BETTER MEDICARE ALLIANCE

1411 K Street NW, Suite 1400
Washington, DC 20005
202.735.0037 (office)
202.885.9968 (fax)

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

March 4, 2022

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

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Administrator Brooks-LaSure:

On behalf our Alliance and the 28 million beneficiaries enrolled in Medicare Advantage, Better Medicare Alliance (BMA) is pleased to submit the following comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies ("Advance Notice").

Better Medicare Alliance is a diverse coalition of 170 Ally organizations and more than 600,000 beneficiaries who value Medicare Advantage. Together, our Alliance of community organizations, providers, health plans, aging service organizations, and beneficiary advocates share a deep commitment to ensuring Medicare Advantage remains a high-quality, cost-effective option for current and future Medicare beneficiaries.

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

Medicare Advantage accounts for approximately 43 percent of all eligible Medicare beneficiaries, and it is estimated 29.5 million beneficiaries will be enrolled in Medicare Advantage in 2022.[1] Access to Medicare Advantage is nearly universal (99.7 percent), and beneficiaries are able to choose from over 3,800 health plans across the country.[2]

For 2022, the average Medicare Advantage premium is $19,[3] a 15-year low, and 98 percent of beneficiaries have access to a $0 premium plan with prescription drug coverage (MA-PD plan).[4] In addition, 99 percent of beneficiaries have access to a health plan that offers dental, vision, hearing, or fitness benefits,[5] and the percentage of plans offering Special Supplemental Benefits

[1] Centers for Medicare & Medicaid Services, CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans, September 30, 2021. Available at: https://www.cms.gov/newsroom/press-releases/cms-releases-2022-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug
[2] Kaiser Family Foundation, Medicare Advantage 2022 Spotlight: First Look, November 2, 2021. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/
[3] Centers for Medicare & Medicaid Services, CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans, September 30, 2021. Available at: https://www.cms.gov/newsroom/press-releases/cms-releases-2022-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug
[4] Kaiser Family Foundation, Medicare Advantage 2022 Spotlight: First Look, November 2, 2021. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/
[5] *Id*.

for the Chronically Ill (SSBCI) to address social needs increased 6 percent from last year.[6] All the while, approximately 90 percent of beneficiaries are enrolled in an MA-PD plan with a 4 Star rating or higher in 2022.[7]

A recent analysis finds Medicare Advantage beneficiaries report $1,640 less in total spending than their Fee-for-Service (FFS) Medicare counterparts.[8] Separate research finds Medicare Advantage offers $32.5 billion in additional value to the federal government through lower cost sharing and extra benefits relative to FFS Medicare.[9] Medicare Advantage beneficiaries are also highly satisfied with their care; Medicare Advantage earned a 94 percent satisfaction rating in a recent poll and 93 percent of beneficiaries say protecting Medicare Advantage funding should be a priority for the Biden-Harris Administration.[10] This year, a record-setting 80 percent, or 346 members, of the U.S. House of Representatives and nearly two-thirds of the U.S. Senate showed bipartisan support for Medicare Advantage in letters sent to the Administration, serving both as a testament to constituents' satisfaction, as well as increasing recognition by policymakers of the value and success of this option for Medicare.[11]

We appreciate CMS' support of Medicare Advantage, especially during the COVID-19 public health emergency (PHE) and believe this Advance Notice aims to create a positive rate and policy environment for Medicare Advantage providers, health plans, and community partners and organizations to offer beneficiaries innovative, high-quality, affordable care that improves health care experiences and outcomes as well as addresses social determinants of health and advances health equity. Payment stability and support during COVID-19 has enabled Medicare Advantage to respond quickly and leverage the flexible capitated payment model to deploy resources and services like telehealth to meet beneficiary needs. As the PHE winds down, we look forward to working in partnership with CMS and stakeholders to determine the path forward and ensure best practices and innovations developed during the PHE continue.

Overview of Comments

As we address the needs of the Medicare population, there are important proposed payment policy changes in the Advance Notice. Below are highlights of our comments, which are further detailed in the attachments.

- **Addressing social determinants of health and advancing health equity:** Better Medicare Alliance supports CMS' efforts to address social determinants of health and advance health equity in Medicare Advantage and across other programs and is committed to policy changes in this area. We appreciate a number of the thoughtful policy options to better address screening for social risk factors and provide incentives for Medicare Advantage plans to drive continued improvements in reducing disparities and closing gaps

[6] Centers for Medicare & Medicaid Services, CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans, September 30, 2021. Available at: https://www.cms.gov/newsroom/press-releases/cms-releases-2022-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug

