



# Sustaining and Strengthening Medicare Advantage:

Policy Recommendations to Maintain Accountability and Support Beneficiaries

**REPORT**  
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BETTER MEDICARE  
ALLIANCE

# Executive Summary

In 2022, more than 29 million Medicare beneficiaries are enrolled in Medicare Advantage, and 50% of all Medicare beneficiaries are expected to be enrolled by 2026.<sup>i,ii</sup> As the program grows, Better Medicare Alliance (BMA) seeks to partner with health plans, providers, policymakers, patient advocates, and beneficiaries to ensure that Medicare Advantage continues to innovate to provide coordinated, value-based, and affordable care for all beneficiaries.

In this issue brief, BMA makes a series of recommendations designed to strengthen Medicare Advantage by developing a comprehensive approach to program integrity, better identifying and addressing beneficiaries' needs using in-home health risk assessments (HRAs), giving beneficiaries the information and support they need to choose the right Medicare coverage based on their unique needs, and realizing the full potential of supplemental benefits to improve beneficiaries' health. The goal of these policy solutions is to build upon the success of Medicare Advantage and improve the value of the program for beneficiaries.

## Summary of BMA's Recommendations to Strengthen Medicare Advantage

Goal	Recommendations
<b>Ensuring Program Integrity to Promote High-Quality, Affordable Care for Beneficiaries</b>	<p>Ensure program integrity by adopting a comprehensive and accurate approach to risk adjustment data validation (RADV) by:</p> <ul style="list-style-type: none"><li>• Conducting audits of all Medicare Advantage plans annually, greatly increasing oversight of the program.</li><li>• Applying RADV prospectively, not retroactively, because the retrospective application of the changes proposed in the RADV rule invalidates the actuarial assumptions plans incorporated in plan bids from 2011 onwards. Changes to RADV rules should be announced annually in the Advanced Notice of Methodological Changes for Medicare Advantage Payment Rates and Part C and D Payment Policy.</li><li>• Applying a Fee-for-Service (FFS) Adjuster, as outlined in CMS's 2012 Notice.<sup>iii</sup> The FFS adjuster should be used to calculate the beneficiary-level discrepancy rate for a representative sample of FFS beneficiaries and incorporate the payment impact of those discrepancies into RADV audits.</li></ul>

	<ul style="list-style-type: none"> <li>• Using extrapolations when the RADV audit results clearly support the finding of a Medicare Advantage plan being overpaid by using the lower bound of the 99th percent confidence interval, consistent with CMS's 2012 methodology.</li> <li>• Recouping any net overpayment at the parent organization level by adjusting the payment for each RADV-eligible beneficiary in each audited contract for which an overpayment has been determined.</li> </ul>
<b>Implementing Best Practices for In-Home Health Risk Assessments (HRA)</b>	<ul style="list-style-type: none"> <li>• Codify and require best practices as described in the CY 2016 Rate Announcement and Final Call Letter <sup>iv</sup> for in-home HRAs to ensure that plans apply consistent criteria in how they conduct these visits.</li> </ul>
<b>Ensuring Beneficiaries Receive Accurate Information About Their Medicare Choices</b>	<ul style="list-style-type: none"> <li>• Enhance regulation and oversight on marketing communications and oversight over Third Party Marketing Organizations and improve beneficiary decision-making support tools.</li> </ul>
<b>Delivering Coordinated Supplemental Benefits to Meet Beneficiaries' Medical and Social Needs</b>	<ul style="list-style-type: none"> <li>• Create best practices for managed and coordinated supplemental benefits to improve beneficiary health and care coordination.</li> </ul>

# Introduction

Medicare Advantage is a public-private partnership through which nearly half of seniors and Americans with disabilities eligible for Medicare receive coverage. Unlike traditional, fee-for-service (FFS), Medicare, for which an individual pays separately for hospital visits, doctors/outpatient, and prescription drugs, Medicare Advantage typically covers all of these services in one monthly premium, often with extra benefits, at a lower cost to the enrollee. In addition, Medicare Advantage offers additional, supplemental benefits that are not available in FFS, such as dental, vision, hearing, and wellness.

