difficult for consumers to assess plan networks (names are similar, it is hard to see distinctions, etc.). Consumers would greatly benefit from additional help in this area, along with accurate and up-to-date provider directories. Given the nature of the choice between Medicare options, consumer access to personalized and unbiased information such as that provided by the State Health Insurance Information Programs is critical.

**Telehealth and Broadband**

Telehealth has proven to be a vital tool in ensuring access and continuity of care to millions of MA enrollees, especially considering the ongoing impact of the COVID-19 pandemic, and it will likely grow in the coming years. Expanding access to this mode of health care delivery has significant implications for the Medicare programs and Medicare beneficiaries. The wider use of telehealth in MA – which was expanding prior to the pandemic under implementation of the Bipartisan Budget Act of 2018 – can provide beneficiaries with more timely and efficient care in addition to easier access to certain health care providers.

Unfortunately, there are still millions of older Americans who are on the wrong side of the digital divide. This is especially true for residents of rural and urban communities that lack the
broadband infrastructure needed for high-speed internet service. Even where that technology is available, many older adults still lack the digital know-how to appropriately utilize the internet. As telehealth continues to expand along with other means of virtual communication via the internet, it is important that access to broadband service is no longer a luxury but essential to carry out day-to-day tasks.

That’s why AARP supported permanent subsidies to help households pay for broadband service, investments in new deployment to expand reach for unserved and underserved areas, and efforts to promote and fund digital equity to ensure that those with access know how to use high-speed internet effectively. This has included direct outreach to the public about the financial help to gain broadband access provided for in the new Affordable Connectivity Program (ACP) that was enacted into law under the Infrastructure Investment and Jobs Act of 2021. Approximately 42% of the over 13 million Americans enrolled in the ACP to date are age 50+.

We strongly encourage CMS to coordinate efforts with the Federal Communications Commission (FCC) to educate consumers about the availability of this program and how they can utilize it to gain broadband access. Additionally, brokers and agents selling MA plans could provide enrollees information on the ACP and even enroll them in the program, if qualified. Information about the ACP and the ability to enroll could also be included in any marketing materials and beneficiary information put forth by MA plans.

**Improving Prior Authorization Process**

AARP is encouraged by legislation currently pending before the House of Representatives (H.R. 8487, the Improving Seniors Timely Access to Care Act of 2022) that would give CMS a framework to meaningfully evaluate and improve oversight of MA prior authorization requests. This is especially urgent given the April 2022 findings of HHS Office of Inspector General (OIG) that MA beneficiaries were denied prior authorization requests at a significantly higher rate than traditional Medicare beneficiaries. The wide range of data that the legislation requires from MA providers on the nature of prior authorization request denials will give CMS a clearer picture of the scope of the OIG’s findings and inform ways to better eliminate inappropriate denials. We are also supportive of language around enrollee protection standards that will establish a collaborative process between beneficiaries, providers, and CMS to ensure that denials of prior authorization requests no longer produce obstacles to needed care. In addition to the legislation, we urge CMS to work to address the issues raised in the OIG’s report.

**Extending and Expanding Current Programs**

There are several examples of innovative pilot programs conducted by CMS that could improve health equity and expand access in the Medicare program. We recommend that CMS continue to pursue these programs and extend or expand them, where appropriate.

*Independence at Home: Comprehensive In-Home Primary Care for People with High Needs*

Over the first five years of this demonstration (2012-17), the total cost of services (before accounting for incentive payments) for beneficiaries participating was about $116 million lower than the benchmark, or an average cost reduction of $2,142 per person. Overall, service costs
were 5 percent to 9 percent lower than the benchmark between the program’s third and fifth years. A study of this demonstration estimated that if Medicare expanded Independence at Home nationwide, up to 2.4 million people with a similar health profile as people currently in the pilot program could receive comprehensive in-home primary care visits. Such an expansion would generate estimated Medicare savings (after accounting for the shared savings incentive payments) of approximately $2 billion to $11 billion over 10 years. In addition, participating providers generally performed well on the demonstration’s quality of care standards. The vast majority of patients and their family caregivers were highly satisfied with the program—with 93 percent of them reporting being satisfied or very satisfied with the overall quality of care they received from their Independence at Home practice.