[7] Centers for Medicare & Medicaid Services, CMS Releases 2022 Medicare Advantage and Part D Star Ratings to Help Medicare Beneficiaries Compare Plans, October 8, 2021. Available at: https://www.cms.gov/newsroom/press-releases/cms-releases-2022-medicare-advantage-and-part-d-star-ratings-help-medicare-beneficiaries-compare

[8] Better Medicare Alliance, Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest-Income Populations, March 2021. Available at: https://bettermedicarealliance.org/publication/data-brief-medicare-advantage-outperforms-traditional-medicare-on-cost-protections-for-low-and-modest-income-populations-2/

[9] Milliman, Value to the Federal Government of Medicare Advantage, October 2021. Available at: https://bettermedicarealliance.org/publication/milliman-report-value-to-the-federal-government-of-medicare-advantage/

[10] Morning Consult & Better Medicare Alliance, Survey Results: Annual Seniors on Medicare Survey, January 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/01/BMA_Seniors-on-Medicare-Memo_final3.pdf

[11] U.S. House of Representatives, Letter to Administrator Brooks-LaSure re Bipartisan Support for Medicare Advantage, January 28, 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/01/final_2022_house_ma_letter_.pdf ; U.S. Senate, Letter to Administrator Brooks-LaSure re Bipartisan Support for Medicare Advantage, February 18, 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/02/22.02.18_Senate-Bipartisan-Medicare-Advantage-Letter.pdf

in care, including consideration of new quality measures and establishing a health equity index. As these policies continue to be considered and refined through future rulemaking, we encourage CMS to continue engaging stakeholders on important policy design elements so that these proposals can work effectively to advance the goals of reducing disparities and improving access to person-centered care for Medicare beneficiaries. Moreover, we look forward to partnering with CMS on efforts to support accurate and comprehensive social determinants of health data collection to achieve these proposals and priorities.

- **Payment stability for beneficiaries with ESRD**: Better Medicare Alliance appreciates CMS' continued assessment of payment for beneficiaries with ESRD. We renew our recommendation to set ESRD rates at the sub-state level as it would reduce disparity in payments based on geography and further advance health equity for this clinically complex population.

Better Medicare Alliance shares the Administration's commitment to Medicare Advantage policies that ensure adequate and stable resources to offer beneficiaries the care and services they choose. Continued support for Medicare Advantage has led to increased enrollment, higher provider engagement in value-based payment arrangements, new relationships with community partners, lower consumer costs, and widespread 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 continued engagement and partnership to ensure Medicare Advantage is able to offer high-quality and affordable health care and extra benefits tailored to meet the needs of current and future Medicare beneficiaries.

We appreciate your consideration of these comments and policy recommendations and look forward to partnering with CMS on our shared goals of promoting stability and affordability for the millions of beneficiaries who choose and rely on Medicare Advantage.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

ATTACHMENT A
Better Medicare Alliance's Comments on Proposed Policy Changes

Changes in the Payment Methodology for Medicare Advantage and PACE

- **MA End-Stage Renal Disease Rates**

Better Medicare Alliance appreciates CMS' continued analysis of the methodology for setting ESRD payment rates in Medicare Advantage. We urge CMS to change Medicare Advantage ESRD rates to a sub-state level to ensure payment and policies enable health plans and providers to offer high-quality care and treatment for beneficiaries with ESRD, without decreasing supplemental benefits or increasing premiums or the cost burden for all Medicare Advantage beneficiaries.

Consistent with previous years, CMS proposes to set Medicare Advantage ESRD rates on the state level, using updated FFS costs, including reimbursement and enrollment data from 2016-2022 for beneficiaries receiving dialysis services.

BMA Comments:

Better Medicare Alliance supports access to Medicare Advantage for beneficiaries with ESRD beginning in 2021, the first year all Medicare beneficiaries with ESRD could choose and enroll in Medicare Advantage. In January 2021, over 40,000 beneficiaries with ESRD enrolled in Medicare Advantage. As a result, the share of beneficiaries with ESRD in Medicare Advantage grew from 22.7 percent to 30.3 percent.[12] As the share of beneficiaries with ESRD choosing Medicare Advantage increases, we urge CMS to ensure Medicare Advantage ESRD payment rates are accurate, stable, and sufficient. Better Medicare Alliance seeks to ensure beneficiaries with ESRD, as well as all other Medicare Advantage beneficiaries, do not see higher out-of-pocket costs, reduced benefits, or limited service areas as a result of increased enrollment of beneficiaries with ESRD in Medicare Advantage.

Many beneficiaries with ESRD benefit from supplemental benefits and the enhanced care coordination inherent in Medicare Advantage. However, ESRD payments must be accurate, stable, and sufficient to maintain and enhance this level of care to an increasing number of beneficiaries. Moreover, inadequate ESRD payments negatively impact the broader Medicare Advantage beneficiaries within a plan. It is not uncommon for health plans to redistribute payments to offset ESRD payment deficits associated with providing care to beneficiaries with ESRD. Thus, beneficiaries without ESRD may see changes in the benefit design, such as reduced supplemental benefit offerings or higher out-of-pocket costs as a result of inadequate ESRD payments.

