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November 1, 2019

Seema Verma, Administrator
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

Re: Calendar Year 2021 Medicare Advantage Advance Notice and Call Letter

Dear Administrator Verma:

As you prepare to release the Calendar Year (CY) 2021 Medicare Advantage Advance Notice and Call Letter, we write to underscore our support for Medicare Advantage and urge you to propose policies that maintain stability and support a strong Medicare Advantage option for beneficiaries. Better Medicare Alliance (BMA) is a community of over 140 ally organizations, along with 400,000 beneficiaries, who value the option of Medicare Advantage. Together, our alliance of health plans, provider groups, aging service organizations, and beneficiaries share a commitment to ensuring Medicare Advantage remains a high-quality, cost-effective option for current and future beneficiaries.

BMA wishes to thank CMS for its work over the past year in support of Medicare Advantage. Overall, the CY2020 Rate Notice and Call Letter and other regulatory activities created a positive environment in which Medicare Advantage plans, providers, and community partners are able to offer and participate in high-quality, cost-effective care that improves patient experience and outcomes. CMS finalized policies to guide the design and offering of a new set of supplemental benefits that are not "primarily health-related," targeted to enrollees with chronic conditions, which has the potential to improve outcomes and quality of life for millions of Medicare Advantage beneficiaries. CMS also finalized new policies to help Medicare Advantage plans prevent and combat opioid overuse and misuse. In addition, the President's Executive Order directs new regulations that may enhance Medicare Advantage for future beneficiaries. BMA appreciates the positive course CMS is charting for the Medicare Advantage program and looks forward to partnering with CMS to continue this trend.

The stability of payment and policy changes have enhanced the opportunity for Medicare Advantage plans, providers, community partners, and entrepreneurs to continue to deliver high quality care, add benefits, and reduce consumer costs. CMS has recognized this progress, and recently announced that, continuing a trend begun in 2015, Medicare Advantage premiums will continue to decline while plan choices, benefits, and enrollment will increase in 2020.[1] CMS projects that 40 percent of Medicare beneficiaries will enroll in Medicare Advantage plans in 2020.[2] The average monthly premium for Medicare Advantage is expected to drop 14 percent to $23 next year and beneficiaries will have more plan choices, with an average of 39 plan choices per county. These results are due in large part to the positive environment for Medicare Advantage that the Administration has created and supported.

In consideration of the CY2021 Advance Notice and Call Letter, BMA first and foremost urges CMS to maintain the stability in the Medicare Advantage program and support a strong Medicare Advantage option for America's Medicare beneficiaries. As CMS considers policy and programmatic changes for Medicare Advantage, we urge the agency to give consideration to the Affordable Care Act's health insurance tax which is set to take effect on January 1, 2020. We recognize authority for delaying or repealing the tax rests with Congress but ask CMS to be mindful of the $20 billion in increased costs for health insurers this tax

[1] Centers for Medicare and Medicaid Services, "Trump Administration Drives Down Medicare Advantage and Part D Premiums for Seniors," September 24, 2019, Web.
[2] Ibid.

represents, which may limit Medicare Advantage plans' abilities to invest in new care delivery strategies and impact millions of Medicare Advantage enrollees and other Americans.

BMA also asks CMS to address the chronic underfunding and fluctuating nature of end-stage renal disease (ESRD) payment in Medicare Advantage by ensuring ESRD benchmark calculations reflect actual costs and provide accurate and adequate payment for the ESRD population. As CMS is aware, it is critical to address these payment concerns before enrollment in Medicare Advantage is available to all beneficiaries with ESRD in 2021.

BMA also encourages CMS to initiate a fresh look at the Star Rating System. The Stars Rating System is a successful program that has resulted in 81 percent of Medicare Advantage beneficiaries enrolling in high quality plans with 4- or 5-Star ratings. While changes have been made to the measures and methodology, it is time for an update of measures and their relationship to the goal of assessing quality and driving improvements in health outcomes. The process for such an update should draw on the experience of plans, providers, researchers, and experts, as well as other stakeholders. Changes could include establishing prospective thresholds for 4-Star or higher ratings in order to further drive quality improvement, reviewing the validity of consumer experience measures, eliminating compliance measures that do not relate to quality, and enhancing outcomes measures to reflect health status as well as utilization. We provide these recommendations, not for the 2021 Advance Notice and Call Letter, but for consideration as CMS contemplates future rulemaking.

Finally, BMA asks CMS to ensure that any programmatic changes protect the ability of Medicare Advantage plans to use valuable care management tools to improve health care delivery and outcomes for enrollees. This includes utilization management tools that ensure enrollees receive the most clinically appropriate and cost-effective care while protecting enrollees from unexpected medical bills and reducing exposure to duplicative and unnecessary services. These tools are essential to the ability of plans and providers to provide high-quality, high-value care that enables the innovative use of services to improve health outcomes and quality of life.

Our priorities are detailed in Attachment A. We have also included additional recommendations designed to foster quality and innovation, support growth and choice, and support quality and growth in value-based care in Attachment B.

We are grateful for the Administration's continued effort and focus on ensuring Medicare Advantage remains and grows as a high-quality and cost-effective option for the millions of Medicare Advantage beneficiaries who choose it. We appreciate your attention to our comments and look forward to continuing to work with you on these and other critical issues. Should you wish to discuss the issues raised in this letter or others that may be raised related to the 2021 Notice, we can be reached by contacting Robin Goracke at RGoracke@bettermedicarealliance.org or (202) 735-0297.