Medicare Advantage is a leader in the innovative use of value-based care—delivering better health outcomes, through better quality care at a lower cost for Medicare beneficiaries. As a result, beneficiaries are increasingly choosing Medicare Advantage over traditional Medicare. Enrollment in Medicare Advantage has more than doubled in the past ten years, from 13.1 million in 2012 to 29.1 million beneficiaries today.<sup>v</sup> In addition, since 2013, enrollment in Medicare Advantage has grown 111% among minority beneficiaries and 125% among beneficiaries dually eligible for Medicare and Medicaid.

Furthermore, 94% of Medicare Advantage beneficiaries report that they are satisfied with their health coverage, and 95% report satisfaction with their network of physicians, hospitals, and specialists.<sup>vi</sup>

The aged population grows each year and, with 50% of Medicare beneficiaries anticipated to enroll in Medicare Advantage by 2026,<sup>vii</sup> it is essential that Medicare Advantage continues to meet the needs of a growing population who are living longer. As Medicare Advantage continues to grow, BMA is committed to working with beneficiaries, health plans, providers, patient advocates, community-based organizations, and policymakers to advance solutions that will promote coordinated and affordable care for all beneficiaries.

In this issue brief, we put forward a series of recommendations designed to sustain and strengthen Medicare Advantage by:

- Ensuring program integrity through accurate risk adjustment data validation (RADV) audits;
- Implementing best practices for in-home health risk assessments (HRAs) to better address beneficiary health care needs;
- Ensuring beneficiaries receive the information and support they need to choose the right health plan based on their unique needs, and
- Delivering coordinated supplemental benefits to realize their full potential to improve health and address social risk factors.

In addition, across all areas of Medicare Advantage, we recognize the need for better collection of data to enable stakeholders to better identify disparities in health outcomes and beneficiary experience based on race, ethnicity, geography, or other factors and to implement solutions to address social determinants of health and advance health equity for beneficiaries.

Below, we offer detailed recommendations for the Centers for Medicare & Medicaid (CMS), Medicare Advantage plans, and other stakeholders to promote reliable, equitable, and high-quality care for seniors and people living with disabilities in Medicare Advantage.



# Ensuring Program Integrity to Promote High-Quality, Affordable Care for Beneficiaries by Promoting Accurate Risk Adjustment Data Validation (RADV) Audits

Ensuring Medicare program integrity is fundamental to safeguarding the future of Medicare and the ability to provide sustainable, high-quality, and affordable care to seniors and people with disabilities. The U.S. Department of Health and Human Services (HHS) conducts program integrity activities to prevent fraud, waste, and abuse in the Medicare program. These activities include reviews of claims paid by Medicare, as well as audit activities in the Medicare Advantage program. Because Medicare Advantage plans are paid based on prospective, per-enrollee bids, HHS conducts different program integrity activities in Medicare Advantage than in FFS. Nonetheless, a comparison of the relative error, as measured by overpayments and underpayments, is important context in understanding HHS's current oversight of these programs, and the role of RADV and current proposed changes in program integrity.

CMS monitors payment error (i.e., overpayments and underpayments) across 13 programs designated by HHS or Office of Management and Budget (OMB) as "risk susceptible" (i.e., monetary loss estimates are greater than \$100 million in a fiscal year). OMB designated the following six programs as high priority for FY 2022: FFS Medicare, Medicare Advantage, Medicare Part D, Medicaid, Children's Health Insurance Program (CHIP), and the Child Care and Development Fund (CCDF). To identify overpayments and underpayments in Medicare Advantage, CMS conducts a RADV audit of medical records for a set of diagnoses across Medicare Advantage plans. As shown in Table 1, the Medicare Advantage overpayment rate is substantially lower than the FFS overpayment rate (4.93% vs. 7.27%). In addition, the net overpayment rate, which is the overpayment minus the underpayment rate, is lower in Medicare Advantage than in FFS (4.44% vs. 7.09%).