We urge CMS to consider changes to the methodology used to calculate Medicare Advantage ESRD rates to reduce year-over-year volatility, reflect actual costs, and ensure accurate and adequate payments for the ESRD population. It is estimated that costs for beneficiaries with ESRD will be 8 times higher than costs for beneficiaries without ESRD in 2022.[13] A 2019 analysis comparing Medicare Advantage ESRD rates based on state level rates to actual costs in FFS Medicare finds FFS Medicare costs for beneficiaries with ESRD exceed the Medicare Advantage ESRD rates, and payment is lower for Medicare Advantage beneficiaries in certain

[12] Avalere, ESRD Enrollment in MA Now Exceeds 30 Percent of all Dialysis Patients, December 16, 2021. Available at: https://avalere.com/insights/esrd-enrollment-in-ma-now-exceeds-30-percent-of-all-dialysis-patients
[13] *Id*.

geographic areas across the country.[14] This underpayment typically occurs in high-density metropolitan areas, likely resulting in payment not being adequate for beneficiaries residing in those specific areas.

The 2019 analysis shows 10 of the 15 top Metropolitan Statistical Areas (MSA), which align with the Core-Based Statistical Areas (CBSAs) used by CMS, had FFS Medicare costs for beneficiaries with ESRD exceeding the Medicare Advantage ESRD rate. Medicare Advantage payments were between 2 and 12 percent lower than FFS Medicare costs in these MSAs, which could make it challenging for plans to continue to provide high-quality, coordinated care to beneficiaries. The table below reflects payment differences in the top 15 MSAs.

In addition to health plans receiving lower payments relative to FFS Medicare costs, there are other financial pressures when contracting for dialysis services. Due to the market concentration of dialysis providers, Medicare Advantage plans pay on average about 14 percent higher than FFS Medicare rates for dialysis services.[15] MedPAC estimates 15 percent of Medicare Advantage contracts "paid rates at or above 40 percent of FFS rates."[16] Because they are unable to negotiate rates closer to FFS Medicare rates, plans may "offset higher dialysis spending by reducing costs for other services provided to these enrollees (e.g. care coordination to reduce inpatient hospital and emergency room visits) or risk losses on ESRD enrollees."[17] As such, changing the methodology to a sub-state level rate may assist in lessening the financial pressures health plans face in delivering care to beneficiaries with ESRD and ensure critical benefits like care coordination are not reduced for this population.

[14] Avalere, Medicare Advantage Plans May Be Paid Below Actual ESRD Patients' Costs in Large Metropolitan Areas in 2021, December 9, 2019. Available at: https://avalere.com/insights/medicare-advantage-plans-may-be-paid-below-actual-esrd-patients-costs-in-large-metropolitan-areas-in-2021 ; Better Medicare Alliance, Analysis of End-Stage Renal Disease Payment Adequacy in Medicare Advantage, December 2019. Available at: https://bettermedicarealliance.org/publication/analysis-of-end-stage-renal-disease-payment-adequacy-in-medicare-advantage/
[15] MedPAC, Report to Congress: Medicare Payment Policy, March 2021, 389-90. Available at: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf
[16] *Id.* at 390.
[17] *Id.* at 389.

Top 15 Metropolitan Statistical Areas with Underpayment or Overpayment (FFS Costs Exceeding the Medicare Advantage ESRD Benchmark)

MSA	Number of ESRD Beneficiaries	Payment Relative to Benchmark	Annual Payment Difference Per Beneficiary
New York, NY	24,034	88%	($10,836)
Los Angeles, CA	14,116	98%	($1,980)
Chicago, IL	12,388	96%	($3,624)
Dallas, TX	9,309	105%	$3,972
Atlanta, GA	8,339	101%	$864
Philadelphia, PA	8,167	97%	($2,808)
Houston, TX	7,921	91%	($7,608)
Washington, D.C.	7,449	104%	$3,324
Miami, FL	6,662	94%	($5,328)
Detroit, MI	5,922	92%	($6,528)
Baltimore, MD	4,342	96%	($3,396)
St. Louis, MO	4,225	101%	$1,044
San Francisco, CA	3,937	90%	($9,216)
Boston, MA	3,866	91%	($8,916)
Riverside, CA	3,835	109%	$8,460
The average payment relative to benchmark across the 75 MSAs included in this analysis (225,321 enrollees) was 106%.			

