

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

May 29, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-4207-NC
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

Re: Centers for Medicare & Medicaid Services Request for Information on Medicare Advantage Data (CMS 4207-NC)

Justice in Aging appreciates the opportunity to comment on the above-referenced Request for Information (RFI). Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on long-term services and supports and the particular needs of those dually eligible for Medicare and Medicaid coverage. Our advocacy focuses on populations of older adults who have historically faced discrimination, including women, LGBTQ+ people, people of color, people who have limited English proficiency, and people with disabilities. Ensuring that programs and services fully and fairly serve these communities in an equitable manner is at the heart of our work.

We advocate for culturally competent, person-centered care in Medicare and Medicaid to meet the diverse needs of seniors with limited incomes and resources across the country. We work with a network of advocates and professionals serving older adults who benefit from Medicare and Medicaid, and we often see problems arise due to a lack of data transparency.

This RFI response focuses on two audiences for MA data:

- **Medicare enrollees (especially dually eligible (DE) individuals) and their advisors.** This group has consistently told researchers and evaluators that they need more data to make informed decisions about their Medicare Advantage choices.
- **Advocates for health care access.** This group does not necessarily have the funds or specific expertise to access Medicare Advantage (MA) data through currently available datasets, and yet they can have in depth knowledge and insight into how MA plans are experienced by Medicare enrollees. With data and data tools, they could contribute powerfully to understanding and addressing issues that arise for enrollees in MA.

Washington, DC



Los Angeles, CA



Oakland, CA

1. Release data in formats that improve usability

We appreciate the Centers for Medicare & Medicaid Services' (CMS') work to make data available, including through tools like Medicare Plan Finder and public use files. Below are some additional suggestions to improve data use by DE individuals, their advisors, and health care access advocates.

Provide tools for Medicare enrollees and their advisors to meaningfully compare MA plans based on an individual's unique circumstances. Medicare enrollees and their advisors report an overwhelming amount of dense information associated with MA plan choice, while still lacking specific information about how plan choice will affect a person's care. Basic questions like whether an individual's medical services will be covered, or whether there is a provider in network that speaks the individual's language, can be hard to come by. SHIP counselors tell us that they do not have the information on services, utilization management, formularies, or network to give effective individualized counseling to individuals. We encourage CMS to build on available tools like Medicare Plan Finder to increase access to meaningful choices. For example, as we will discuss below, requiring direct links from Medicare Plan Finder to (1) The specific plan's Evidence of Coverage and (2) The specific plan's electronic provider directory would allow Medicare enrollees and their advisors to perform a more detailed comparison of plans to make an appropriate choice for their individual needs.

Offer a free data lab tool that lowers the threshold for access to descriptive Medicare data.

We appreciate the effort CMS has made to make data accessible, including Special Need Plan (SNP) datasets and other public use files. We encourage CMS to build on these efforts to create a data lab or similar tool that allows for descriptive data queries. For example, the following federal websites allow individuals to run free data queries without needing to code or download datasets: (A) The Department of Education's [data lab](#), which allows queries for a couple dozen datasets related to schools and students; (B) The Center for Disease Control's [WONDER database](#), which allows queries for public health datasets; and (C) The Census Bureau's [Microdata Access Tool](#), which allows for queries into census data. Each of these online tools allow users to build tables providing custom descriptive data, while offering guardrails to protect privacy and alert users when data is unreliable. For example, the Department of Education's data lab has been used by advocates to track college hunger, and Census microdata has been used to predict the effects of the Public Charge rule.¹ Developing a data lab or similar tool for Medicare Advantage data would similarly allow for advocates to provide context for issues they are seeing in their communities.

¹ Bryce McKibben, Jiayao Wu, and Sara Abelson, Temple University, New Federal Data Confirm that College Students Face Significant – and Unacceptable – Basic Needs Insecurity (Aug. 2023); Kelly A. Love, Rachel Gershon, and Margaret Sullivan, BCBSMA Foundation, The Final Public Charge Admissibility Rule: Implications for Massachusetts," (Sept. 2020).

