BETTER MEDICARE ALLIANCE

1411 K Street NW, Suite 1400
Washington, DC 20005
202.735.0037

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

March 6, 2020

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

Re: CMS-2018-0154, Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies, Part I, CMS-HCC Risk Adjustment Model, and Part II

Dear Administrator Verma:

Better Medicare Alliance (BMA) is pleased to submit the following comments on the Advance Notice for Calendar Year (CY) 2021 ("Advance Notice") on behalf of our Alliance and the 24 million beneficiaries enrolled in Medicare Advantage. BMA is a community of more than 140 ally organizations and 460,000 beneficiary advocates who value Medicare Advantage and the affordable, high-quality and coordinated care it provides millions of seniors and those with disabilities across the country. Together, our alliance of health plans, provider groups, aging service organizations, and beneficiaries share a commitment to ensuring Medicare Advantage is a high-quality, cost-effective option for current and future beneficiaries.

Seniors and individuals with disabilities eligible for Medicare deserve the value-driven, affordable, quality, and innovative health care available in Medicare Advantage. Through value-based payment and care management that results in quality care, improved health outcomes, extra benefits, and lower costs for consumers, Medicare Advantage is addressing the needs of today's beneficiaries. With growing enrollment and high consumer satisfaction, Medicare Advantage is building the future of Medicare.

Today, Medicare Advantage covers more than 24 million American seniors and people with disabilities, or about 35 percent of all eligible beneficiaries. This year Medicare Advantage beneficiaries were able to choose from nearly 4,300 plans with the average beneficiary having access to 39 plan choices in their county. For 2020, Medicare Advantage reported the lowest average premiums since 2007 and the third consecutive year of premium decreases, while 94 percent of beneficiaries have access to at least one $0 premium plan.[1] The decline in premiums over the last three years is estimated to save taxpayers $6 billion in lower Medicare premium subsidies.[2] In addition, 97 percent of Medicare Advantage beneficiaries have access to a plan with dental vision, hearing, or fitness benefits, and nearly 6-in-10 plans provide all four supplemental benefits. Further, 81 percent of Medicare Advantage beneficiaries are enrolled in four- or five-star plans, the highest ratings for quality.[3] In a recent study, Medicare Advantage beneficiaries reported $1,598 less in total spending than those in Traditional Fee-for-Service (FFS) Medicare.[4] And, beneficiaries are highly satisfied, with Medicare Advantage earning a 94 percent satisfaction rating in a recent poll.[5] This year, a record-setting 403 Members of Congress sent bipartisan companion letters to the Administration expressing strong support for Medicare Advantage, which serves both as a testament to constituents'

[1] https://www.bettermedicarealliance.org/policy-research/resource-library/medicare-advantage-2020-fact-sheet
[2] https://www.cms.gov/newsroom/press-releases/trump-administration-drives-down-medicare-advantage-and-part-d-premiums-seniors
[3] https://www.bettermedicarealliance.org/policy-research/resource-library/medicare-advantage-2020-fact-sheet
[4] Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest-Income Populations, March 2020: Better Medicare Alliance.
[5] https://www.bettermedicarealliance.org/policy-research/resource-library/medicare-advantage-2020-fact-sheet

satisfaction as well as increasing recognition by policymakers of the value and success of this option for Medicare.[6]

We appreciate CMS' support of Medicare Advantage and believe that this Advance Notice creates a positive environment for Medicare Advantage plans, providers, and community partners to offer Medicare Advantage beneficiaries innovative, high-quality, cost-effective care that improves beneficiaries' experiences and health outcomes. We have comments on several provisions both in strong support of changes, such as greater flexibility in network adequacy and telehealth, and expressing concerns such as implementation of expanded enrollment opportunities in Medicare Advantage for individuals with End Stage Renal Disease (ESRD) in 2021, among others. These issues are briefly highlighted in this letter, with detailed comments offered in the attachments.

As CMS considers stakeholder comments and finalizes the Rate Notice for CY 2021, we note CMS has also proposed a separate rule (CMS-4190-P) which includes substantial policy and technical changes that will affect Medicare Advantage beneficiaries, plans, providers, and partners. BMA will share our comments on this proposed rule by the April 6 deadline which is the same day by which CMS intends to finalize the CY 2021 Rate Notice. With so many moving parts, we are concerned Medicare Advantage stakeholders may have an incomplete understanding of rules and regulations governing 2021 bid proposals. In the future, we urge CMS to stage its proposals such that plans have all relevant information for plan design and bid submission and that all stakeholders are better able to offer a full set of comments based on more complete information on proposed changes for the following year.

BMA asks CMS to consider our comments on the following key issues in the final Rate Notice, including reference to related concerns in the MA-PD proposed rule:

End-Stage Renal Disease. BMA shares the Administration's goal to improve care for those with Chronic Kidney Disease (CKD) and welcomes the opportunity for Medicare Advantage to care for beneficiaries with ESRD, as well as to work to slow disease progression for those at risk, and expand access to transplantation. Medicare Advantage is well-positioned to provide high-quality, integrated care for beneficiaries with ESRD. However, in order to ensure a smooth transition and successful implementation of this new policy, CMS must address the chronic underfunding and fluctuating nature of ESRD payment in Medicare Advantage. CMS must ensure the ESRD benchmark calculations and risk scores reflect actual costs and provide accurate and adequate payment for this high-need, high-cost patient population.

BMA recommends updating the Bid Pricing Tool instructions so that the ESRD subsidy falls under Medicare covered benefits rather than under Mandatory Supplemental benefits. The benchmark must also be adjusted to account for the fact that Medicare Advantage payments to dialysis providers are significantly higher than Traditional FFS Medicare rates due to market concentration. In addition, risk adjustment should account for the high cost of the first year of entry into renal failure in recognition of the care and services which are so important to the health and well-being of these chronically ill beneficiaries. We ask CMS to attend to these and other comments to ensure appropriate payment without adding cost burden to all Medicare Advantage beneficiaries. Low premiums and low out-of-pocket costs for consumers have been the hallmark of Medicare Advantage. Ensuring payment accuracy and stability in ways that acknowledge the real costs of care is essential to enabling plans and providers to offer high-quality, innovative care and services to those with ESRD, and protect all beneficiaries from increased costs.