Analysis conducted by Avalere Health and cited in: Better Medicare Alliance, Analysis of End-Stage Renal Disease Payment Adequacy in Medicare Advantage, December 2019. Available at: https://bettermedicarealliance.org/publication/analysis-of-end-stage-renal-disease-payment-adequacy-in-medicare-advantage/

Moreover, a change in payment methodology will reduce the disparities among beneficiaries with ESRD that live in urban or metropolitan areas relative to those that live in more rural areas of a state. A recent analysis shows the number of Medicare Advantage beneficiaries with ESRD living in urban settings greatly outnumbers those living in rural settings, 161,728 beneficiaries and 7,782 beneficiaries, respectively. Beneficiaries with ESRD living in urban areas enroll in Medicare Advantage at a higher rate than in rural areas, 35 percent and 27 percent, respectively. Higher representation among Medicare Advantage beneficiaries with ESRD in urban areas is consistent when comparing full dual, partial dual, and non-dual populations by geography. Furthermore, Black and Hispanic beneficiaries with ESRD living in urban areas enroll in Medicare Advantage at slightly higher rates than white beneficiaries with ESRD, 39 percent and 36 percent, respectively compared to 34 percent.[18] The table in Attachment B further shows beneficiaries with ESRD disproportionately live in urban areas. Because of the cost of care difference between urban and rural areas, a methodology change will provide

[18] Avalere Health, Analysis of 2021 Enrollment of Beneficiaries with ESRD in Medicare, March 2022. Note: Avalere conducted the analysis under a research-focused data use agreement with the CMS.

additional resources to adequately deliver high-quality care and further advance health equity, a goal Better Medicare Alliance and CMS share.

For the reasons stated above, Better Medicare Alliance supports adopting a sub-state level ESRD payment rate methodology to ensure payments are accurate, stable, and sufficient, and we look forward to working with CMS as it considers changing its methodology.

- **MA Employer Group Waiver Plans**

Better Medicare Alliance supports CMS' proposal to continue the current payment methodology and the Bid Pricing Tool, as well as the continuation of the policy permitting EGWPs to buy down Part B premiums. We also appreciate and support CMS publishing preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice.

CMS proposes to continue the current payment methodology used in 2022 for CY 2023, as well as waiving Bid Pricing Tool bidding requirements. The policy permitting EGWPs to buy down Part B premiums will also continue. New for CY 2023, CMS published preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice.

BMA Comments:

EGWPs represent a successful public-private partnership that addresses the health care needs of an important segment of today's retirees and accounts for nearly 20 percent of the Medicare Advantage population.[19] EGWPs successfully enable employers nationwide to maintain consistent benefits and manage costs for retirees' health coverage. Employers, state and local governments, and unions increasingly rely on Medicare Advantage to provide health benefits to retirees.

Accordingly, Better Medicare Alliance supports CMS' proposal to continue the current methodology and the Bid Pricing Tool for EGWPs for CY 2023, and we support the continuation of the policy permitting EGWPs to buy down Part B premiums. Furthermore, we appreciate CMS' intent to continue adjusting the individual plan bid-to-benchmark ratios to account for enrollment differences based on the timing of the Rate Announcement release and publishing preliminary bid-to-benchmark ratios ahead of the Final Rate Announcement. Providing the additional month supports EGWPs in what to expect for the upcoming year.

- **CMS-HCC Risk Adjustment Model for CY 2023**

Better Medicare Alliance strongly supports actions that incentivize and support health plans in addressing social risk factors, as many interventions to address beneficiary social needs require upfront investments. We believe incorporating social risk factors in the risk adjustment model is one way CMS can support health plans by providing appropriate compensation to address such factors and further aid in predicting beneficiary costs more accurately. However, accurately incorporating data on social risk factors into the risk adjustment model will require a thoughtful approach, and Better Medicare Alliance is eager to continue communicating and working in partnership with CMS as it explores ways to fully capture and address the health and social needs of beneficiaries. We further ask CMS to organize opportunities such as roundtables or listening sessions so other stakeholders can offer their feedback and perspective on how to best address beneficiary social needs.

[19] Kaiser Family Foundation, Medicare Advantage in 2021: Enrollment Update and Key Trends, June 21, 2021. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/

CMS is considering ways to revise the risk adjustment model to ensure appropriate payment for the Medicare population and sub-populations. CMS solicits comments on the following: whether there are enhancements to address the impact of social determinants of health (SDOH) through additional factors that predict relative cost of Medicare Advantage beneficiaries; what data should be collected for more complete information to calibrate the risk adjustment model; how data collection can be improved; and additional factors to include in the risk adjustment model to improve payment accuracy and advance health equity.

BMA Comments:

Better Medicare Alliance recognizes the importance of addressing beneficiary social needs and is a leader in promoting the innovative approaches in Medicare Advantage doing just that.[20] Many interventions addressing social needs require upfront support, resources, and investments, and we believe accounting for beneficiary social needs through risk adjustment is a potential avenue for health plans to properly invest in and address social needs.