Sincerely,

Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

CC: Demetrios Kouzoukas, Director, Center for Medicare;
Cheri Rice, Deputy Director, Center for Medicare

Attachment A

In this attachment, BMA provides recommendations for our policy priorities. The recommendations for each of these policy priorities are explained in further detail below.

- Ensure adequate payments for ESRD beneficiaries;
- Update the Star Rating System;
- Ensure beneficiary education on Medicare choices; and
- Promote policies that protect Medicare Advantage plans' ability to offer care management services that improve care delivery and outcomes.

ESRD Benchmark

- **Provide consistency and predictability as to ESRD payments year over year;**
- **Update the Bid Pricing Tool (BPT) instructions so the ESRD subsidy falls under Medicare covered benefits instead of mandatory supplemental benefits;**
- **Account for the maximum out-of-pocket (MOOP) limit in ESRD benchmark calculations;**
- **Consider changes to Medicare Advantage network adequacy requirements for dialysis providers;**
- **Consider a transition period given the potential number of new ESRD patients enrolling in Medicare Advantage; and**
- **Consider risk score adjustments to account for multiple other conditions and ensure adequate payment for highest risk beneficiaries.**

As CMS is aware, the *21st Century Cures Act* changed Medicare Advantage eligibility for beneficiaries with ESRD, allowing them to freely enroll in a plan during the annual open enrollment period beginning in 2021. Medicare Advantage is well-positioned to provide high-quality, integrated care for enrollees with ESRD. In addition, the financial protections provided under Medicare Advantage make it a very attractive option to Medicare beneficiaries with ESRD. Given the predictable frequency and cost of dialysis, it will be fairly straightforward for most ESRD beneficiaries to quickly determine that Medicare Advantage is a more cost-effective option for them than Traditional fee-for-service (FFS) Medicare. We believe this could result in the highest-cost ESRD beneficiaries opting for Medicare Advantage, with lower- and average-cost beneficiaries potentially remaining in FFS Medicare. On average, the cost to care for an ESRD beneficiary is at least *eight times* the cost to care for a non-ESRD beneficiary. We believe that ESRD benchmarks do not appropriately account for these higher costs, resulting in ongoing underpayments to Medicare Advantage plans.

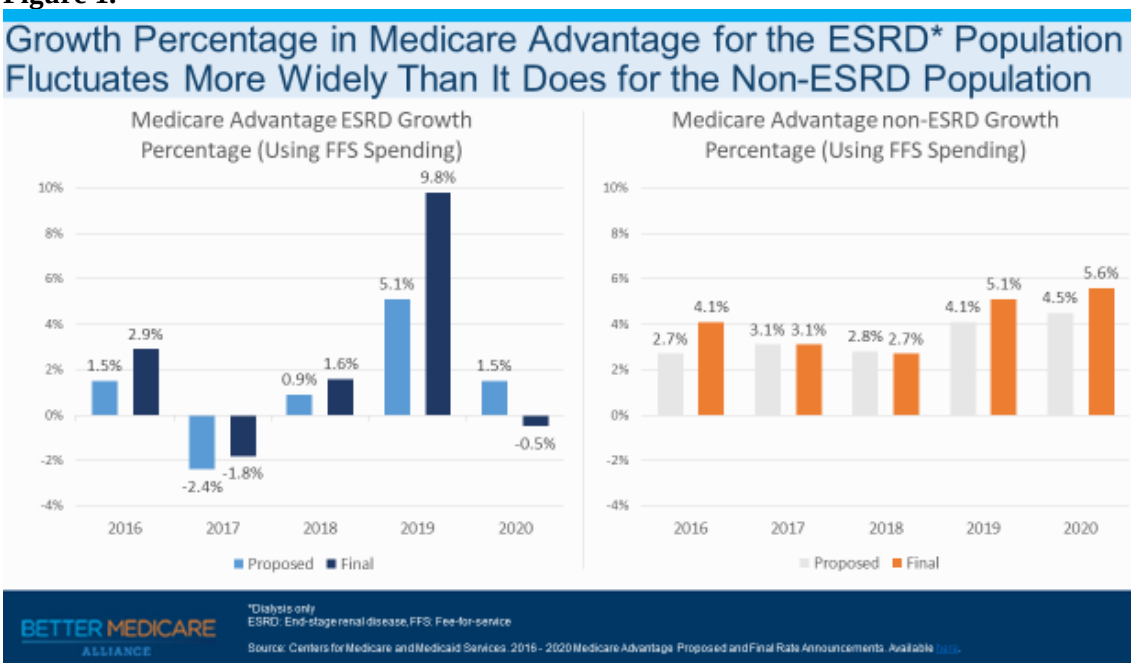
Increased enrollment in Medicare Advantage by ESRD beneficiaries, combined with the high cost of caring for these enrollees, will exacerbate existing problems caused by the chronic underfunding and volatile year-to-year payment for the care of ESRD beneficiaries in Medicare Advantage. These issues could destabilize the program for the 24.4 million beneficiaries projected to choose Medicare Advantage in 2020.[3] One analysis estimated that if no changes are made to the ESRD payment calculation, premiums for all Medicare Advantage enrollees could increase on average by $16 per member per month, or more than 50 percent.[4]

As Figure 1 illustrates, Medicare Advantage ESRD growth rate updates tend to vary more between the Proposed and Final Rule as compared to non-ESRD Medicare Advantage updates. On average, from 2016

[3] CMS, Press Release, Trump Administration Drives Down Medicare Advantage and Part D Premiums for Seniors, September 24, 2019. Web.
[4] Wakely, *White Paper: Increased ESRD Beneficiary Flexibility Presents a Potential Financial Challenge for Medicare Advantage Plans in 2021*. February 2019. Web.