[6] https://www.bettermedicarealliance.org/newsroom/press-releases/better-medicare-alliance-helps-set-new-record-bipartisan-congressional

Network Adequacy. BMA supports CMS' proposed changes to network adequacy standards included in the Policy and Technical Changes proposed rule (CMS-4190-P) and agrees that revisions to telehealth and maximum time and distance standards would improve access to Medicare Advantage plans for those in rural and underserved areas. We recommend CMS finalize the network adequacy policy updates as soon as possible to allow Medicare Advantage plans to incorporate this change into their CY 2021 bids. Further, such changes will encourage the use of telehealth services that can better ensure access to services and continuity of care for beneficiaries, especially in rural areas. We support and encourage the innovation in treatment for ESRD beneficiaries that may result from these changes including the increased utilization of home dialysis, mobile dialysis units, and other innovative means of delivering care.

We look forward to offering additional feedback in our comments on the proposed rule, but in the interim, we encourage CMS to expand the proposed 10 percent credit towards the percentage of beneficiaries residing within published time and distance standards to include telehealth nephrologists, in addition to other proposed specialists. Expanding the credit to include nephrologists may assist plans and providers in ensuring access to care and services for beneficiaries with CKD and ESRD. We also support CMS' proposal to modify network adequacy standards by lowering the percentage of beneficiaries that must reside within the maximum time and distance standards in Micro, Rural, and Counties with Extreme Access Considerations (CEAC) counties. Additionally, we support the proposal for Medicare Advantage plans to attest to providing dialysis as part of their application and support other ways to modify network requirements that could increase access to a diversity of outpatient facilities, such as hospital outpatient dialysis units.

Star Ratings – Patient Experience/Complaints and Access Measures. Medicare Advantage demonstrates high-quality performance with 81 percent of beneficiaries enrolling in a high-performance plan. BMA, with our 460,000 beneficiary advocates, agrees that patient experience measures can offer important insights into consumer satisfaction with their Medicare Advantage plan. However, critical concerns about the accuracy and usefulness of the current methodologies used to assess all consumer experience remain. In the Policy and Technical Changes proposed rule (CMS-4190-P), CMS proposes to double the weight of Consumer Assessment of Healthcare Provides and Systems (CAHPS) patient experience/complaints and access measures in the Star Ratings program, from a current weight of two to a proposed weight of four. BMA encourages CMS to not increase the weight of these measures until the serious methodological concerns with the calculation of these measures are resolved or replaced with a better methodology.

Growth Rates. We encourage CMS to finalize a strong and stable rate environment for the Medicare Advantage program, and we ask CMS to provide more transparency into the calculation of the FFS Growth Percentage. CMS projects a FFS USPCC—Non-ESRD growth percentage of 2.57 percent for 2021, which is substantially lower than the 4.46 percent FFS growth percentage projection included in the December 3, 2019 early preview. This is a significant change in a short period of time that impacts the payments to Medicare Advantage plans. BMA encourages CMS to provide transparency into the rate calculation and promote payment stability as it finalizes rates for CY 2021.

Our more detailed comments on these priorities and other policy proposals follow in Attachments A and B. Also attached is a list of our 143 ally organizations (Attachment C) and selected quotes from ally organizations sharing their strong support for successful integration of beneficiaries with ESRD into Medicare Advantage, support for proposed changes to network adequacy and telehealth, and the need to improve the methodology for consumer experience measures in the Star Rating System (Attachment D).

BMA shares the Administration's commitment to Medicare Advantage payment and policies that ensure adequate and stable resources to offer beneficiaries the care and services they deserve. Recent changes in

law and regulations for Medicare Advantage have led to increased enrollment, higher provider engagement in value-based payment arrangements, new relationships with community partners, lower consumer costs, and wider support from policymakers. CMS' support for this integrated care model has driven innovation in financing and care delivery for millions of Medicare beneficiaries. We appreciate your efforts and we look forward to working with you and your staff to ensure Medicare Advantage is able to offer high quality care, lower consumer costs, and extra benefits tailored to meet the needs of current and future Medicare beneficiaries.

Thank you for the opportunity to submit comments and we welcome further discussion.

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

Summary of Better Medicare Alliance's Comments and Recommendations

Better Medicare Alliance (BMA) asks CMS to consider the following comments and recommendations in the Final Rate Notice:

End-Stage Renal Disease

- Ensure the smooth transition of new beneficiaries into Medicare Advantage. This includes ensuring payment and policies that enable Medicare Advantage plans and providers to offer high-quality care and treatment for ESRD patients, while keeping premiums and out-of-pocket costs low for all beneficiaries.
    - Support innovations in care, including the use of telemedicine for routine dialysis-related check-ups, advances in home dialysis, and strides in other treatment modalities.
    - Update the Bid Pricing Tool instructions so that the ESRD subsidy falls under Medicare covered benefits instead of Mandatory Supplemental Benefits as it does today.
    - Provide additional detail regarding how CMS proposes to calculate organ acquisition costs for kidney transplants.
    - Account for the maximum out-of-pocket (MOOP) limit in the calculation of ESRD benchmarks in a way that protects all beneficiaries from high out-of-pocket spending.
    - Fix the ESRD benchmark calculation to reduce year-over-year volatility, reflect actual costs, and ensure accurate and adequate payment for the ESRD population.
    - Ensure the ESRD benchmark accounts for Medicare Advantage payments to dialysis providers that are significantly higher than Traditional FFS Medicare rates due to market concentration.
- Ensure the accuracy of risk scores for ESRD beneficiaries in order to provide adequate resources to care for this group of beneficiaries with complex clinical conditions and need for ongoing, expensive treatments, and to avoid adverse consequences, including increased cost burdens or reduced supplemental benefits for all Medicare Advantage beneficiaries.
- Engage stakeholders and provide ample notice in developing measures to incentivize early diagnosis of CKD and high-quality care for ESRD beneficiaries in Medicare Advantage.