**Table 1: Estimated Improper Payments by Program  
– OMB High-Priority (Fiscal Year 2022)**

Program	Overpayments		Underpayments	
	Dollars (in millions)	Percent	Dollars (in millions)	Percent
FFS Medicare	\$30,677.99	7.27%	\$778.72	0.18%
Medicare Advantage	\$12,686.06	4.93%	\$1,254.76	0.49%
Medicare Part D	\$1,323.24	1.50%	\$37.87	0.04%
Medicaid	\$80,203.69	15.55%	\$369.34	0.07%
CHIP	\$4,303.02	26.74%	\$1.52	0.01%
CCDF	\$91.04	1.05%	\$23.13	0.27%

Source: Department of Health and Human Services (HHS) Annual Financial Report 2022, P228 – Payment Integrity Report

The underpayment rate for Medicare Advantage reported in Table 1 is likely underreported due to a change in methodology for the 2022 report. In 2021, HHS reported a Medicare Advantage overpayment rate of 5.96% and underpayment rate of 3.55% for a net improper payment rate of 2.41%.<sup>viii</sup> In 2022, HHS revised its methodology for determining underpayments by not counting certain additional diagnoses found during the review of medical records included in national audit sample.<sup>ix</sup> HHS's updated national improper payment estimation procedure is inconsistent with how CMS conducts RADV audits to estimate contract level payment error. Under either methodology, the reported estimates establish that the Medicare Advantage improper payment is lower than the FFS Medicare improper payment rate and significantly lower than other major programs such as CHIP and Medicaid.

## Current RADV Process

CMS employs RADV audits to ensure Medicare Advantage program payment integrity.<sup>x</sup> Under RADV, CMS selects a subset of plans to audit. CMS then generates a small random sample of enrollees (typically 201 enrollees) for each selected Medicare Advantage contract and conducts medical record reviews to determine whether diagnoses submitted by health plans from provider claims and medical records for risk adjustment are supported by medical record documentation. CMS uses this information to validate enrollees' risk scores and payments to the health plan. Any difference between the actual paid amount (based on plans' submitted diagnoses) and the amount that would have been paid based on RADV-validated diagnoses is known as the payment error. The error rate of the sampled enrollees is then extrapolated to the entire plan membership. This methodology on the number of enrollees audited changed in 2014 as outlined under a proposed rule, and before the rule was finalized.<sup>xi</sup>

In 2010, CMS proposed a methodology for selecting "a statistically valid sample of enrollees from each audited Medicare Advantage contract and extrapolating from the results of that sample audit to calculate a contract-level payment adjustment".<sup>xii</sup> In response to this rule, Medicare Advantage plans expressed concern over the lack of a "FFS Adjuster" that would account for differences in documentation standards between how the risk adjustment model is calibrated and how the audit is conducted. Stakeholders explained that a FFS Adjuster is necessary to account for coding errors that are embedded into the CMS-Hierarchical Condition Category (HCC) model, which have an impact on Medicare Advantage payment.

In 2012, CMS released its "Notice of Final Payment Error Calculation Methodology for Medicare Advantage RADV Contract Level Audits." In response to stakeholder feedback, CMS included the sampling framework and extrapolation calculation and announced that the agency would apply a FFS Adjuster in extrapolating payment error rates.<sup>xiii</sup>

CMS announced the use of a FFS Adjuster to meet the legal requirement for actuarial equivalence. Actuarial equivalence in Medicare Advantage is defined as meaning that aggregate payments for Medicare Advantage enrollees should be based on the payments that would be made for beneficiaries with similar risk if they were enrolled in FFS Medicare. The Medicare Advantage payment and bidding system is based on the statutory requirement of actuarial equivalence. Applying different standards for payment versus auditing violates the actuarial equivalence requirement. The documented standard difference between model calibration (where undocumented conditions are included) and RADV audits (where undocumented conditions are eliminated) requires that CMS apply the FFS Adjuster. Otherwise, the estimate of payment error produced under the proposed

RADV methodology will overstate the true payment error and violate the concept of actuarial equivalence.

In 2018, CMS published a proposed rule that departed from the methodology included in its 2012 Notice (“Proposed RADV Rule”). CMS proposed not to use a FFS Adjuster.<sup>xiv</sup> CMS cited an internal study to support this decision, which found that errors in FFS claims data do not have a systematic effect on FFS risk scores and, therefore, do not have an impact on Medicare Advantage plan payment. CMS also proposed making changes to regulations retroactively that would allow it to use the new methodology (i.e., without a FFS Adjuster), to recoup payments from RADV audits conducted from 2011-2013. CMS also asserted its authority to use unspecified variants of the proposed methodology in subsequent years. Medicare Advantage plans and other stakeholders disagreed with CMS’s decision to not use a FFS adjuster and commented on the errors in the internal study CMS used to justify its decision.