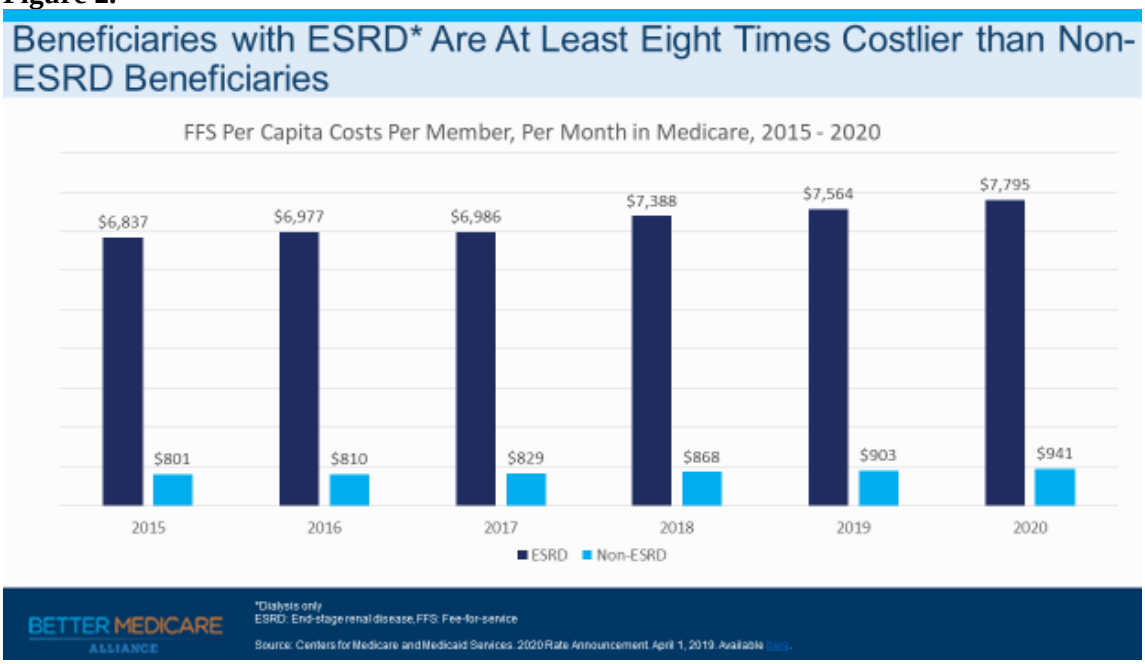
to 2020, ESRD growth rate updates varied by 1.84 percentage points from proposed to final, compared to 0.72 percentage points in non-ESRD Medicare Advantage. For 2019, the difference between the proposed payment rate estimate and final payment rate was $340 per month, resulting in a total payment difference of $4,080 per member per year. In some years, the proposed and final rules were directionally different, something that has not happened in non-ESRD Medicare Advantage. It is unclear why there is no directional correlation between the updates in ESRD and non-ESRD.

Figure 1.



Finally, estimates for ESRD were negative in 2017, implying that costs for ESRD beneficiaries are decreasing, which is inconsistent with true spending (see Figure 2). Unstable payment estimates for ESRD may indicate difficulty estimating costs for these beneficiaries. In addition, BMA conducted an analysis on the assessment of FFS Medicare and Medicare Advantage spending on ESRD beneficiaries at the state and county level relative to today's benchmark and found significant variation in payment based on geography which creates additional volatility for plans.

Figure 2.



We urge CMS to fix the ESRD benchmark calculation to reduce volatility year-over-year, reflect actual costs, and ensure accurate and adequate payment for the ESRD population and protect Medicare Advantage as an important option for millions of Medicare beneficiaries. To achieve these goals, CMS should:

- Update the Bid Pricing Tool (BPT) instructions so the ESRD subsidy falls under Medicare covered benefits instead of mandatory supplemental benefits. Because the vast majority of the ESRD expenses are Medicare covered, they should not be considered supplemental benefits and should not be funded through rebate dollars.
- Account for the MOOP limit in ESRD benchmark calculations. Medicare Advantage beneficiaries have the benefit of an annual out-of-pocket maximum spending limit, which does not exist in FFS Medicare. Because of the predictable and high cost of dialysis, ESRD beneficiaries in Medicare Advantage are considerably more likely than non-ESRD beneficiaries to hit the MOOP limit. To ensure adequacy of payments, CMS should account for the MOOP limit in the calculation of ESRD benchmarks.
- Consider changes to Medicare Advantage network adequacy requirements for dialysis providers. The dialysis provider market is highly concentrated, largely dominated by two provider organizations. Because Medicare Advantage plans must meet network adequacy requirements, they have few options to leverage price competition in most markets, and actual Medicare Advantage payments are significantly higher than Traditional FFS rates. Because the ESRD benchmarks are based on FFS payment rates, they underrepresent the true cost of care in Medicare Advantage. CMS should consider changes to network adequacy requirements or other tools that would allow Medicare Advantage plans to leverage market forces while ensuring enrollees have access to dialysis services.

Finally, BMA is currently modeling various policy and payment solutions aimed at correcting inadequate payment for ESRD enrollees. For example, we are considering the possibility of a transition period for implementation that would offer the opportunity to collect and assess data on the number and health status of new ESRD Medicare Advantage enrollees and the impact these they may have on plan costs. BMA expects to share these options with CMS in the near future for your consideration.