Advance Notice Part I, CMS-HCC Risk Adjustment Model

- Continue efforts to improve the completeness, accuracy, and validity of encounter data used as the primary diagnosis source for beneficiary risk scores.

Advance Notice Part II, Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

- Provide additional transparency into the calculation of the Fee-for-Service (FFS) Growth Percentage, including identification and quantification of all factors contributing to the substantial restatement of the FFS United States per capita cost (USPCC) growth percentages between the December 2019 Early Preview and the February 2020 Advance Notice.
- Continue the current policy of waiving bidding requirements for employer group waiver plans (EGWPs) for 2021 and minimize disruption to the EGWP market by considering the unique effect of any proposed policy changes on EGWPs.
- Provide detail on the quantification of each driver of the increasing normalization factor trend (demographics, health status of the Traditional FFS Medicare population, and ICD-10 implementation).
- Align policies on disasters and catastrophic events across the Medicare Advantage program, lower the threshold of beneficiaries impacted by a disaster required to qualify for Star Ratings accommodations to 20 percent, and take a more holistic view of the impact of separate disasters on a plan's beneficiaries.

Attachment B

Better Medicare Alliance's Detailed Comments on Proposed Policy Changes

End-Stage Renal Disease (ESRD)

- **Benchmark Calculation**

BMA urges CMS to ensure the smooth transition of expanded Medicare Advantage enrollment options for beneficiaries with ESRD. This includes ensuring payment and policies that enable Medicare Advantage plans and providers to offer high-quality care and treatment for patients with ESRD, while keeping premiums and out-of-pocket costs low for all beneficiaries.

CMS is using the 2015-2018 FFS reimbursement and enrollment data for beneficiaries in dialysis status for each state to develop 2021 ESRD Medicare Advantage benchmarks. The geographic indices for each year will be calculated by dividing the state per capita cost by the total national per capital cost. The average geographic adjustment by state is then determined by calculating a five-year weighted average of the geographic indices. CMS calculated the 2018 FFS ESRD dialysis United States per capita cost (USPCC) based on the 2018 data and, using trend factors, developed the prospective 2021 FFS ESRD dialysis USPCC.

BMA Comments:

The experience and accomplishments of Medicare Advantage plans in providing care to beneficiaries with ESRD, including those in ESRD Chronic Condition Special Needs Plans (C-SNPs) strongly demonstrates the value that Medicare Advantage can bring to beneficiaries with ESRD. Many of these beneficiaries benefit from the supplemental benefits provided and enhanced care coordination inherent in Medicare Advantage. However, in order to maintain and enhance this level of care to an increasing number of beneficiaries, payments must be accurate, stable, and sufficient. BMA wants to ensure that beneficiaries with ESRD, and *all* beneficiaries, do not see higher out-of-pocket costs, reduced benefits, or limited service areas as a result of the increased enrollment of ESRD beneficiaries in Medicare Advantage expected in 2021.

BMA, therefore, urges CMS to consider six key points with regard to the ESRD benchmark. First, CMS should support innovations in care, including the use of telemedicine for routine dialysis-related check-ups, advances in home dialysis, and strides in other treatment modalities. Advances in dialysis now allow individuals with ESRD to treat themselves at home, improving independence and convenience.[7] Some home hemodialysis and home peritoneal dialysis treatments involve nocturnal dialysis or shorter, more frequent sessions than the three times per week model typical of in-center dialysis. We encourage CMS to enact policies that support these dialysis innovations, and we support the goal of the Administration's 'Advancing American Kidney Health' initiative, which seeks to have 80 percent of new ESRD patients receive a transplant or home dialysis by 2025.

Second, BMA asks CMS to update the Bid Pricing Tool so that the ESRD subsidy is moved under Medicare covered benefits from mandatory supplemental benefits as the majority of expenses associated with caring for ESRD beneficiaries are Medicare covered services, and funding should not come out of rebate dollars as it does today. This will ensure rebate dollars are available for use as supplemental benefits to non-ESRD beneficiaries, including those who have chronic conditions, multiple co-morbidities

[7] https://www.bettermedicarealliance.org/sites/default/files/2020-01/BMA_WhitePaper_CaringForESRDBeneficiaries-FIN_0.pdf

and social risk factors. This change would enhance the ability to provide quality, innovative care for ESRD patients and to meet the needs of other non-ESRD beneficiaries who rely on these benefits and cost savings.

Third, BMA asks CMS to provide additional detail regarding how it proposes to calculate organ acquisition costs for kidney transplants. Per the *21st Century Cures Act*, these costs are to be covered by Traditional FFS Medicare and thus eliminated from both the benchmark and plan bids. However, CMS has not provided critical details such as the exact codes it plans to eliminate from the benchmark. This information is key to ensuring accuracy of both benchmarks and plan bids.

Fourth, BMA appreciates CMS' understanding that current ESRD reimbursement will not cover the high costs of ESRD beneficiaries in Medicare Advantage, and could lead to premium increases. However, we do not agree with CMS' proposed solution of increasing the maximum out-of-pocket (MOOP) limit for all beneficiaries. While some increase in the MOOP may be justified, the current proposal simply raises costs for all beneficiaries. It functionally asks non-ESRD beneficiaries to shoulder the financial burden of adding ESRD beneficiaries to the risk pool. To ensure adequacy of payments, CMS should account for the MOOP limit in the calculation of ESRD benchmarks in a way that protects all beneficiaries from high out-of-pocket spending. If the benchmark does not account for the MOOP limit, all beneficiaries (ESRD and non-ESRD alike) will bear a greater cost burden.

Fifth, BMA encourages CMS to fix the ESRD benchmark calculation to reduce year-over-year volatility, reflect actual costs, and ensure accurate and adequate payment for the ESRD population. A recent study from Avalere Health concludes that payment to Medicare Advantage plans for ESRD patients in highly populated regions are significantly below actual patient costs.[8] This is key, given that Medicare spends $67,116 annually per ESRD beneficiary, or four times more than an average disabled beneficiary, and six times more than an average aged beneficiary. Medicare Advantage payment rates must cover actual costs of care for ESRD patients, with particular attention to underpaid states, and provide consistency and predictability.