Stable and accurate risk adjustment models rely on a robust and accurate data source due to the prospective and predictive nature and framework of Medicare Advantage. Presently, health plans do not have a central or uniform method to report social risk factor data at scale, hindering the development of a comprehensive data set necessary to calibrate the risk adjustment model with social risk factors. We recommend CMS explore established data sources to reduce administrative burden from collecting such data, while also engaging with stakeholders to better understand potential gaps in data and operational challenges when considering additional factors in the future.

A 2019 analysis supports accounting for social risk factors and SDOH in risk adjustment to improve beneficiary outcomes. The analysis examined whether current dual eligible and disability status adjustments are sufficient to account for social risk factors and SDOH on beneficiary health outcomes. It found that including additional, census block group (CBG) factors like income, education, marital status, home ownership, and ethnicity better predicts and captures the impact of SDOH on outcomes. More granular, neighborhood-level factors like a beneficiary's 9-digit zip code further improved the model, supporting a range of factors to measure social risk that impact beneficiary health outcomes.[21]

Developing a data set for purposes of the Medicare Advantage risk adjustment model from established sources may potentially ease the collection burden for health plans. However, this approach must be used with caution for timing and relevancy purposes. Relying on established data sets may be inadequate due to the infrequency in which data are collected and updated. For example, if there is a significant lapse in time between data collections, the data will likely not be an adequate and accurate reflection of social risk factors given the substantial changes that may occur during that time as well as those regularly faced by many individuals when once eligible for Medicare and enrolling in Medicare Advantage. Thus, data sets that are updated infrequently should be used with caution.

[20] Center for Innovation in Medicare Advantage, Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, August 2021. Available at: https://bettermedicarealliance.org/publication/report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries/ ; Center for Innovation in Medicare Advantage, Case Study Report: Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, January 2022. Available at: https://bettermedicarealliance.org/publication/case-study-report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries-2/

[21] Avalere, How to Account for the Full Impact of Social Determinants of Health in Medicare Advantage Plans, June 24, 2019, Available at: https://avalere.com/insights/how-to-account-for-the-full-impact-of-social-determinants-of-health-in-medicare-advantage-plans

Additionally, we request CMS thoroughly analyze, model, and test any proposed updates to the risk adjustment model prior to implementation to ensure stability in the model and ensure that updates do not negatively impact the beneficiaries the model was updated with the intent to support. In other words, CMS should ensure beneficiaries with high social needs are not inversely impacted by risk adjustment model updates, as they will likely benefit most with regard to improved health outcomes.

Better Medicare Alliance looks forward to being an active, engaged partner in conversations related to incorporating social risk factors into the risk adjustment model and how Medicare Advantage more broadly can meet beneficiary needs by addressing SDOH. We recommend a series of listening sessions or a work group to better understand the varying perspectives stakeholders may have on this particular proposal and offer our ability to convene the many voices in Medicare Advantage as CMS considers ways to update the risk adjustment model to more accurately capture and predict the cost of care for current and future beneficiaries.

- **End-Stage Renal Disease (ESRD) Risk Adjustment Models for CY 2023**

Better Medicare Alliance supports beneficiaries with ESRD and their access to Medicare Advantage and urges CMS to ensure accurate risk adjustment and adequate payment for this clinically complex population. We are concerned about the revised ESRD risk adjustment model for CY 2023, as it results in approximately $470 million in savings for the Medicare program due to reduced risk scores, meaning payments to deliver care will be reduced. We ask CMS to consider the compounded effect the risk adjustment model updates have on payment in areas where covering the actual cost of care for beneficiaries with ESRD is already challenging.

CMS proposes a number of updates to the ESRD risk adjustment model for CY 2023, including updating the clinical version of the ESRD model from Version 21 to Version 24, updating the data years used for calibration to 2018 diagnoses to predict 2019 costs, accounting for differences in cost patterns for dual eligible beneficiaries, and other model adjustments.

BMA Comments:

Better Medicare Alliance supports access to Medicare Advantage for beneficiaries with ESRD and urges CMS to ensure accurate risk adjustment and adequate payment for the clinically complex beneficiaries with ESRD. Nevertheless, we are concerned about the impact the proposed risk adjustment model updates will have on payment for beneficiaries with ESRD. CMS estimates risk scores for beneficiaries with ESRD will decline overall, resulting in approximately $470 million in savings for the Medicare program in CY 2023, though it remains unclear what will lead to this reduction.