## Addressing Regulatory Gaps and Improving the Audit Process

BMA supports CMS’s overall goal of improving program integrity by ensuring that health plans are paid appropriately for the health status of enrollees. However, BMA has concerns about key aspects of the 2018 Proposed RADV Rule, particularly the proposals to eliminate the application of a FFS Adjuster and to retroactively apply a new methodology to RADV audits from 2011-2013.

Below is a new approach to add stability and predictability to the Medicare Advantage program with respect to RADV.

- **Audit Every Medicare Advantage Plan Annually:**  
CMS should conduct RADV audits of all Medicare Advantage plans annually to increase program oversight so that arbitrary decisions about which contracts are audited do not disproportionately impact some organizations more than others. CMS’s current approach to RADV audits only targets a subset of contracts annually (historically 5% or approximately 40 contracts) and the criteria CMS uses to select contracts for audit have not been made public. This means that some contracts are exposed to more audit risk than others. Under the 2018 Proposed RADV Rule, contracts have an unknowable probability of being included in an audit, causing uncertainty in bidding, accounting, and financial reporting. This proposal would be a significant improvement to the current approach and increase confidence in CMS’s program integrity efforts.
- **Changes Should Be Prospective, Not Retroactive:**  
Changes to the RADV process should be applied to the methodology prospectively, not retroactively. By statute, changes to Medicare Advantage payment and bidding must be announced prior to the submission of bids annually and subject to notice and comment. The retrospective application of the changes in the Proposed RADV Rule violates statute and invalidates the actuarial assumptions health plans incorporated in their bids from 2011 onwards. Specifically, any final methodology should only be implemented for years after the regulation is finalized. After finalization of the Proposed RADV Rule, future changes to RADV rules should be announced annually in the Advanced Notice of Methodological Changes for Medicare Advantage Payment Rates and Part C and D Payment Policy.

- **Apply a FFS Adjuster:**

A FFS Adjuster, as outlined in CMS's 2012 Notice,<sup>xv</sup> should be used to calculate the enrollee-level discrepancy rate for a representative sample of FFS enrollees and evaluate the payment impact of those discrepancies from RADV audits. The FFS Adjuster should be announced in the Advance Notice of Changes to Part C and D payment methodology so it can be accounted for in the annual bids due in June. Once an appropriate methodology for calculating the FFS Adjuster has been proposed and finalized, CMS should then conduct RADV audits of all Medicare Advantage plans annually for plan years that are bid for after the FFS Adjuster for that year was announced. Annual audits enable Medicare Advantage plans to obtain records from providers.

- **Extrapolate When Evidence Supports a Finding of Overpayment:**

Consistent with current RADV methodology, CMS should extrapolate when the RADV audit results clearly support the finding of a Medicare Advantage plan being overpaid by using the lower bound of the 99th percent confidence interval.

- **Recoup Medicare Advantage Plan Overpayment:**

When Medicare Advantage parent organizations have a net RADV overpayment across all Medicare Advantage plans in any given year after consideration of the FFS Adjuster, CMS should recoup that overpayment. CMS should recoup the net overpayment by adjusting the payment for each RADV-eligible enrollee in each audited contract for Medicare Advantage when an overpayment has been determined.





# Implementing Best Practices for In-Home Health Risk Assessments

Health risk assessments (HRAs) are an established component of the Medicare program. CMS covers an initial health assessment for beneficiaries in FFS Medicare and in Medicare Advantage within 90 days of the effective date of Medicare enrollment. This can be accomplished through a FFS Medicare initial preventive visit (i.e. “Welcome to Medicare” visit), an Annual Wellness Visit, or in Medicare Advantage, a health risk assessment.

Per CMS guidance, Medicare Advantage plans must make a best effort to conduct a health assessment annually to ensure coordinated and continuous patient care. Within Medicare Advantage, CMS requires health plans that offer a Special Needs Plan (SNP) to conduct a comprehensive HRA at the time of enrollment and annually thereafter, and new regulations will standardize some of the information collected, including questions on beneficiary social risk factors.<sup>xvi</sup>

An HRA is an objective evaluation tool that identifies gaps in care and collects critical beneficiary information that informs a beneficiary’s care plan to improve health. Information gathered includes:

- Health status,
- Demographics,
- Health risk factors, including physical, psychosocial, and behavioral risks,
- Social determinants of health, and
- Functions of daily living.