Sixth, BMA encourages CMS to ensure that the ESRD benchmark accounts for Medicare Advantage payments to dialysis providers that are significantly higher than Traditional FFS Medicare rates due to market concentration. To meet network adequacy requirements, Medicare Advantage plans do not have negotiating leverage in most geographic areas across the country due to the highly consolidated nature of the dialysis market. This is unlikely to change even as more ESRD beneficiaries choose Medicare Advantage plans in 2021.

Lastly, BMA is pleased that CMS is soliciting feedback in the Policy and Technical Changes proposed rule (CMS-4190-P) on network adequacy flexibility as it relates to time and distance standards for telehealth providers, and the time and distance standards for Micro, Rural, and CEAC counties. In response to CMS's request for feedback on the inclusion of nephrology as a specialty for the 10 percent credit, we want to express our strong support for the addition of nephrology.

BMA believes CMS' proposals on network adequacy and telehealth increase market competition, expand access to care in the home and other innovative models of care, lower costs for beneficiaries and lead to improved health outcomes for those with kidney disease. BMA commends CMS for putting forth these proposals and we urge the agency to act swiftly thus ensuring beneficiaries can benefit from these new policy proposals in 2021.

[8] https://avalere.com/insights/medicare-advantage-plans-may-be-paid-below-actual-esrd-patients-costs-in-large-metropolitan-areas-in-2021

- **Risk Adjustment**

CMS must ensure that risk scores for new ESRD beneficiaries accurately reflect the health status of this population. BMA continues to have concerns that the current risk adjustment model results in inadequate plan payments that fail to account for the high costs of these complex, vulnerable, and high-need patients.

For Calendar Year (CY) 2020 ESRD risk adjustment, CMS is blending 50 percent of the risk score using the 2019 ESRD models (using diagnoses from CMS' Risk Adjustment Processing System (RAPS) and FFS) summed with 50 percent of the risk score calculated with the 2019 ESRD models (using diagnoses from encounter data, RAPS inpatient records, and FFS). For CY 2021, CMS proposes to increase the proportion of the risk score calculated with the 2020 ESRD model to 75 percent and reduce the portion of the risk score calculated with the 2019 ESRD model to 25 percent.

BMA Comments:

As CMS knows well, expenditures associated with ESRD care and the incremental costs of an ESRD patient's co-morbidities are much higher than those for non-ESRD patients. It is critical that CMS accurately adjust payments to reflect the health status of this high-risk population to maintain stability of the entire Medicare Advantage program through the substantial change that will occur in 2021 as beneficiaries with ESRD are able to enroll in Medicare Advantage plans.

BMA previously expressed concerns about CMS' 2020 proposal to reduce ESRD risk scores for the dialysis new enrollee segment by 14.9 percent and in its Final 2020 Rate Announcement, CMS finalized this proposal. BMA asks that CMS consider recalibrating the ESRD model more frequently using updated data to increase the accuracy of the model and decrease the impact of the normalization factor.

BMA again asks CMS to reassess the new enrollee dialysis model and explore whether the sample size truly must be augmented with beneficiaries who have been on dialysis longer than one year. We continue to be concerned that including the costs of beneficiaries on dialysis for three years or more distorts the risk score for beneficiaries newly on dialysis. The life-altering nature of an ESRD diagnosis is part of what causes costs in the first year of dialysis to be so much higher than in subsequent years. For example, the most recent data on Medicare beneficiaries aged 67 years and older, indicates per capita monthly costs averaged $1,323 six months prior to initiation of dialysis.[9] Costs rose steadily and then spiked in the month following ESRD diagnosis to $19,343. Costs fell following dialysis initiation, but six months later remained six times higher than before the ESRD diagnosis, at $8,058 per month. CMS must adequately risk adjust payments for beneficiaries newly on dialysis who would most benefit from care management and care coordination as they navigate the many changes that accompany an ESRD diagnosis.

Finally, BMA encourages CMS to consider risk score adjustments to account for multiple co-morbidities and ensure adequate payment for the highest risk beneficiaries, as well as to consider the demonstration authority it has to smooth the transition for these new Medicare Advantage beneficiaries.

[9] https://www.usrds.org/2013/pdf/v1_ch7_13.pdf

- **Star Ratings**

BMA supports CMS' interest in developing measures to incentivize high-quality care for the ESRD population.

CMS notes that the National Committee for Quality Assurance (NCQA) is engaged in work to develop a new kidney health evaluation measure that may eventually replace the Diabetes Care — Kidney Disease Monitoring measure that is currently included in the Star Ratings. The potential new measure will provide information regarding screening and monitoring of kidney health for patients with diabetes.

BMA Comments:

BMA applauds the work of plans and providers in meeting high-quality standards set by CMS, with 81 percent of Medicare Advantage beneficiaries now enrolled in health plans with four- or five-Star ratings. This is an increase from 67 percent of beneficiaries in the highest rated plans in 2017. The drive to meet quality measurements is a proven success that is benefiting the 24 million Medicare beneficiaries who enrolled in Medicare Advantage plans for 2020. Helping consumers make a choice using quality ratings, as well as information on supplemental benefits and total costs, gives seniors the ability to become active choosers in their health care. We acknowledge CMS' continuing efforts to incentivize the high-quality care and value that Medicare Advantage provides to beneficiaries.

As CMS moves forward with the Star Ratings program, CMS should carefully consider appropriate measures of quality care for ESRD beneficiaries and ensure that all measures are accurate, actionable, and drive high-quality, value-based care. In developing such measures, BMA urges CMS to engage in a broad stakeholder process and to provide ample notice of proposed changes. BMA looks forward to more information on how CMS will work with nephrologists and other ESRD providers to evaluate the Star Ratings system to ensure it effectively assesses and incents improved quality for this complex cohort of patients.