We discussed earlier our concerns about inadequate payment for beneficiaries with ESRD given the current methodology for setting payment rates. Looking at the top 15 MSAs in the country, an analysis found Medicare Advantage ESRD rates were lower in 10 of the 15 MSAs relative to the actual FFS Medicare costs for beneficiaries with ESRD. Medicare Advantage rates were between 2 and 12 percent lower than FFS Medicare costs in these MSAs, meaning ESRD payment for Medicare Advantage beneficiaries was not adequate for delivering high-quality care.[22]

[22] Avalere, Medicare Advantage Plans May Be Paid Below Actual ESRD Patients' Costs in Large Metropolitan Areas in 2021, December 9, 2019. Available at: https://avalere.com/insights/medicare-advantage-plans-may-be-paid-below-actual-esrd-patients-costs-in-large-metropolitan-areas-in-2021 ; Better Medicare Alliance, Analysis of End-Stage Renal Disease Payment Adequacy in

As such, we ask CMS to consider the compounded effect these risk adjustment model updates will have on payments when there is evidence health plans are currently undercompensated for providing care to beneficiaries with ESRD. Further, we recommend CMS monitor health plan costs and engage with stakeholders to ensure Medicare Advantage can provide high-quality care to these beneficiaries and the burden of payment does not result in increased premiums or cost burden to all Medicare Advantage beneficiaries.

Updates for Part C and D Star Ratings

- **Changes to Existing Star Ratings Measures in 2023 and Future Years**

CMS seeks comment on several updates to existing Star Ratings measures. Better Medicare Alliance's comments are specific to 3 measures – Complaints about the Health Plan/Drug Plan, Colorectal Cancer Screening, and Adult Immunization Status.

Complaints about the Health Plan/Drug Plan (Part C and D)

Better Medicare Alliance supports the intent behind the category 1.30 complaints and the importance of reducing beneficiaries' confusion around marketing materials and personnel. Including the category 1.30 complaints into the Star Ratings measure will further hold health plans accountable in identifying, monitoring, and responding to beneficiary confusion, as they already do for category 2.30 complaints. However, including the category 1.30 complaints in the measure could significantly change plan performance and necessitates careful consideration, as this change may lead to reduced supplemental benefits and increased cost-sharing for beneficiaries. Pursuant to CMS' test of including category 1.30 complaints in the measure, we request clarification on the distribution of the changes in performance.

CMS solicits feedback on including category 1.30 (CMS Lead Marketing Misrepresentation: Allegation of inappropriate marketing by plan, plan representative, or agent/broker) complaints in the Complaints about the Health Plan/Drug Plan Star Ratings measure. Currently, only category 2.30 (Plan Lead Marketing Misrepresentation: Allegation of inappropriate marketing by plan, plan representative, or agent/broker) complaints are included in the Star measure.

BMA Comments:

Better Medicare Alliance supports efforts to reduce confusion for beneficiaries in the enrollment and selection process and the intent behind category 1.30 complaints. However, we are concerned the inclusion of category 1.30 complaints will have a significant impact on contract performance, potentially leading to smaller quality bonus payments (QBPs) and fewer supplemental benefits offered to beneficiaries. Supplemental benefits are a critical tool in Medicare Advantage to deliver whole person care and address SDOH. As such, actions that reduce supplemental benefits offerings in the program may negatively impact beneficiaries and lead to a stagnation of the innovative approaches developed to address SDOH and advance health equity.

Better Medicare Alliance requests additional information on the distribution of performance to better understand the magnitude of the estimated Stars reduction for nearly 25 percent of MA-PD contracts, based on CMS' findings when it tested the inclusion of category 1.30 complaints.

Medicare Advantage, December 2019. Available at: https://bettermedicarealliance.org/publication/analysis-of-end-stage-renal-disease-payment-adequacy-in-medicare-advantage/

The additional information will be helpful in determining the impact category 1.30 complaints may have on QBPs and the relation to supplemental benefit offerings. We further request CMS delay any action on this measure until stakeholders have sufficient time to assess the impact of this change and mitigate likely disruption to coverage and benefit offerings.

Colorectal Cancer Screening (Part C)

Better Medicare Alliance supports the inclusion of individuals 45-49 years old in the colorectal cancer screening measure pursuant to the recently updated screening guideline recommendation and under consideration by the National Committee for Quality Assurance (NCQA).

Based on updated screening guideline recommendations for colorectal cancer screening by the U.S. Preventive Services Task Force (USPSTF), NCQA is considering adding a rate assessing screening for individuals 45-49 years old for measurement year 2022. NCQA is also considering removing the hybrid reporting methodology and transitioning to the electronic clinical data systems (ECDS) beginning in measurement year 2023 or 2024. CMS would follow NCQA and include this group in the screening measure.