As an integral part of Medicare Advantage’s care coordination model, these evaluations are primarily used for preventive care and to assess the overall health of beneficiaries, document diagnoses, and identify gaps in care and unmet needs based on the information collected.

HRAs are provided through two key modalities:

- Survey-based HRAs identify critical beneficiary information on a variety of health status and social risk factors and inform care plans and next best clinical actions.
- In-home HRAs are part of comprehensive clinical care models in which a qualified health professional provides a clinical primary care visit, identifies and addresses gaps in care and works to identify and address social needs and health risk factors.

During an in-home HRA, a qualified health professional conducts a clinical primary care visit at the beneficiary’s home. In the home setting, the clinician has the ability to identify and address gaps in care that may not be identifiable in an office setting. The clinician evaluates a beneficiaries’ health status, key demographic information, health risk factors, social determinants of health, and other beneficiary social risk factors. The clinician also conducts a comprehensive review of medications, identifies and determines approaches to manage acute and chronic conditions, and develops a care coordination plan.

In addition, the clinician connects beneficiaries with other providers, programs, and resources as part of the overall holistic approach to manage and improve the beneficiary's wellbeing. In-home HRAs serve a valuable function for enrollees by providing a convenient and effective method for providers to collect information that can be used for patient care.

Diagnoses from in-home HRAs are permissible for risk adjustment if collected in person from a qualified clinical professional, which includes doctors, nurse practitioners, physician assistants, and clinical nurse specialists. CMS has proposed making changes to how diagnoses from HRAs can be used for risk adjustment but did not finalize these proposals. For CY 2014, in the Advance Notice CMS proposed only allowing diagnoses collected from HRAs to be used for risk adjustment that were confirmed by a subsequent clinical encounter.<sup>xvii</sup> For CY 2015, CMS proposed this same requirement but applied it to include all home visits, not just in-home HRAs.<sup>xviii</sup>

CMS has noted the importance of in-home HRAs. In the CY 2016 Rate Announcement and Final Call Letter, CMS pointed out that in-home assessments can have significant value as care planning and care coordination tools. In the home setting, the provider has access to more information than is available in a clinical setting; the provider can evaluate the enrollee's home for potential risks, identify needed supports to enable an enrollee to continue living in the community, and identify other relevant aspects of the enrollee's living situation.

CMS noted that "we expect plans to take advantage of the opportunities afforded by performance of in-home assessments to obtain and use that full spectrum of information to revise, develop, or implement comprehensive care plans for affected enrollees." CMS also noted that adoption of a standardized framework such as the CDC model HRA<sup>xix</sup> would provide consistency in how plans collect data from enrollees, would provide uniform and comprehensive information to support care planning, and would encourage a proactive approach for initiating preventive and other appropriate care.

To ensure all in-home HRAs are high-quality and delivering value to the beneficiary, BMA believes CMS should codify and require the best practices as described in the CY 2016 Rate Announcement and Final Call Letter for in-home HRAs.<sup>xx</sup> These best practices cited by CMS include the following:

- All components of the annual wellness visit, including a health risk assessment such as the model health risk assessment developed by the CDC;
- Medication review and reconciliation;
- Scheduling appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources;
- Conducting an environmental scan of the enrollee's home for safety risks, and need for adaptive equipment;
- A process to verify that needed follow-up care is provided;
- A process to verify that information obtained during the assessment is provided to the appropriate plan provider(s);
- Provision to the enrollee of a summary of the information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources; and
- Enrollment of assessed enrollees into the health plan's disease management/case management programs, as appropriate.

To ensure transparency and accountability for in-home HRA best practices, CMS should mandate annual reporting from Medicare Advantage plans that could include the following metrics:

- The organization's in-home HRAs are compliant with CMS guidelines, including the specified components of the HRA (e.g., contain questions on housing, transport, and nutrition)
- Key metrics, including the number of:
  - » In-home HRAs conducted
  - » Medication reviews conducted
  - » Appointments scheduled as a result of an in-home HRA
  - » In-home HRA reports delivered to enrollee's primary care provider (PCP) or conducted by the enrollee's PCP
  - » Enrollees receiving an in-home HRA that are enrolled in disease or case management programs

By codifying and requiring these best practices for in-home HRAs and appropriately monitoring use of in-home HRAs, CMS would ensure that health plans apply consistent criteria in how in-home HRAs are conducted, prevent the use of sub-standard in-home HRAs that are not providing clinical value, and promote access to holistic primary care.