Star Rating System

- **Establish 4-Star rating thresholds prospectively to further drive quality improvement;**
- **Delay planned weight increase for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) in 2021 and increase transparency and clarity of survey methodology;**
- **Retire Healthcare Effectiveness Data and Information Set (HEDIS) measures as appropriate, consider others to better measure outcomes and focus changes to enhance measures that are actionable;**
- **Eliminate compliance-related administrative measures;**
- **Streamline performance measures across its quality improvement programs to reduce administrative burden and incentivize greater focus on health outcomes; and**
- **Evaluate whether adjustments to the Star Rating System for social risk factors are appropriate and effective, including modification to the Categorical Adjustment Index (CAI) to ensure it accurately incorporates needs related to social determinants of health.**

We continue to appreciate CMS' work to codify the Star Rating methodology and employ greater use of rulemaking to make changes to the program. These improvements give Medicare Advantage organizations more time to prepare for changes and enhance transparency and predictability of the Star Rating methodology and process. We recognize that CMS is unlikely to use the Advance Notice and Call Letter to propose changes to the Star Rating methodology, but we provide our recommendations here for consideration as CMS contemplates future rulemaking.

CMS' efforts are clearly driving change as 81 percent of 2020 Medicare Advantage enrollees will be enrolled in plans with a 4- or 5-Star ratings.[5] To further drive quality improvement, we encourage CMS to establish prospective thresholds, or cut-points, required to achieve a 4-Star or higher rating. CMS does not announce cut-points prospectively, instead scoring each plan's performance relative to other plans. This, in addition to large fluctuations in measure cut-points, creates uncertainty as plans set quality improvement goals and try to integrate performance goals into value-based provider contracts. Setting the 4-Star rating threshold in advance will allow plan sponsors to focus financial and other investments on the quality objectives CMS identifies as important, rather than chasing moving targets. As CMS is likely aware, the Medicare Payment Advisory Commission (MedPAC) supports using predetermined 4-Star thresholds.[6]

Medicare Advantage plans have largely achieved equivalence on outcome measures correlated with quality. This means that the primary driver of plans achieving a 4-Star rating is performance on the CAHPS survey. Yet the CAHPS survey fails to accurately identify high-quality plans due to similarity of plan scores, resulting in cut-points between Star Rating levels being contained within a typical margin of error for a CAHPS sample. This means that statistically similar plans may receive different Star Ratings, and thus different quality bonus payments.

Until these and other issues with the CAHPS survey are addressed, we recommend that CMS delay the planned weight increase of the CAHPS survey. Further, the survey should be more transparent, and CMS should release detailed data for CAHPS as it does for all other Star Ratings data sources. CMS should ensure the methodology for the survey is clear, to address concerns surrounding bias in the data, and CMS should better consider the transparency, fairness, and accuracy of the CAHPS survey.

[5] Centers for Medicare and Medicaid Services, "Trump Administration Drives Access to More High-Quality Medicare Plan Choices in 2020," October 11, 2019, Web.
[6] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2019) ("March 2019 MedPAC Report"), p. 376.Web.

Compliance measures, although useful in determining whether a plan is performing certain functions, are not appropriate to include in the Star Rating System, because they are less relevant to patient care.[7] In addition, CMS has other opportunities to enforce compliance outside of the Star Ratings. By including compliance in the Star Ratings, CMS is "double-dipping" compliance issues in its evaluation and action toward plans. To address this, CMS should eliminate compliance-related administrative measures from the Star Ratings.

CMS should also streamline measures across its quality improvement programs to reduce administrative burden and incentivize greater focus on health outcomes. Measurement is essential, but it is not a goal in and of itself, and complying with the current, misaligned measurement system is taking too much time away from improving care. CMS should align the ACO, MIPS, and Stars measures so that plans and providers, especially, are able to more easily assess their progress towards key outcomes.

Finally, in recent years, research has suggested that the Star Rating System does not accurately reflect the quality of care delivered by health plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees.[8] Several studies have found patients with sociodemographic challenges have worse outcomes on some quality measures that inform Star Ratings.[9,10] Additionally, ASPE reported that dual-eligible status was found to be one of the greatest predictors of poor health outcomes, leading to high health care needs and cost indicated by disability status, low income, and a lack of social supports.[11] CMS should continue to evaluate whether adjustments to the Star Rating System for social risk factors are appropriate and effective, including modification to the Categorical Adjustment Index (CAI), implemented in 2017, to ensure it accurately incorporates needs related to social determinants of health.

Beneficiary Education

- **Continue efforts to update and improve the Medicare Plan Finder while ensuring accuracy and offering price comparisons that include both premiums and out-of-pocket (OOP) costs;**
- **Continue improvement of beneficiary education and outreach efforts by CMS, Social Security Administration (SSA), and other agencies to ensure beneficiaries have the information they need to make a choice between Traditional FFS Medicare and Medicare Advantage;**
- **Translate Medicare educational materials into more languages to meet the needs of an increasingly diverse senior population;**
- **Continue to improve decision-making tools to help more beneficiaries make an active choice during Medicare enrollment; and**
- **Consider means to offer guidance on the options and simplify the selection process.**

BMA appreciates CMS' work to update the Medicare Plan Finder tool and improve to the Medicare & You Handbook and "What's Covered?" online tool. These tools are critical to ensuring beneficiaries have access to information and decision-making tools on their choices in Medicare coverage, and align with BMA's Active Choosers Campaign, which advocates for improvements in education of, and outreach to, beneficiaries on the Medicare Advantage option.[12] Beneficiaries must have information that is readable, accessible, complete, and unbiased to make a choice on coverage.