Advance Notice Part I

- **Use of Encounter Data as a Diagnosis Source**

BMA asks CMS to continue improving the completeness, accuracy, and validity of encounter data to be used as the primary diagnosis source for beneficiary risk scores.

CMS proposes to calculate risk scores for payment to Medicare Advantage organizations by adding 75 percent of the risk scores calculated using risk adjustment eligible diagnoses identified from encounter data, FFS claims, and Risk Adjustment Processing System (RAPS) inpatient records, with 25 percent of the risk scores calculated with risk adjustment eligible diagnoses identified from all RAPS data and FFS claims.

BMA Comments:

BMA appreciates CMS' responses to observations we have previously shared about the use of the encounter data system (EDS) as a diagnosis source and operational challenges surrounding this transition. BMA recognizes the advantages that using encounter data provides over RAPS records and FFS claims, such as the inclusion of reporting from a broader group of providers, the inclusion of more information than RAPS data, and more frequent data reporting.

However, encounter data also has some key limitations. For example, the quality of encounter data reporting across care delivery sites is inconsistent, the data is limited to claims submitted for payment (which includes only billed services, not all care provided), it excludes both items and services not covered by Medicare and supplemental benefit data, and it offers limited physiological and behavioral health data.

Most importantly, as the Government Accountability Office, the Medicare Payment Advisory Commission, and the Department of Health and Human Services Office of the Inspector General have reported, limited progress has been made to validate the EDS, and incompleteness and inaccuracies in the data may underreport inpatient and skilled nursing facility claims, limiting the strength of the data. These reports offered recommendations for CMS to address encounter data accuracy issues, and BMA was pleased to see CMS concurred with many of the recommendations.

BMA calls on CMS to recognize the EDS data accuracy challenges and commit to additional work needed to fully validate the EDS, including improving data quality by site of service and benchmarking the data to other plans and to FFS claims. We appreciate CMS' ongoing efforts to improve the quality of encounter data.

Advance Notice Part II

- **Fee-for-Service Growth Percentage**

BMA asks CMS to promote benefit stability and provide more transparency into the calculation of the Fee-for-Service (FFS) Growth Percentage, including identification and quantification of all factors contributing to the substantial restatement of the FFS United States per capita cost (USPCC) growth percentages between the December 2019 Early Preview and the February 2020 Advance Notice.

CMS projects a FFS USPCC—Non-ESRD growth percentage of 2.57 percent for 2021, which is substantially less than the 4.46 percent FFS growth percentage projection included in the December 3, 2019 early preview.

BMA Comments:

BMA notes the change in the projected FFS Growth Percentage from the early preview in December 2019 (4.46 percent) to the Advance Notice in February 2020 (2.57 percent), and acknowledges that CMS restates the growth rates in the final rate notice to update its analysis for additional claims runout and other factors. BMA requests that CMS offer more transparency into the factors that comprise the analysis so that we may better understand what drove the restatement between December and February, and the dynamics that influence the calculation of the FFS growth percentage projection. In response to a question posed during a stakeholder call on February 7, 2020, CMS suggested the change was driven by reclassification of ESRD vs. non-ESRD costs, bad debt cost resettlements (requiring restatement of several years of historical FFS estimates), increased 2018 FFS enrollment, and emerging experience suggesting lower 2019 Part D spending. BMA would appreciate more specificity around the impact of each of these factors on the FFS growth percentage and more clarity on why they changed so significantly during such a short period of time.

We are also concerned about the effect of this lower growth percentage on the overall expected change in payments to Medicare Advantage plans in CY 2021, which CMS currently estimates to be 0.93 percent. BMA encourages CMS to provide transparency into the rate calculation and promote benefit stability as it finalizes rates for CY 2021.

BMA asks CMS to provide more transparency into the calculations utilized to determine the FFS Growth Percentage, and the factors contributing to the difference in rates released in December 2019, and those released in the Advance Notice in February 2020.

- **Employer Group Waiver Plans**

BMA appreciates CMS' intention to continue to waive bidding requirements for Employer Group Waiver Plans (EGWPs) in 2021. We encourage CMS to minimize disruption to the EGWP market by considering the unique effect of any proposed policy changes on EGWPs and to consider additional improvements to rules and regulations governing EGWPs.

CMS proposes to continue to waive bidding requirements for EGWPs in 2021 and to use the payment methodology implemented in the final 2020 Rate Announcement. CMS also proposes to continue to allow EGWPs to buy down Part B premiums for beneficiaries using a portion of the Part C payment, as is permitted in individual Medicare Advantage plans.

BMA Comments:

EGWPs represent a successful public-private partnership that addresses the health care needs of an important segment of today's retirees. EGWPs successfully enable employers nationwide to maintain consistent benefits and control costs for retirees' health coverage. Employers, state and local governments, and unions increasingly rely on employer retiree Medicare Advantage health plans to sustain their promise to provide health benefits to retirees.

BMA supports CMS' proposal to continue to use the 2020 payment methodology for 2021. In particular, we appreciate CMS' intent to continue adjusting the individual plan bid-to-benchmark ratios to account for differences in the proportion of enrollment in HMOs and PPOs between EGWPs and individual plans. We continue to see higher enrollment in local PPO plans among EGWP beneficiaries as compared to individual Medicare Advantage beneficiaries, who tend to favor HMO plans.

We look forward to sharing with CMS in our comments on the Policy and Technical Changes proposed rule (CMS-4190-P) ideas for improving the rules and regulations governing EGWPs to expand availability and utilization of this highly successful retiree coverage option. In brief, we believe regulatory modifications around rural provider network flexibility, an expanded definition of employment-based retiree coverage, and flexibility in setting member coinsurance amounts will allow EGWPs to serve more markets and mirror the benefits provided to active employees in their retiree health benefit plan. In addition, outreach and education efforts by CMS, as well as permitting EGWPs and employers to communicate with potential beneficiaries about value-added items and services, could ensure employers and retirees have more complete information about EGWPs and plan benefits.