2. Allow for data stratification to better assess characteristics and experiences of Medicare enrollees and MA plans

The Medicare population is diverse, with different levels of coverage, access, and experiences of care. Collecting and releasing data on population and plan characteristics is helpful for making trends clear and addressing disparities. For all measures of plan enrollment, disenrollment, care access, and quality of care, we ask for disaggregation and plan-level data, described further below.

Disaggregate by demographic data. We ask CMS to collect and report data, disaggregated by race/ethnicity, age, rural/urban status, disability, language, sex, sexual orientation, and gender identity. This demographic data collection and release promotes Executive Order 13985, which calls for advancing equity for underserved populations, and advances the goals and objectives outlined in the CMS Framework for Health Equity 2022-2032 and the HHS Equity Action Plan.

Disaggregate by DE status. We ask CMS to collect and report data disaggregated by full-benefit dually eligible status and partial-benefit dually eligible status. These populations have access to a dramatically different type of Medicaid assistance and access to Dual-Eligible Special Needs Plans (D-SNPs), and should be disaggregated.

Publish data at the plan level. We ask CMS to publish data on the plan level rather than the contract level. Today, most quality and financial data is collected and publicly reported at the contract level, rather than at the plan level. This is the case even where plans might serve significantly different populations. D-SNPs are only made available to people who are dually eligible and are supposed to be tailored to meet their needs, yet a D-SNP can be embedded in an insurer's broader Medicare Advantage contract that includes many general Medicare Advantage plans. This hinders consumer choice and research – for example, a recent brief on prior authorization was unable to provide a comprehensive look at D-SNP prior authorization because of the contract-level data.²

3. Publish data and documents to inform choice and access

Make State Medicaid Agency Contracts (SMACs) public. Currently, many D-SNP policies - including who is eligible for D-SNP enrollment and what care coordination requirements a plan must follow - are *only* available in State Medicaid Agency Contracts (SMACs). And yet, 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. For example, we were unable to advise a state disability advocate about whether his clients would be eligible for a D-SNP if they were on spend-down Medicaid – because that information is only available in the state's SMAC, which is not publicly available in his state.

² Salama Freed et. al., KFF, "[10 Things to Know About Medicare Advantage Dual-Eligible Special Needs Plans](#)," (Feb. 2024).

In addition, for health care advocates, access to *draft* SMACs accompanied by a required public commenting process would be greatly useful in order to give actionable feedback to state Medicaid agencies before the policies contained within SMACs become finalized. We ask that CMS require states to make SMACs public, both in draft and final form. CMS should also post the final versions of SMACs in a centralized website, to facilitate analysis by advocates and policymakers.

Publish D-SNP integration levels. The levels of D-SNP integration (FIDE, HIDE, CO levels and AIP designation) can have a significant impact on enrollment processes, care coordination, communications, and appeals. We often hear questions from SHIP counselors asking how to identify an MA plan’s level of integration in order to inform DE individuals of what level of integration to expect from their plans. While SNP data tables do identify plan integration, it takes a few steps to crosswalk from Medicare Plan finder and plan materials to those tables. As these designations become more impactful, we ask CMS to make it easier to understand integration level from Medicare Plan finder.

Publish D-SNP affiliation data. Both state and federal rules encourage exclusive alignment – where a person’s Medicaid managed care plan is affiliated with their D-SNP. And yet, we are not aware of any federal source of data informing the public of which D-SNPs are aligned with which Medicaid managed care plans. We ask for accessible, up to date information on which plans are aligned with each other, so that Medicare enrollees can make informed plan enrollment decisions and advocates can better understand the impact of upcoming policy changes.

This is becoming more and more critical as more people are auto-enrolled in Medicaid or Medicare managed care plans based on their affiliated enrollments. We hear from advocates counseling clients on planning for their future health insurance needs. Without knowing their affiliated plans, it can be hard to understand the services and providers that will be available to them when auto-enrolled in the future.

Publish information about the availability and use of services and supports. Many aspects of coverage availability and use are not readily available to Medicare enrollees or researchers. We often hear from SHIP counselors that service availability is top of the list when it comes to picking plans, and yet the information available does not adequately inform MA plan choice. Publishing additional information about service availability and utilization will allow MA plans to compete on providing access to quality, timely care.