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7 Better Medicare Alliance, "Improving Medicare Advantage Quality Measures," October 2018. Web.
8 Assistant Secretary for Planning and Evaluation. "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." December 21, 2016. Web.
9 Durfey, Shayla N. M. et al. "Impact Of Risk Adjustment For Socioeconomic Status On Medicare Advantage Plan Quality Rankings." Health affairs (Project Hope) 37.7 (2018): 1065–1072. PMC. 13 Sept. 2018. Web.
10 Melony E. Sorbero, PhD, MS, MPH et al. "Adjusting Medicare Advantage Star Ratings for Socioeconomic Status and Disability." www.ajmc.com. 6 Sept. 2018. Web.
11 Assistant Secretary for Planning and Evaluation. "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." December 21, 2016. Web.
12 Better Medicare Alliance, "Active Choosers Campaign." Web.

As CMS continues to refine the Medicare Plan Finder, we ask you to consider the following technical improvements:

- Improve the ability to sort by total OOP costs combined with prescription drug costs. It is important that beneficiaries know their total OOP costs, not just the premium costs;
- Reinstate the ability of the beneficiary to determine their health status so they can better predict their costs for the year; and
- Ensure accurate, up-to-date prescription drug and provider information.

We ask CMS to continue its commitment to improving education materials and decision-making tools, as well as outreach and enrollment efforts, to help more Medicare beneficiaries make an active enrollment choice.[13] We encourage CMS to partner with the SSA to ensure beneficiaries understand that they have multiple decisions to make after enrolling in Part B regarding their Medicare coverage, starting with choosing the type of Medicare coverage in which they will enroll. It is important that CMS align with SSA to convey this message six months before individuals turn age 65 (more than the current three months). Equally as important, CMS and SSA should clearly inform beneficiaries on the enrollment process and timeline for their required decision points throughout their enrollment experience. To avoid confusion when transitioning into Medicare, CMS should provide a clear checklist of "next steps" for signing up and emphasize rules and requirements (e.g., potential late enrollment penalties).

CMS and SSA should deploy more creative methods for engaging Medicare beneficiaries at different decision points and different outreach tactics for different types of beneficiaries, like newly eligible, transitioning from previous coverage or current beneficiaries reassessing options during annual enrollment. For example, CMS could survey individuals with pre-Medicare questionnaires to better understand their individual needs (e.g., health insurance literacy) and tailor future communication about Medicare coverage options. Finally, CMS and SSA should expand their partnerships with trusted community sources, such as provider offices, pharmacies, churches and faith-based organizations, barber shops and hair salons, grocery stores, and benefit enrollment centers. Social media may also be a useful way to communicate with a broad group of beneficiaries.

Care Management

- **Promote policies that protect Medicare Advantage plans' ability to offer care management and utilization management services that improve care delivery and outcomes.**

Unlike Traditional FFS Medicare, Medicare Advantage provides integrated care through networks of providers, offers chronic disease management programs not available in FFS Medicare, and incorporates a strong focus on primary care and care management. As a result, primary care teams are at the center of care and incentivized to attend to gaps in care important to improving health status. This team-based, patient-centered approach is designed to assist patients in managing medical conditions more effectively. One study showed Medicare Advantage results in more appropriate use of ambulatory services and lower rates of avoidable hospitalizations and ER visits when compared to FFS Medicare. This difference is potentially a result of a focus on preventive services and care management.[14]

Care management tools are essential to the functioning of Medicare Advantage in its many efforts to achieve the best outcomes for patients, reduce inappropriate or unnecessary utilization, and provide early intervention to reduce disease progression. We ask CMS to ensure that its policies and programmatic changes protect the ability of Medicare Advantage plans to use valuable care management tools to

[13] Better Medicare Alliance, "Improving Consumer Understanding of Medicare Advantage," March 2018. Web.
[14] Avalere, "Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare," Better Medicare Alliance, July 2018. Web.

improve health care delivery and outcomes for enrollees. This includes utilization management tools that ensure enrollees receive the most clinically appropriate and cost-effective care while protecting enrollees from unexpected medical bills and reducing exposure to duplicative and unnecessary services. Medicare Advantage plans, for their part, are continuing efforts to streamline and simplify their utilization management processes for providers and reduce uncertainty for beneficiaries.

Attachment B

In this attachment, we provide additional recommendations to foster quality and innovation, support growth and choice, and support quality and growth in value-based care. The remainder of this attachment provides details on these important recommendations.

Foster Quality and Innovation

- Remove barriers to telehealth access in Medicare Advantage; and
- Expand allowable supplemental benefits for dual-eligible enrollees.

Support Growth and Choice

- Support a predictable and stable environment by maintaining the coding pattern adjustment at the current statutory minimum;
- Avoid further disruption to Employer Group Waiver Plans (EGWPs) by carefully considering the differing impact of policy changes on EGWPs; and
- Explore methods to inform beneficiaries of or enroll them in options to provide continuity of coverage and care, including default enrollment into a 4- or 5-Star plan for beneficiaries already in a similar managed care plan.