Instability in the EGWP payment and policy can potentially cause higher costs to the employer or union sponsors, fewer supplemental benefits, and increased cost sharing for current and future EGWP beneficiaries. We ask CMS to promote stability in the EGWP market by specifically modeling the impact of proposed policy changes on EGWPs. EGWPs are very different from individual Medicare Advantage plans in terms of cost protections, benefit design waivers and flexibilities, and payment rates, among other functional structures. CMS should seek to understand these different impacts on EGWPs and work to minimize any disruption to the EGWP market.

- **Normalization Factors**

BMA asks CMS to provide detail on the quantification of each variable driving the increasing normalization factor trend (demographics, health status of the Traditional FFS Medicare population, and ICD-10 implementation) so that stakeholders can better understand current and potential future trends.

CMS proposes to use the same methodology used in CY 2020 to calculate normalization factors, resulting in CY 2021 normalization factors of 1.106 for the 2017 CMS-HCC model and 1.097 for the 2020 CMS-HCC model. Consistent with CMS' proposed risk score calculation, these two risk scores will be blended. In the Fact Sheet that accompanied Part II of the Advance Notice, CMS indicates the CY 2021 normalization factor results in a 2.54 percent decrease in payments relative to CY 2020. CMS notes that the risk scores underlying the normalization factors have increased at a faster rate in recent years and attributes this trend to a number of factors, including: 1) Demographics, 2) Reported health status in the Traditional FFS Medicare population, and 3) Implementation of ICD-10. CMS notes it expects the impact of ICD-10 implementation will stabilize over time and result in more constant risk scores, year over year, but demographics and reported health status will continue to increase and drive the normalization factor trend upward.

BMA Comments:

CMS states that demographics contribute to the increasing normalization trend. However, demographic trends in Medicare Advantage would suggest higher risk scores than for Traditional FFS Medicare beneficiaries. For example, a higher proportion of Medicare Advantage beneficiaries are age 75 and older (37.5 percent) compared to Traditional FFS Medicare (33.7 percent).[10] Medicare Advantage beneficiaries are also more likely than Traditional FFS Medicare beneficiaries to have less than a high school education (19 percent in Medicare Advantage versus 13.5 percent in Traditional FFS Medicare), while Traditional FFS Medicare beneficiaries are more likely to have completed college (35.8 percent in Traditional FFS Medicare versus 29.8 percent in Medicare Advantage). Medicare Advantage beneficiaries are also more likely to be black or Hispanic (22.9 percent) compared to Traditional FFS Medicare beneficiaries (15.2 percent).

In addition, in 2017, 50.3 percent of Medicare Advantage beneficiaries lived below 200 percent of the federal poverty level (FPL) compared to 40.1 percent in the Traditional FFS Medicare population.[11] Medicare Advantage also serves a higher proportion of beneficiaries who are eligible for Medicaid (21.4 percent) compared to Traditional FFS Medicare beneficiaries (15.7 percent). Similarly, only about a quarter of the Medicare Advantage population lives above 400 percent of FPL compared to more than one-third of the Traditional FFS Medicare population.

CMS also points to reported health status in the Traditional FFS Medicare population as a driver of increasing normalization factors. However, rates of self-reported chronic conditions are similar across the Medicare Advantage and Traditional FFS Medicare populations, though slightly higher for Medicare Advantage beneficiaries.

As in previous years, BMA reiterates our request that CMS identify all factors driving the increasing normalization trend and quantify the effect of each driver. This will require quantification of how much each factor CMS identifies—demographics, reported health status in the Traditional FFS Medicare population, and ICD-10 implementation—contributes to the trend. This information will allow

[10] Analysis of 2017 Medicare Current Beneficiary Survey (MCBS) Data, Provided by ATI Advisory.

[11] Better Medicare Alliance, "Medicare Advantage Provides Strong Protections to Low- and Modest-Income Populations Over Traditional Fee-for-Service Medicare," Data Brief, February 2020.

stakeholders to understand the magnitude of each driving factor and the likelihood that it will continue to drive risk score trends upward in future years.

- **Extreme and Uncontrollable Circumstances Policy**

BMA asks CMS to align its policies on disasters and catastrophic events across the Medicare Advantage program, to lower the threshold of beneficiaries impacted by a disaster required to qualify for Star Ratings accommodations to 20 percent, and to take a more holistic view of the impact of separate disasters on a plan's beneficiaries.

In 2021, CMS proposes to use the policy finalized for the 2020 Star Ratings to take into account the effects of extreme and uncontrollable circumstances that occurred during the performance period. CMS notes that such circumstances not only affect beneficiaries and providers, but also the operational and clinical systems on which CMS relies for accurate Star Ratings performance measurement.

BMA Comments:

BMA notes that CMS uses different standards to trigger different accommodations in response to extreme and uncontrollable circumstances. We ask CMS to align its policies on disasters and catastrophic events across the Medicare Advantage program. Such alignment should ensure that any type of federal disaster declaration triggers the flexibility and accommodations available to beneficiaries and plans. CMS currently uses different thresholds to trigger a waiver of benefit limitations and special enrollment periods that are available to Medicare Advantage beneficiaries in the event of an emergency or disaster declaration. CMS uses a third standard to determine when Medicare Advantage plans qualify for adjustments to their Star Ratings calculation following an extreme or uncontrollable circumstance. Aligning the accommodations available to beneficiaries and plans due to extreme or uncontrollable circumstances will provide a more seamless application of CMS' policies across the program, enabling plans to better assist beneficiaries and ensure plans are appropriately measured on their performance during and after emergencies and disasters

BMA encourages CMS to permit these accommodations when any federal disaster or emergency is declared. We note that the current extreme and uncontrollable circumstances policy in the Star Ratings program is limited to Individual Assistance disaster declarations made by the Federal Emergency Management Agency (FEMA). While we appreciate that the intent of this policy is to target Star Ratings adjustments to areas where services provided to beneficiaries may be impacted, we believe the current policy is too limited and does not appropriately consider the circumstances that beneficiaries and plans face under other types of FEMA disaster and emergency declarations. For example, in 2019, beneficiaries living in many California counties suffered from wildfires, but, under the current policy, the Medicare Advantage plans serving them are ineligible for Star Ratings adjustments because of the type of disaster declaration FEMA used. This is despite the fact that several California counties qualified for the adjustments due to wildfires during the two previous years.