**Community-based Care Transitions Program: Partnerships between Community-Based Organizations and Hospitals to Improve Post-Hospital Transitions**

Overall, individuals who participated in the Community-based Care Transitions Program had lower 30-day readmission rates and lower Medicare spending relative to comparable nonparticipants. Readmissions were 1.8 percentage points lower (14.6 percent versus 16.4 percent). An analysis of the 44 longest-serving sites (that is, combination of hospitals and community-based organizations) found that they successfully improved quality and reduced costs by identifying patients’ needs, effectively linking participants with community-based services, and effectively coordinating with post-acute care providers. These 44 sites (with about 530,000 discharges) had 30-day Medicare spending that averaged $570 (7 percent) less for people in the program, and a readmission rate that was almost 13 percent less, than would otherwise have been expected based on a comparison group. After considering the fees paid to the community-based organizations for the program, net savings averaged $211 (2.8 percent) per participating individual.

**Competitive Bidding for Durable Medical Equipment (DME)**

According to MedPAC, competitive bidding has proven successful for DME. In 2017, total Medicare spending on competitively bid DME supplies was $4.7 billion less than in 2010, and median payment rates for the 25 highest spending DME supplies declined by nearly 50 percent. MedPAC has suggested resuming the competitive bidding program for DME and expanding it to include additional DME items. The success of Medicare’s DME competitive bidding program suggests that extending competitive bidding to other Medicare services, such as clinical laboratory services, might yield even more savings for the program and beneficiaries.

**Payment Models for Accountable Care Organizations (ACO)**

Although results have varied among individual ACOs, results showed that Medicare ACOs generated modest savings while maintaining or improving care quality. ACOs have the potential to improve care quality for many people with Medicare. This payment model also shows the promise for patients to receive safer and more appropriate care that fosters their and their family caregivers’ involvement in making care decisions. A key feature of this innovation is that it encourages health care providers to work together as a team to deliver higher-value care.
Support Affordability & Sustainability

The long-term sustainability of the Medicare program is a top priority of AARP. Now that MA is a substantial part of Medicare, it is more important than ever to make sure that federal dollars spent on MA are spent efficiently and accurately and that we are properly incentivizing quality care without overpaying. Perhaps the most significant improvement to the sustainability of Medicare was recently enacted in the Inflation Reduction Act. That legislation will allow Medicare to negotiate for better drug prices, which will save out-of-pocket costs for all Medicare beneficiaries and will save the Medicare program itself billions of dollars each year.

We can also improve Medicare’s program-wide finances by addressing MA payments. AARP believes that Medicare payments should be neutral with respect to coverage options. Benchmarks for MA plans should be set and maintained in line with traditional Medicare costs and performance incentive payments should be a tool that appropriately identifies and rewards high performing plans. As MedPac has recommended, policy makers should periodically evaluate the impact of the MA reimbursement methodology to ensure reasonable private health plan participation in the Medicare program and appropriate Medicare payments to participating plans.

Additionally, there is a wide range of incremental changes that could extend the overall solvency of Medicare. History shows that relatively small payment modifications to slow spending growth can have a significant positive impact on the Trust Fund. Policies to increase Trust Fund revenue that have been adopted numerous times throughout Medicare’s history should also be considered again, including raising new revenue or redirecting revenue from existing sources. As has always been the case, sustaining Medicare for the future will require continued attention to reducing unnecessary spending, addressing quality of care improvements and ensuring adequate revenue.

Conclusion

We thank you for the opportunity to respond to this important RFI. It is critical that all Medicare beneficiaries – whether enrolled in MA or traditional Medicare – are treated equitably and maintain access to all necessary health care services. If you have any questions, please do not hesitate to contact me or have your staff contact Brendan Rose on our Government Affairs team at 202-434-3770 or brose@aarp.org.

Sincerely,

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Government Affairs