It is particularly important for DE individuals to have this information in order to assess whether an MA plan is offering coverage and benefits beyond what they already have access to under Medicaid like dental, vision, hearing, and home and community-based services. We ask for CMS to make the following more accessible:

- **Coverage availability and eligibility criteria.** This should take the form of both (1) Direct links to evidence of coverage and other relevant materials from Medicare Plan finder; and (2) A consistent, researcher-friendly format to allow for plan comparison. CMS should continue to work towards integrated descriptions of coverage availability for DE individuals, and making sure service criteria information in plan materials is sufficiently detailed for individuals to be able to understand how the plan’s coverage intersects with their individual circumstances.
- **Claim requests, approvals, denials, and timeframes.** We ask that CMS release data that gives a fuller picture of service requests that are delayed or denied. Specifically, we ask MA plans to release data on claim denials, including by clinical condition, service type, and for supplemental benefits. Denials should be incorporated into encounter data. Responsive time should also be reported. And, as noted above, data should be accompanied with demographic data to help understand how claim denials are impacting health equity.
- **Service utilization.** We ask that CMS release information on service utilization, including supplemental benefit utilization, along with demographics.
- **Language and disability service utilization.** We ask that CMS also release data on requests for language or disability accommodations, approvals, and denials for those accommodations.

Publish prior authorization and other utilization management data. Prior authorization and other utilization management practices can have a significant impact on access to timely care. We appreciate the steps CMS is taking to improve transparency around prior authorization, including the recent CY 2025 Part C and D rule requiring plans to release prior authorization data. We ask CMS to build on these improvements, including making the following more transparent, including in a format where researchers can spot trends and compare plans.

- **Prior authorization processes.** We appreciate CMS’ efforts to make prior authorization processes more transparent, including the prior authorization rule published in January 2024 and the recent memo requiring reporting on uses of algorithms and artificial intelligence. We ask that CMS publish information about the processes used in prior authorization, including the use of algorithms and artificial intelligence. In particular, we ask that CMS monitor the reasons given for denials and whether they are sufficiently specific enough to mount a responsive appeal.
- **Prior authorization requests, approvals, denials, and timeframes.** 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.

- **Rate of other utilization management practices.** We ask that CMS include step therapy and other utilization management data, broken out by medication, service, and provider types.

Publish information on coordination Medicare and Medicaid. D-SNPs were created, in part, to address the challenges of navigating Medicare and Medicaid at the same time. Yet, the available data on plan performance do not address the pain points we often hear about from DE individuals. We ask CMS to develop meaningful measures at the D-SNP level for coordination of Medicare/Medicaid benefits that address known issues. For example, how long do eligible DE individuals in a D-SNP have to wait to access a power wheelchair? How fast and able are individuals able to navigate the Medicaid and Medicare appeals processes? What are the rates of transitions from hospitals and nursing facilities to the community?

Publish DSNP integration activity data. We ask CMS to publish data on how well D-SNPs are complying with integration requirements, including level of care coordination, integrated communications, integrated appeals, enrollee assistance with Medicaid appeals, and establishment and use enrollment advisory committees (including the proportion of committees that are DE individuals and minutes from those meetings). As CMS tests new approaches to integrating Medicare and Medicaid, part of understanding how well these approaches are working includes understanding of how well MA plans comply with new requirements.

Publish network information and data. We ask for CMS to make available up to date plan network information. Currently, provider network links from Medicare Plan finder often go to a company's generic page – we ask for these links to go to the specific, electronic network for the specific plan, to ensure that potential enrollees have up to date information on the providers available to them. We ask for that electronic network to include information about provider language and disability accessibility. We ask CMS take steps to make clear where provider networks may be more limited – including shadow networks (where a provider is available on paper but not in practice) and Accountable Care or delegated networks (where selection of a primary care provider can limit networks).