Support Quality and Growth in Value-Based Care

- Develop guidelines and best practices for data sharing and collection in value-based arrangements;
- Create template model designs to assist with the development of value-based care contracts and facilitate the adoption of best practices;
- Modify current guidelines to expand allowable rewards and incentives in Medicare Advantage and Part D to improve health through encouraging the of use of high-value, low-cost care and services;
- Promote the Medicare Diabetes Prevention Program and permit virtual delivery to improve access;
- Further incentivize the move to value-based care in Medicare Advantage by treating Medicare Advantage Advanced Alternative Payment Models (APMs) the same as Medicare Advanced APMs, rather than as Other Payer Advanced APMs; and
- Develop and disseminate education materials and resources to improve beneficiary understanding of value-based care.

Foster Quality and Innovation

Telehealth

- **Remove barriers to telehealth access in Medicare Advantage.**

Expanding telehealth benefits in federal programs could improve access to care for beneficiaries with limited access to providers, such as those who are homebound, lack transportation, or live in rural counties, including those in Medicare Advantage. In addition to shifting treatment to lower-cost sites of care and reducing potential time and distance barriers, telehealth can also improve access to specialists, particularly in rural areas, where few may be available. Though telehealth offerings and patient education about telehealth are currently limited, the benefit shows promise for improving health outcomes and increasing care efficiency for a range of beneficiaries.

Medicare Advantage health plans must cover all telehealth services included in Traditional FFS Medicare Part B benefits. Therefore, telehealth coverage in Medicare Advantage includes those in Traditional FFS

Medicare, which limits eligible beneficiaries, originating sites, and services.[15] However, Medicare Advantage can utilize telehealth to improve beneficiary outcomes through benefit design and supplemental benefits.[16]

To remove barriers to telehealth access in Medicare Advantage, CMS should:

- Ensure that Medicare Advantage health plans can go beyond telehealth benefits available under Part B, by broadening the categories of clinically appropriate telehealth services annually designated by the HHS Secretary.
- Provide user-friendly technology platforms that are seamless and convenient for all beneficiaries to use and ensure availability in multiple languages. This will help to ensure adequate access to telehealth services and assuage potential hesitancy from beneficiaries.
- Permit Medicare Advantage plans to test innovative telehealth services that reduce costs or improve outcomes (while ensuring beneficiaries have the option of receiving care in-person), since plans bear financial risk.
- Accommodate innovative care delivery models by allowing telehealth and mobile providers to count towards network adequacy, especially for rural areas.[17] Telehealth should be able to help a Medicare Advantage health plan operating in a county in a rural Health Professional Shortage Area or outside of a Metropolitan Statistical Area meet network adequacy standards if the area would not otherwise have a Medicare Advantage option.
- Include telehealth as an eligible encounter in Star Rating measures. For example, some HEDIS measures currently require a visit for the denominator, numerator, or exclusion. Including telehealth in the quality measures underlying the Star Rating calculations would provide a more accurate indication of plan quality.
- Allow for Medicare enrolled physicians licensed in another state to provide appropriate services. This change would help alleviate some of the onerous state-level physician and nurse regulations to which telehealth programs operating across state lines must adhere.[18]

Supplemental Benefits

- **Expand allowable supplemental benefits for dual-eligible enrollees.**

BMA has long-supported Congressional and regulatory efforts to expand Medicare Advantage supplemental benefits, particularly those that address social determinants of health. CMS recently expanded supplemental benefits to allow Medicare Advantage plans to provide non-primarily health related supplemental benefits that address chronically ill beneficiaries' social determinants of health as long as the benefits maintain or improve the health or function of that chronically ill beneficiary.

BMA asks CMS to improve access to supplemental benefits for dual-eligible enrollees by allowing dual-eligible special needs plans (D-SNPs) to provide "not primarily health related" supplemental benefits to certain dual-eligible beneficiary categories (such as Qualified Medicare Beneficiaries (QMBs)). These benefits would likely be similar to those currently available under special supplemental benefits for the chronically ill and would allow Medicare Advantage plans to complement Medicaid benefits. For example, providing an enrollee with home- and community-based services may allow a dual-eligible beneficiary who is not eligible for this benefit from Medicaid to remain home rather than in a nursing facility.

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[15] CMS, Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, July 25, 2019. Web.
[16] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy – Chapter 16 Mandated Report: Telehealth Services and the Medicare Program. March 2018. Web.
[17] CMS, "Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 2, 2018. Web.
[18] Ibid.

Support Growth and Choice

Coding Pattern Adjustment

- **Support a predictable and stable environment by maintaining the coding pattern adjustment at the current statutory minimum.**

BMA has long advocated for application of the minimum coding pattern adjustment. As CMS is aware, coding variation between Traditional FFS Medicare and Medicare Advantage arises from structural, payment, and care model differences between the two programs. As such, risk scores estimated using FFS Medicare data may not accurately predict health care costs for Medicare Advantage enrollees. The coding pattern adjustment is born from the assumption that FFS Medicare coding is the correct standard, without sufficiently capturing the structural differences that drive coding variation, such as the different emphasis on diagnosis vs. procedure codes in the two programs. We urge CMS not to exceed the minimum coding pattern adjustment permitted by statute in order to foster stability in and adequacy of Medicare Advantage payments, enabling plans and providers to gather the data necessary for early intervention and care management.

Avoid Disruption to Employer Group Waiver Plans (EGWPs)

- **Minimize further disruption to EGWPs by carefully considering the differing impact of policy changes on EGWPs.**

EGWPs represent a unique, highly successful public-private partnership that addresses the health care needs of an important segment of today's retirees. Nearly 20 percent of Medicare Advantage enrollees receive their benefits through an EGWP, and EGWPs are the fastest-growing segment of Medicare Advantage. As CMS considers policy changes in Medicare Advantage, we ask that you specifically model the impact of such changes on EGWPs which, though part of Medicare Advantage, are very different from individual Medicare Advantage plans in terms of cost protections, benefit design waivers and flexibilities, and payment rates, among other things. CMS should seek to understand these different impacts on EGWPs and work to minimize any disruption to the EGWP market.