# Ensuring Beneficiaries Receive Accurate Information About Their Medicare Choices

Nearly all Medicare beneficiaries nationwide have multiple Medicare Advantage plan options from which to choose. To support the best possible health care experience, it is crucial that beneficiaries have tools and information they need to identify and choose the health plan that will best meet their needs. Accurate marketing of Medicare Advantage plans is essential for beneficiary education, choice, and trust in the Medicare program. Unfortunately, beneficiary complaints about marketing practices of Medicare Advantage plans conducted by private sector agents, brokers, or third-party marketing organizations (TPMOs) nearly doubled from 2020 to 2021.<sup>xxi</sup>

BMA supports many of the suggestions included in the recent U.S. Senate Finance Committee Majority Staff's report on addressing deceptive and predatory marketing practices.<sup>xxii</sup>

The report recommends that CMS:

- Improve its oversight of marketing materials to ensure Medicare Advantage plans and subcontractors are not purposely misleading beneficiaries by:
  - » Purchasing list of leads that result in overwhelming seniors with marketing information
  - » Calling beneficiaries multiple times a day and multiple days in a row
  - » Marketing benefits that are not available in a beneficiary's geography
- Improve communication to beneficiaries by:
  - » Issuing warnings for seniors and people with disabilities regarding aggressive and misleading marketing tactics
  - » Reflecting marketing complaints in the Medicare Advantage plan's Star Ratings
  - » Simplifying the process for comparing Medicare Advantage plans online and offline (e.g., including an option in Medicare Plan Finder that allows beneficiaries to compare Medicare Advantage plan networks)
  - » Providing model language for Medicare Advantage plan marketing to clearly explain out-of-pocket costs and network limitations for supplemental benefits
  - » Require Medicare Advantage plans to clearly explain supplemental benefits, including Special Supplemental Benefits for the Chronically Ill (SSBCI)
- Require that agents/brokers adhere to best practices, such as:
  - » Requiring that agents/brokers review beneficiary prescription drugs and regularly visited health care providers to ensure that a new/renewed plan meets the beneficiary's needs
  - » Review agent/broker compensation model to ensure that their incentives align with the interest of beneficiaries

The report also recommends that Congress provide improved funding support for unbiased sources of information for beneficiaries, including State Health Insurance Assistance Programs and Senior Medicare Patrol Programs.

While the Senate Finance Committee Report did not specifically focus on TPMOs, it noted that CMS believes many of the marketing issues are related to TPMO marketing. TPMOs are considered first tier, downstream and/or related entities, terms that are defined



in regulation.<sup>xxiii</sup> Medicare Advantage Organizations (MAOs) are required to hold first tier, downstream and related entities accountable to Medicare Advantage and Part D requirements as set forth in their contractual relationships. In turn, CMS holds Medicare Advantage plans accountable for first tier, downstream or related entities activity (which includes TPMO activity) and can bring compliance actions against Medicare Advantage plans for TPMO actions. That said, not all entities that generate leads are TPMOs and therefore may not have contractual relationships with Medicare Advantage plans, meaning certain types of lead generating activities fall outside of the regulatory structure entirely.<sup>xxiv</sup> Recognizing that Medicare Advantage plans are accountable for appropriate oversight at all levels, BMA supports measures to improve and support Medicare Advantage plans' ability to conduct oversight over TPMOs, including:

- **Provider Activities.**

While CMS has developed marketing guidance for MAO activities with providers, and includes recommendations on agent oversight, CMS has not developed marketing guidance for TPMO activities with providers. This lack of guidance has allowed TPMOs to develop marketing practices that are inconsistent with marketing created in partnership with MAOs, leading to confusion among Medicare beneficiaries. CMS should require that marketing guidance applying to MAO activities with providers also extends to TPMO activities with providers.

- **Consolidated Guidance.**

Specifically, CMS should consolidate all marketing rules for MAOs and TPMOs into a single source of information provided by CMS to minimize the possibility of stakeholders adopting differing interpretations that can lead to beneficiary confusion. CMS should also provide regulatory guidance over "permission to contact" forms and processes and business reply cards, which are not currently filed with CMS.