Second, BMA asks CMS to consider lowering the threshold of beneficiaries impacted by a disaster required to qualify for Star Ratings accommodations from 25 percent to 20 percent. Currently, at least 25 percent of a plan's enrollees must reside in a FEMA-designated Individual Assistance area in order for the plan to qualify for Star Ratings adjustments. We believe this threshold is unnecessarily high and that 20 percent is a more appropriate threshold for Star Ratings adjustments. When 20 percent of a plan's enrollees are affected by natural disaster, it can substantially impact a plan's Star Rating performance.

Finally, BMA asks CMS to consider a more holistic view of how multiple disasters may impact a plan's beneficiaries and Star Rating, particularly for plans that provide coverage to beneficiaries in multiple

states, and to offer clarification of its application of this policy in such a circumstance. On its own, one disaster may not affect the required percentage of beneficiaries to trigger Star Ratings adjustments. However, multiple disasters across several states may, in aggregate, reach the threshold and should be considered together. This may be especially true for EGWPs that serve retirees living in many different states. We urge CMS to clarify application of this policy and take a holistic view as it considers the effect of different extreme and uncontrollable circumstances on enrollees and Medicare Advantage plans.

Given the extraordinary circumstances of Coronavirus (COVID-19), the declaration of a public health emergency by the Department of Health and Human Services, the Congressional appropriation of federal funds, and the Administration's efforts to use this funding for coverage and reimbursement for expenses incurred by health care providers and systems associated with identifying and treating the disease, there should also be accommodations made to Medicare Advantage plans for costs of screening, treatment, and services for affected beneficiaries.

BETTER MEDICARE ALLIANCE

Attachment C

List of Better Medicare Alliance's National, State, and Local Allies in Support of Medicare Advantage

National, State, and Local Allies

Better Medicare Alliance's work in support of Medicare Advantage is driven by the support of over 140 diverse ally organizations.

BETTER MEDICARE ALLIANCE

Advocacy Organizations

Academy of Managed Care Pharmacy (AMCP)
Alliance for Aging Research
American Telemedicine Association
Asian & Pacific Islander American Health Forum
Association for Behavioral Health and Wellness
Association for Community Affiliated Plans
Coalition of Texans with Disabilities
Coalition to Transform Advanced Care
Consumer Action
Council for Affordable Health Coverage
Direct Primary Care Coalition
Global Alzheimer's Platform Foundation
Healthcare Leadership Council
Hearing Loss Association of America
National Alliance on Mental Illness
National Association of Nutrition and Aging Services Programs
National Caucus and Center on Black Aging
National Coalition on Health Care
National Hispanic Council on Aging
National Minority Quality Forum
National Patient Advocate Foundation
Patient-Centered Primary Care Collaborative
Population Health Alliance
Smarter Health Care Coalition
SNP Alliance
Society for Women's Health Research
The Gerontological Society of America
The Latino Coalition
WomenHeart

Policy and Research Organizations

Health Care Transformation Task Force
Network for Excellence in Health Innovation
University of Michigan Center for V-BID

National/Local Community-Based Organizations

MANNA
Meals on Wheels America
YMCA of the USA

Aging Service Organizations

Area Agency on Aging Palm Beach / Treasure Coast, Inc.
Elder Services of the Merrimack Valley
Florida Health Networks
International Council on Active Aging
LeadingAge
National Association of Area Agencies on Aging
Partners in Care Foundation
Philadelphia Corporation for Aging
Senior Resource Alliance

Benefits Plans

Delta Dental of CA, PA, NY, & Affiliates
LIBERTY Dental Plan Foundation
National Association of Dental Plans
VSP Vision Care

Medicare Advantage Plans

Aetna/CVS Health
Health Partners Plans, Inc.
Humana
SCAN Health Plan
Tufts Health Plan
UnitedHealth Group
UPMC Health Plan

Public Sector Purchaser Organizations

Public Sector Healthcare Roundtable
Teachers' Retirement System of Kentucky

Provider Associations

Academy of Nutrition and Dietetics
American Academy of Audiology
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American Medical Group Association
American Nurses Association
American Occupational Therapy Association
American Osteopathic Association
American Podiatric Medical Association
American Physical Therapy Association
American Speech-Language-Hearing Association
Federation of American Hospitals
Gerontological Advanced Practice Nurses Association
Home Care Association of America
National Adult Day Services Association
National Association of Hispanic Nurses
National Association of Hispanic Nurses Garden State Chapter
National Black Nurses Association
National Hispanic Medical Association
National Hospice and Palliative Care Organization
National Medical Association
National Respite Coalition
New Jersey Association of Nurse Anesthetists
New Jersey State Nurses Association
Nurse Practitioner Association of New York State
Visiting Nurses Association of America

National Business Organizations

American Benefits Council
Dental Trade Alliance
National Association of Health Underwriters
National Association of Manufacturers
National Business Group on Health
National Retail Federation
U.S. Chamber of Commerce

Health Companies

Tivity Health
SilverSneakers – a Tivity Health Company
naviHealth

Health Systems/Provider Groups

Atrius Health
Austin Regional Clinic
Banner Health
Central Ohio Primary Care Physicians
ChenMed
Commonwealth Care Alliance
ConcertoHealth
Einstein Healthcare Network
Gundersen Health System
Health Quality Partners
Indiana University Health
Intermed
Iora Health
Landmark Health
Lehigh Valley Health Network
Martin's Point Health Care
Mercy Health
Northwell Health
Novant Health
Oak Street Health
Prevea Health
SSM Health
Summa Health
Temple Health
Trinity Health
UnityPoint
Vancouver Clinic
Virtua
Visiting Nurse Service of New York