BMA Comments:

Colorectal cancer (CRC) is the second most common cancer death in the U.S., and over 52,000 people are expected to die from CRC in 2022.[23] Despite only 3.1 percent of Medicare Advantage beneficiaries being under 50 years old in 2019,[24] including individuals 45-49 years old in the CRC screening measure may have a significant impact on health outcomes and further reduce disparities, especially for Black beneficiaries. CRC disproportionately impacts Black Americans who are about 20 percent more likely to be diagnosed with CRC than other populations and are 40 percent more likely to die from CRC.[25] Yet 60 percent of CRC deaths in the U.S. could be prevented with screening.[26] Better Medicare Alliance supports expanding CRC screening to individuals 45-49 years old because it can lead to earlier detection and intervention, decrease disparities, advance health equity, and result in fewer deaths from CRC.

Adult Immunization Status (Part C)

Better Medicare Alliance applauds CMS' leadership in educating and vaccinating millions of beneficiaries, and we look forward to further partnership on this particular measure. However, Better Medicare Alliance believes adopting a COVID-19 vaccination performance measure at this time presents challenges due to uncertainty around how to best measure vaccination status and quality and vaccine acceptance.

CMS solicits feedback on the utility and feasibility of including a COVID-19 vaccination status measure.

[23] American Cancer Society, Key Statistics for Colorectal Cancer, Last Revised January 2022. Avalable at: https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html
[24] Milliman, Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare, October 2020. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/10/Comparing-the-Demographics-of-Enrollees-in-Medicare-Advantage-and-Fee-for-Service-Medicare-202010141.pdf
[25] Fight Colorectal Cancer, Facts and Stats, 2022. Available at: https://fightcolorectalcancer.org/about-colorectal-cancer/general-information/facts-stats/
[26] *Id*.

BMA Comments:

Better Medicare Alliance's comments are specific to CMS adopting a measure related to COVID-19 vaccinations. We appreciate CMS' continued dialogue regarding the adoption of a Star Ratings measure related to the COVID-19 vaccine and agree that Medicare Advantage plays an important role in education and encouraging beneficiaries to receive a safe and effective COVID-19 vaccination when appropriate. We recognize the value of tracking COVID-19 vaccine status, however, a performance measure at this time presents challenges for stakeholders. Therefore, a COVID-19 vaccine measure is premature, and CMS should continue to solicit feedback on the utility and feasibility of a vaccination measure in the future.

When CMS first proposed the inclusion of a COVID-19 vaccination measure, vaccines were not yet being distributed to the general public, nor were they formally approved by the U.S. Food and Drug Administration. Now, a majority of Americans are vaccinated and 86 percent of individuals 65 and older who are likely eligible for a booster reported getting a COVID-19 booster shot.[27] Nevertheless, there are several challenges to address before CMS includes the COVID-19 vaccine into the immunization status measure. First, vaccine guidance is still evolving, as is the understanding of how to best measure vaccination status – Did the beneficiary receive one-dose, two-doses, a booster shot, a second booster shot? The nature of multi-dose vaccines and boosters, along with evolving guidelines make it difficult to ascertain vaccination status of beneficiaries and what the appropriate quality metric is to measure vaccination status.

Second, beneficiaries still have reservations about getting the vaccine and/or a booster shot, particularly among minority beneficiaries, so incorporating a measure may stifle efforts to increase equitable access and uptake. Lastly, aggregating the data to determine vaccination status for purposes of a measure here is difficult due to the initial vaccine distribution and how all claims for vaccine administration were submitted under FFS Medicare for 2020 and 2021. The use of administrative claims for monitoring and evaluating vaccination status has limitations, and other sources for immunization data should be considered. As CMS continues to consider a COVID-19 vaccination status measure, aligning approaches to vaccine data capture and reporting could support health plans in feasibly evaluating beneficiary status in the future.

Better Medicare Alliance recognizes the value and usefulness of a measure related to COVID-19 vaccination status at some future point for quality improvement and to ensure accountability in Medicare Advantage. However, there remain too many uncertainties associated with vaccine guidance, acceptance, and the ability to track who receives it to implement a Star Ratings measure. We applaud CMS' leadership in educating and vaccinating the millions of beneficiaries served and look forward to further partnership on this particular measure.

- **Potential New Measure Concepts and Methodological Enhancements for Future Years**

Better Medicare Alliance shares the Administration's goal in reducing disparities in health care and outcomes and advancing health equity in communities across the country. Medicare Advantage is uniquely positioned to identify and address disparities among beneficiaries, as it serves a more medically and socially complex population and enrolls beneficiaries that identify