One example of such consideration is the proposed rule removing safe harbor protection for prescription drug rebates (OIG-0936-P). The impact of this proposed rule on EGWPs, particularly self-funded EGWPs, would have been very different from the impact on individual Medicare Advantage plans. This is because self-funded EGWPs regularly use prescription drug rebate funds to later offset premium costs for all enrollees. EGWPs would have no choice but to increase premiums by the amount of the lost rebates.[19] While some enrollees would receive point-of-sale rebates when they purchase prescription drugs, all enrollees would experience substantially higher premiums. One such plan, the Teachers' Retirement System (TRS) of the State of Kentucky, found the loss of in rebates from drug manufacturers would require the plan to increase premiums for its 35,000 members by $27 million per year, or approximately $64 PMPM.

This is more than double the impact of the same policy on individual Medicare Advantage premiums. According to a BMA-commissioned analysis, using the same assumptions on rebate allocation as CMS' Office of the Chief Actuary (OACT), Avalere estimates that consolidated Part C and D monthly premiums would increase by $29 per beneficiary.[20] Even these lower premium increases would be the

[19] National Association of Health Underwriters, Comment Letter to Secretary Azar and Inspector Levinson, April 8, 2019. Web.
[20] Avalere Health, "Impact of Proposed Rule to Eliminate Prescription Drug Rebates on Medicare Advantage Beneficiaries, April 5, 2019. Web.

largest in the program's history. The magnitude of the disparate impact of this proposed policy on EGWPs suggests that such impact was not fully and carefully considered as the policy was being drafted.

Improved Enrollment Process

- **Explore methods to inform beneficiaries of or enroll them in options to provide continuity of coverage and care, including default enrollment into a 4- or 5-Star plan for beneficiaries already in a similar managed care plan.**

BMA appreciates the work CMS has undertaken to make Medicare enrollment decision-making tools more usable and making the choice between Medicare Advantage and Traditional FFS Medicare clearer for beneficiaries. We encourage CMS to continue this important work. Yet, many beneficiaries still do not make an active choice and default into FFS Medicare, which may not be the best health or financial option for them.

To improve continuity of care for beneficiaries, BMA encourages CMS to work with Medicare Advantage organizations and consumer advocates to allow the default enrollment of beneficiaries from one type of health plan into a comparable, high-quality Medicare Advantage plan, with appropriate protections. Such protections may include those CMS finalized in the CY2019 Policy and Technical Changes rule. In that rule, CMS permitted default enrollment into a D-SNP for certain dual-eligible enrollees to avoid disruption to the beneficiary's integrated care coverage. We would argue that all beneficiaries, not just those who are dual-eligible, deserve the same consideration of their care continuity and integration as they transition into Medicare.

CMS might explore allowing seamless conversion from a non-Medicare HMO to a Medicare Advantage HMO, and may consider limiting the policy to those Medicare Advantage plans with 4- or 5-Star ratings. In addition, CMS may consider permitting automatic enrollment of Part D-enrolled beneficiaries who receive the Low-Income Subsidy (LIS) into a D-SNP. Simplifying the enrollment process in this way would help vulnerable, LIS beneficiaries obtain access to important care coordination benefits while also providing them with financial protections such as an out-of-pocket maximum and reduced cost-sharing.

In addition, CMS could consider offering beneficiaries personalized options in the online tool that would met the individual's health status and financial needs, are similar to coverage they have had, and/or stated preferences to sort the options that would be suitable to that individual's coverage needs and facilitate decision-making. The goal should be to increase the number of people who make an active choice, ensure the ability to remain in a familiar coverage option, or default into a coverage option that best meets their needs and preferences. We encourage CMS to explore further ways to meet these goals.

Support Value-Based Care

Data Sharing and Collection

- **Develop guidelines and best practices for data sharing and collection in value-based arrangements.**

The ability to collect complete and accurate data, and then to use the data to target care to high-need patients and to evaluate outcomes, is crucial for developing value-based approaches, yet plans and providers often struggle to effectively gather and share data in a timely manner. CMS should bring together stakeholders who are successfully leveraging data in value-based arrangements and facilitate consensus around best practices for creating and maintaining efficient reporting systems and using data in real time to better coordinate care for beneficiaries.

Similarly, CMS should convene plans and providers who are early in the process of transitioning to value-based arrangements to gain an understanding of the data challenges they face and the tools and information that would be most helpful. Based on these conversations, CMS could lead efforts to develop tools (e.g., vehicles for sharing data), best practices (e.g., guidelines around data collection practices for providers), and other resources that plans and providers could use to improve their ability to analyze data in real time.

Value-Based Care Contracts

- **Create template model design to assist with the development of value-based care contracts and facilitate the adoption of best practices.**

As more evidence on successful models becomes available, CMS and other stakeholders should collaborate to develop frameworks for value-based arrangements that providers and plan partners can use a base for further customization. These "template model designs" could include best practices based on other plans' and providers' experiences and may ease entry into value-based care, particularly for plans and providers that may be less familiar with these types of arrangements.

These customizable templates can help plans and providers to better understand their respective roles in the partnership and how to approach allocating risk. Further, those considering value-based arrangements could more easily understand the infrastructure required to develop successful partnerships (e.g., data and reporting systems, necessary support staff, etc.). This could be helpful not just for plans and providers poised to enter into a partnership, but also for those that are seeking to understand the steps they would need to take before considering an agreement.