State/Local Business Organizations

Arizona Association of Health Underwriters
Business Council of New York State
Chamber of Commerce Southern New Jersey
Commerce and Industry Association of New Jersey
Connecticut Association of Health Underwriters
Delaware State Chamber of Commerce
Denver Metro Chamber of Commerce
Greater Pittsburgh Chamber of Commerce
Greater Philadelphia Business Coalition on Health
Greater Philadelphia Chamber of Commerce
Inland Empire Association of Health Underwriters
New Jersey Business and Industry Association
New Jersey State Chamber of Commerce
Orange County Association of Health Underwriters
Oregon Association of Health Underwriters
Pacific Business Group on Health
Palm Coast Association of Health Underwriters
Pennsylvania Chamber of Business and Industry
Pittsburgh Business Group on Health
Texas Association of Business

Learn more and sign up for alerts at **www.bettermedicarealliance.org**

Attachment D

Selection of Comments from Ally Organizations of Better Medicare Alliance

"African Americans suffer from some of the highest rates of end-stage renal disease (ESRD). As we look ahead to 2021, when ESRD patients will become newly eligible for Medicare Advantage, CMS must set parameters that give this policy the best chance to succeed. This includes addressing payment disparities that shortchange Medicare Advantage and disproportionately impact people of color," **said Dr. Martha A. Dawson, President, National Black Nurses Association**. *"National Black Nurses Association joins Better Medicare Alliance in working to ensure fair, stable payment to Medicare Advantage for ESRD beneficiaries' care while also working to maintain language in the Medicare Advantage proposed rule that supports all beneficiaries – especially those in rural and underserved areas – by supporting the use of telehealth in determining network adequacy requirements."*

*"As an organization committed to empowering underrepresented consumers nationwide, Consumer Action is proud to advocate for the 500,000 Medicare beneficiaries living with end-stage renal disease (ESRD). We join all who are insisting on stable, predictable payment to Medicare Advantage that reflects the true costs of these individuals' care. ESRD patients deserve nothing less***," said Linda Sherry, Director of National Priorities for Consumer Action**. "*Consumer Action further applauds CMS for protecting beneficiaries in rural and hard-to-reach areas by incentivizing greater use of telehealth in its proposed rule. Telehealth is paramount to ensuring that no consumer's zip code dictates their ability to access quality care. We support maintaining language around telehealth and network adequacy requirements in the final Medicare Advantage rule."*

"AMGA member organizations represent over 175,000 practicing physicians – many of whom are already on the frontlines of the effort to provide coordinated, quality care to end-stage renal disease (ESRD) patients," **said AMGA President and CEO Jerry Penso, M.D., M.B.A.** *"We join Better Medicare Alliance in urging CMS to ensure appropriate, stable payment to Medicare Advantage for ESRD patients so that our clinicians can continue delivering the care these individuals deserve."*

"Congress took an important step forward for people of color living with the challenges of end-stage renal disease (ESRD) with passage of the ESRD Choice Act as part of 2016's 21st Century Cures Law. Beginning next year, ESRD patients will – for the first time – have the opportunity to experience the lower costs, improved care coordination, and better outcomes found in Medicare Advantage. While we celebrate this change, we are also committed to ensuring that Medicare Advantage has the tools to give ESRD patients the care they deserve," **said Gary A. Puckrein, Ph.D., President and CEO, National Minority Quality Forum.** *"That means ensuring that payments to Medicare Advantage for ESRD beneficiaries reflect the true cost of their care. With lengthy dialysis visits, transplant waiting lists, and other hurdles, ESRD patients face unique challenges already. We must not add to their burden by hamstringing Medicare Advantage's ability to serve their complex needs."*

"Healthcare Leadership Council has consistently recognized the value of Medicare Advantage and its role in modernizing Medicare for the seniors of today and tomorrow. For Medicare Advantage to live up to its fullest potential – particularly for vulnerable patients and those with end-stage renal disease (ESRD) – Washington must do its part," **said Mary R. Grealy, President, Healthcare Leadership Council.** *"We encourage CMS to deliver fair, appropriate and stable payments to Medicare Advantage for all patients, particularly for those such as ESRD patients who are facing the greatest health challenges. Thoughtful policy and reimbursement decisions will ensure that Medicare Advantage can continue to innovate and deliver the lower costs, high quality care, and improved health outcomes that Americans have come to know and expect."*

"Telehealth and other 21st-century care delivery tools are critical to meaningful person-centered, value-based care. The Health Care Transformation Task Force (HCTTF) is encouraged that CMS's Medicare Advantage proposed rule fosters increased adoption of telehealth by modernizing network adequacy requirements to support these modes of care delivery," **said Jeff Micklos, Executive Director of the Health Care Transformation Task Force.** "*We urge CMS to finalize these proposed polices and stand with the Better Medicare Alliance and others who support this approach and the drive for successful value-based care models."*

"End-stage renal disease (ESRD) is a pressing challenge to population health management. Medicare Advantage can play a pivotal role in improving outcomes and quality of care for the 500,000 Medicare beneficiaries who are affected. This includes updating the Medicare Advantage ESRD payment methodology to ensure adequate funding so plans can deliver the quality care that these patients deserve," **said Helene Forte, Chair of Government Affairs at the Population Health Alliance.** *"We also applaud language in CMS's Medicare Advantage proposed rule that supports the uptake of telehealth and the availability of Medicare Advantage choices in rural and underserved communities by modernizing network adequacy requirements to reflect the broad use of telehealth that exists already today. We look forward to seeing these network adequacy provisions upheld in the final rule."*

"Telehealth and virtual care technologies not only improve access to care and convenience for patients, but also reduce costs. We applaud CMS for including provisions in its Medicare Advantage proposed rule that embrace these realities by allowing providers accessed via telehealth to count toward network adequacy requirements," **said Ann Mond Johnson, CEO, ATA.** "*We stand with stakeholders across the health care spectrum in urging CMS to maintain this language as part of its final rule. Telehealth is health and Medicare policy should allow this important solution to do more good for more people."*