- **Transparency of Reviewed Marketing Material.**

To further improve the transparency of CMS's marketing requirements, CMS should routinely share examples of approved and denied marketing materials. CMS should also include a comment and feedback period, as well as an implementation date, before CMS makes any changes to the HPMS marketing review approval process.

- **Administrative Fee Payments.**

CMS should also provide clearer guidance to MAOs on administrative fee payments made to sales agencies outside of commissions, including payments to agencies for marketing services and post-enrollment services such as HRAs, appointment scheduling, or benefit education. The current vagueness in these guidelines may misalign incentives across stakeholders and could contribute to the increase in beneficiary complaints.

# Delivering Coordinated Supplemental Benefits to Meet Beneficiaries' Medical and Social Needs

Nearly all Medicare Advantage plans use rebate dollars from bidding below benchmarks to provide supplemental benefits (e.g., dental, vision, hearing, transportation, meals, wellness and fitness) that are not available in FFS Medicare. Supplemental benefits enable providers and health plans to deliver comprehensive, patient-centered care to beneficiaries and address the physical, behavioral, mental, social, and environmental needs that meaningfully influence beneficiary health and wellbeing.

Recent policy changes that provide Medicare Advantage plans the flexibility to offer additional non-medical supplemental benefits to certain beneficiaries are critical in Medicare Advantage's approach to addressing social needs in the community, reducing health disparities, and advancing health equity among beneficiaries and within the broader health care system. For example, Medicare Advantage plans can now provide a targeted set of supplemental benefits to beneficiaries with chronic conditions. These benefits are designed to help beneficiaries better manage their health, such as providing fresh produce and groceries to beneficiaries with diabetes.

As Medicare Advantage plans continue to incorporate new supplemental benefit flexibilities into their strategies for providing holistic care for beneficiaries, BMA recommends that plans and policymakers work together to ensure that health plans can:

- Provide coordinated supplemental benefits rather than cash benefits to ensure beneficiaries are accessing services that will meet their health needs.
- Provide structured ancillary benefits, such as vision, dental, hearing and wellness, to promote beneficiary access to high-quality providers.
- Tailor member benefits for best health so that beneficiaries receive services that align with their care plans.
- Provide support and guidance to beneficiaries on accessing and using member benefits to increase uptake.

The application of these principles would vary by benefit and be designed to ensure access and educate beneficiaries on the available benefits. For example, plans would be required to:

- Assist beneficiaries in accessing supplemental services via customer service centers, web portals, or mobile apps;
- Have a contracted dental network for the provision of services rather than only a cash benefit;
- Have a contracted vision network for the provision of services rather than only a cash benefit;
- Facilitate and track beneficiaries' use of transportation services to ensure patients receive the appropriate transport to their providers;
- Ensure that nutrition benefits provide access to healthy and culturally appropriate foods;
- Monitor enrollee complaints about supplemental benefit providers and provide strong oversight of these service providers;
- Provide advocates on behalf of enrollees to support use of supplemental benefits available in their health plan; and
- Offer enrollees an appeals process if the enrollee reports not receiving a service or receiving poor quality service.

In addition to improving beneficiary health and experience, supplemental benefits can be a high-value way to spend Medicare resources, as they can help prevent beneficiaries' conditions from worsening and requiring more frequent emergency room visits and inpatient care.

# Conclusion

An increasing number of Medicare beneficiaries rely on Medicare Advantage for their coverage and care. As enrollment continues to grow, it is imperative that stakeholders collaborate to identify solutions to challenges facing the program. A stable regulatory environment, combined with targeted, beneficiary-focused reforms, ensure that the Medicare Advantage program can continue to innovate and meet complex social and medical needs of our aging population.

However, the Proposed RADV Rule from CMS, if finalized as proposed, would create uncertainty for Medicare Advantage plans and instability for the Medicare Advantage program. As discussed in this paper, the Proposed RADV Rule is problematic for multiple reasons: it would make changes to regulations retroactively, allow CMS to extrapolate retroactively, and, by eliminating the FFS Adjuster, result in significant underpayments to Medicare Advantage plans in violation of the statutory requirement for actuarial equivalence.