Publish MA enrollment and disenrollment data. We ask that CMS publish, by plan, enrollment and disenrollment data. Disenrollment data should be broken out by demographics, reason for disenrollment, and whether the disenrollment was voluntary or involuntary. Disenrollment data can serve as a useful early indicator of plan performance. An influx of disenrollments may be an indicator that an MA plan's access to services and provider network are not as accessible as they should be for specific populations or people with specific needs.

Publish data on appeals, grievances, and complaints. We ask that CMS publish appeal data, including timeframe, joint Medicaid / Medicare appeals, and outcomes by service type and plan. We ask that CMS track and report on to what extent Medicaid appeals are put on hold for Medicare appeals. We are hearing from advocates that Medicaid coverage is delayed while a

Medicare appeals process is underway. We also ask CMS to publish data on grievances and complaints, including subject matter, as it can provide key indicators of emerging and ongoing issues. For example, we often hear of individuals instructed by their skilled nursing facilities to disenroll from Medicare Advantage in order to stay at the facility, due to provider network issues. For another example, DE individuals often report being improperly billed for covered services to their status as a QMB. DE individuals also report that their provider will not see them as a Medicaid enrollee due to lower reimbursement of the “lesser of” policy. Tracking of these types of complaints will help to determine the extent of this issue and ensure MA plans are properly enforcing federal law protections for their members.

Publish data on MA enrollee access to Medicare Savings Programs (MSPs) and other public benefits. Studies show the importance of connecting Medicare enrollees with food and financial assistance programs. For example, Supplemental Nutrition Assistance Program (SNAP) enrollment is tied to decreased emergency department utilization, delayed nursing facility admission, and over \$2,000/year in Medicaid savings for DE individuals.³ CMS has recognized the importance of connecting Medicaid members with public benefits; it has started asking state Medicaid agencies to report on enrollees who are eligible but not enrolled in SNAP and WIC.⁴ Given that Medicare Advantage plans are well-positioned to provide screening and application assistance for SNAP and MSP, **we ask that CMS collect data on the proportion of each MA plan’s population that are likely eligible but not enrolled in MSP and other public benefits.**

Update MMLEADS data. We appreciate CMS’ efforts to release Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) public use files. These files have been essential for understanding state-by-state demographics, utilization, and health conditions of dually enrolled individuals. We ask for MMLEADS to be updated for more current data than 2012. Especially when trying to understand the demographics of DE populations, this 2012 data set is the most current source available, leading to a limited understanding of the population.

4. Conclusion

Access to accurate information is important for any market to function well, and this is especially true for the Medicare Advantage space. Providing information to Medicare enrollees and their advisors about their MA options is one step towards building a better system. Lowering the threshold for health care advocates to understand the trends in their

³ Sarah L. Szanton et. al., “[Food Assistance is Associated with Decreased Nursing Home Admissions for Maryland’s Dually Eligible Older Adults](#),” BMC Geriatrics 17(1):162 (2017) (Seniors dually enrolled in both Medicaid and Medicare are less likely to need nursing facility care when enrolled in SNAP); Seth A. Berkowitz et. al., “[Supplemental Nutrition Assistance Program Participation and Health Care Use in Older Adults](#),” Annals of Internal Medicine 174:12 (2021) (Higher enrollment by dually eligible adults in the SNAP is associated with fewer hospital and long-term care admissions as well as emergency room visits – and an estimated Medicaid cost-savings of \$2,360 per person annually).

⁴ MassHealth 1115 Demonstration [Special Terms and Conditions](#) as amended April 19, 2024 at STC 15.7; CalAim 1115 Demonstration [Special Terms and Conditions](#) as amended March 6, 2024 at STC 15.5.

communities offers another way to alert the system of emerging trends and give feedback to CMS.

Access to data, however, is not enough. It must be paired with oversight and enforcement. For example, information on plan prior authorization data has limited utility when almost all plans have indications of high levels of inappropriate prior authorization denials. Enrollee rights must be vigorously defended, to ensure that plans are competing on giving the best care.

Thank you again for the opportunity to comment on this RFI. If you have any questions, please contact Rachel Gershon, rgershon@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Amber C. Christ".

Amber C. Christ
Managing Director, Health Advocacy