Expand and Enhance Beneficiary Incentive Guidelines

- **Modify current guidelines to expand allowable rewards and incentives in Medicare Advantage and Part D to improve health through encouraging use of high-value, low-cost care and services.**

BMA appreciates CMS' efforts over the past five years to allow, and slightly expand, limited types of enrollee rewards and incentives. These are used by health plans to encourage healthy behaviors and prevention, improve health outcomes, and reduce costs. We ask CMS to expand allowable rewards and incentives in Medicare Advantage and Part D to further encourage healthier behaviors and use of high-value health services.

Potential modifications to existing guidelines that will facilitate greater engagement and contribute to improved health outcomes for Medicare Advantage and Part D enrollees may include:

- Allowing plans to offer rewards and incentives to beneficiaries if they participate in services or activities focused on improving health, preventing injuries and illness, or encouraging efficient use of health care resources.
- Providing plan flexibility to target programs to certain populations who would most benefit from incentives.
- Allowing plans to offer rewards and incentives that may surpass the value of the health service or activity, allowing incentives for low-cost, high-value services, such as flu shots.
- Allowing electronic communications to educate, inform, and encourage beneficiaries on use of services that may be low-cost, but impact subsequent higher administrative or service costs.
- Allowing plans to offer financial rewards for participation in evidence-based health programs or achievement of health goals.
- Allowing plans to use appropriate marketing to inform beneficiaries of the availability of rewards and incentives for certain services or programs.

- Allowing plans to offer rewards and incentives in the Part D program, specifically including the ability to target beneficiaries who struggle to adhere to medication protocols.

Medicare Diabetes Prevention Program

- **Promote the Medicare Diabetes Prevention Program and permit virtual delivery to improve access.**

The Medicare Diabetes Prevention Program (MDPP) is an evidence-based chronic disease management program aimed at slowing the progression of pre-diabetes and preventing the onset of Type 2 diabetes, added as a new Medicare benefit in April 2018. There is a need to promote the MDPP, which includes informing providers and beneficiaries of its availability, helping to build capacity in MDPP providers, and reimbursing for virtual options for delivery of the program.

In 2018, CMS expected up to 100,000 Medicare beneficiaries to utilize the MDPP benefit. Very preliminary data indicate that just 200 beneficiaries enrolled last year.[21] While the data does not include Medicare Advantage beneficiaries and does not account for delays in paid claims, they do suggest that additional work is needed to promote the program and increase participation. One way CMS could increase access to MDPP is to allow the virtual delivery of the MDPP. This would extend access to this evidence-based program to rural parts of the country and to beneficiaries who may experience difficulties leaving home or finding transportation to program sites.

Medicare Advantage Advanced Alternative Payment Models

- **Further incentivize the move to value-based care in Medicare Advantage by treating Medicare Advantage Advanced Alternative Payment Models (APMs) the same as Medicare Advanced APMs, rather than as Other Payer Advanced APMs.**

BMA is concerned that treating Medicare Advantage Advanced APMs as Other Payer Advanced APMs, rather than as Medicare Advanced APMs, may cause providers to be less inclined to accept risk for Medicare Advantage patients. Furthermore, some providers may be incentivized to see fewer Medicare Advantage patients in favor of patients in Medicare Advanced APMs in order to meet requirements for exemption from MIPS.

With 40 percent of Medicare beneficiaries expected to choose Medicare Advantage plans in 2020, CMS should ensure that both Medicare Advantage and Traditional FFS Medicare are moving to adopt more value-based payment arrangements, specifically CMS could:

- Foster consistency across federal programs in this drive toward value-based payments, creating a level playing field for all Medicare value-based payment arrangements;
- Reward providers who are engaged in any type of qualifying, risk-based contract under Medicare under the Quality Payment Program;
- Encourage value-based payments under federal programs by rewarding physicians who enter into risk-based, value-based contracts with Medicare Advantage plans; and
- Work to align Medicare Advantage and MACRA measurements and to facilitate strong collaboration between APMs under Medicare Advantage and MACRA.

By advancing these policies, CMS can make it easier for even more providers to participate in value-based payment arrangements.

Beneficiary Education of Value-Based Care

[21] Darius Tahir, "Languishing Medicare diabetes program frustrates providers," Politico. October 22, 2019. Web.

- **Develop and disseminate education materials and resources to improve beneficiary understanding of value-based care.**

Speeding the shift to value is a major undertaking for all stakeholders and beneficiaries deserve to have their perspectives included. Beneficiaries should be engaged in the transition to value-based care for it to be truly successful. As previously discussed, value-based arrangements can incentivize meaningful improvements in beneficiary health and experience. For example, value-focused approaches can help ensure that plans seek to include the highest quality, most efficient providers in their networks. Further, the rigorous tracking and measurement central to value-based arrangements can help plans and providers to better target benefits to the high-need beneficiaries who could benefit most. However, many beneficiaries remain apprehensive.

While many plans and providers are working to educate and engage beneficiaries about the shift to value, as well as assuage their fears that "value" means "lower quality," CMS should take a larger role in increasing beneficiary awareness and engagement. In particular, CMS should consider a beneficiary education campaign that highlights the success of value-based approaches at improving health outcomes and makes it clear that there is proper oversight and accountability that protects beneficiaries' interests in value-based care. In addition, CMS should provide plans and providers with additional educational resources to enable them to engage more effectively with beneficiaries.