BMA is committed to the integrity, predictability, and stability of the Medicare Advantage program. These recommendations include multiple proposals to achieve that goal by modifying how CMS would conduct RADV audits and determine payment errors from these audits. These proposals will provide more effective government oversight of this essential program and increase public confidence that the taxpayers' and beneficiaries' investment is best serving Medicare beneficiaries.

BMA also seeks to improve the Medicare Advantage program by ensuring that plans are consistently using in-home HRAs to identify beneficiaries' needs and develop care plans. Further, strengthening regulation and oversight of marketing practices can provide beneficiaries the tools they need to select the best plan for them. Finally, crafting policies to promote targeted, coordinated provision of supplemental benefits can offer greater support to beneficiaries and help advance equity.

In total, these changes would enhance and improve compliance and oversight so that the Medicare Advantage program can continue to effectively provide patient-centered, high-quality, and affordable care to the millions of Medicare beneficiaries enrolled in Medicare Advantage.

# References

- <sup>i</sup> CMS. “Medicare Advantage/Part D Contract and Enrollment Data”. July 2022. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata>.
- <sup>ii</sup> CMS. “2022 Annual Report of The Boards Of Trustees Of The Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds”. June 2022. <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>.
- <sup>iii</sup> CMS. “Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits”. February 2012. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf>.
- <sup>iv</sup> CMS. “Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter”. April 2015. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>.
- <sup>v</sup> CMS. “Medicare Advantage/Part D Contract and Enrollment Data”. July 2022. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata>.
- <sup>vi</sup> Morning Consult: Annual Seniors on Medicare Survey 2022.
- <sup>vii</sup> CMS. “2022 Annual Report Of The Boards Of Trustees Of The Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds”. June 2022. <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>.
- <sup>viii</sup> HHS. “Agency Financial Report Fiscal Year 2021”. November 2021. <https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf>.
- <sup>ix</sup> HHS. “Agency Financial Report Fiscal Year 2022”. November 2022. <https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf>.
- <sup>x</sup> In accordance with § 422.2, 422.310(e), the Secretary has the authority to conduct annual audits to ensure risk-adjusted payment integrity and accuracy.
- <sup>xi</sup> CMS. “Advance Notice of Methodological Changes for Calendar Year (CY) 2014 and Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter.” February 2013. <https://www.cms.gov/medicare/health-plans/medicareadvtgsspecratestats/downloads/advance2014.pdf>
- <sup>xii</sup> CMS. “Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs”. April 2010. <https://www.govinfo.gov/content/pkg/FR-2010-04-15/pdf/2010-7> <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf966.pdf>.



<sup>xii</sup> CMS. “Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits”. February 2012. <https://www.cms.gov/Research-Statistics-Data-and-System> <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf.

<sup>xiv</sup> CMS. “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021”. November 2018. <https://www.govinfo.gov/content/pkg/FR-2018-11-01/pdf/2018-23599.pdf>.

<sup>xv</sup> CMS. “Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits”. February 2012. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf>.

<sup>xvi</sup> 42 CFR § 422.101(f)(1)(i); Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 27,704 (May 9, 2022).

<sup>xvii</sup> CMS. “Advance Notice of Methodological Changes for Calendar Year (CY) 2014 and Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter.” February 2013. <https://www.cms.gov/medicare/health-plans/medicareadvtgsgpeceatestats/downloads/advance2014.pdf>.

<sup>xviii</sup> CMS. “Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter”. April 2014. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf>.

<sup>xix</sup> Model HRA presented in the appendix to “A Framework for Patient-Centered Risk Assessments, Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries”. <http://www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf>.

<sup>xx</sup> CMS. “Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter”. April 2015. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>.

<sup>xxi</sup> CMS. “Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency”. May 9, 2022. <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>.

<sup>xxii</sup> U.S. Senate Committee on Finance. “Deceptive Marketing Practices Flourish in Medicare Advantage”. November 2022. <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>.

<sup>xxiii</sup> 42 CFR § 422.2260, “Third party marketing organization (TPMO).”

<sup>xxiv</sup> Reed Smith. “CMS Issues New Rule Limiting Third-Parties Who Conduct Medicare Advantage Marketing.” June 2022. <https://www.reedsmith.com/en/perspectives/2022/06/cms-issues-new-rule-limiting-thirdparties>