[27] Kaiser Family Foundation, KFF COVID-19 Vaccine Monitor, January 11-23, 2022. Available at: https://www.kff.org/coronavirus-covid-19/dashboard/kff-covid-19-vaccine-monitor-dashboard/

as a minority at a higher rate than FFS Medicare.[28] The recent flexibilities and additional supplemental benefit authorities have proved to be an important tool for stakeholders in addressing SDOH and activity in this space has grown exponentially over the years in response to increased supplemental benefit offerings.[29] Thus, we commend CMS for its focus on addressing social risk factors and its commitment to advancing health equity across its programs. As CMS proposes policy changes, updates payment models and programs, and continues developing its approach to advance health equity, we urge CMS to move forward in a holistic and thoughtful manner to ensure stability in Medicare Advantage. First and foremost, CMS should develop core principles and standards for the agency and stakeholders to help guide the work involving social risk factors, SDOH, addressing disparities, and advancing health equity, particularly when data collection is at the center of the work. As CMS reviews and considers the best path forward, Better Medicare Alliance is eager to partner with CMS to further reduce disparities and advance health equity in Medicare Advantage.

CMS solicits feedback on a number of potential new Star Ratings concepts and measures. Better Medicare Alliance's comments are specific to the concepts and measures focused on SDOH, health equity, and value-based care.

Stratified Reporting (Part C and D)

Better Medicare Alliance supports stratified reporting, as it identifies opportunities for improvements within already defined measures and appreciates CMS for considering both process and outcome measures.

CMS is considering stratifying contract performance for process and outcome measures for certain subgroups of beneficiaries with social risk factors. CMS is considering stratified reporting by disability, Low-Income Subsidy (LIS) status, and dual eligible status.

BMA Comments:

Better Medicare Alliance appreciates CMS' focus on the influence social risk factors have on beneficiary outcomes, and stratifying contract performance for certain subgroups will further support health plans in identifying improvement opportunities across the program. We believe measures should be initially stratified by gender, race, ethnicity, disability status, low-income status, and dual eligibility status. These initial factors will not only help identify opportunities to close disparity gaps for that particular factor but also serve as a surrogate for other social risk factors that impact health outcomes.

[28] Better Medicare Alliance, Social Risk Factors are High Among Low-Income Medicare Beneficiaries Enrolled in Medicare Advantage, September 2020. Available at: https://bettermedicarealliance.org/publication/data-brief-social-risk-factors-are-high-among-low-income-medicare-beneficiaries-enrolled-in-medicare-advantage/ ; Better Medicare Alliance, Medicare Advantage Offers High Quality Care and Cost Protections to Racially and Ethnically Diverse Beneficiaries, June 2021. Available at: https://bettermedicarealliance.org/publication/data-brief-medicare-advantage-offers-high-quality-care-and-cost-protections-to-racially-and-ethnically-diverse-beneficiaries/

[29] Center for Innovation in Medicare Advantage, Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, August 2021. Available at: https://bettermedicarealliance.org/publication/report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries/ ; Center for Innovation in Medicare Advantage, Case Study Report: Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, January 2022. Available at: https://bettermedicarealliance.org/publication/case-study-report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries-2/; Milliman, Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2022 Offerings, March 2022. Available at: https://bettermedicarealliance.org/news/study-99-9-of-medicare-advantage-plans-offering-supplemental-benefits-in-2022/

Health Equity Index (Part C and D)

Better Medicare Alliance is supportive of actions that advance health equity and assist health plans in further identifying and reducing disparities among their enrollees. We request clarification on which subset of Stars measures CMS intends to consider in formulating the index as well as further analysis on the impact performance on this index will have across contracts to ensure beneficiaries are not inadvertently harmed by a contract's performance.

CMS is developing a health equity index that summarizes contract performance among those with social risk factors across various Star Ratings measures into one score. CMS is considering replacing the current reward factor used to incentivize addressing disparities with this new health equity index reward factor.

BMA Comments:

Better Medicare Alliance appreciates CMS' focus on actions to reduce disparities within contracts, and we believe incorporating a health equity index is one avenue to do so. As noted, we request clarification on which subset of Stars measures CMS intends to look at in formulating the index. Moreover, we request further analysis and a model of how performance on the index impacts overall contract performance and beneficiaries. As CMS continues to develop the health equity index, Better Medicare Alliance looks forward to continued dialogue and opportunities for engagement to better understand the impact of a health equity index, as well as the effect of replacing the current reward factor with a health equity index reward factor.

Measure of Contracts' Assessment of Beneficiary Needs (Part C) & Screening and Referral to Services for Social Needs (Part C)

Better Medicare Alliance supports CMS' efforts to assess health plan use of standardized screening tools and data collection to screen beneficiaries for social risk factors. As CMS reviews and formulates a potential measure, it should consider the many data collection tools already deployed and the dynamics and resources available for referrals within the local communities beneficiaries reside in.

CMS is considering a measure that will assess whether beneficiaries are screened annually for social risk factors using a standardized tool. CMS is also considering a measure assessing screening for unmet food, housing, and transportation needs, and whether a referral was made for positive screens pursuant to NCQA's new measure developed for measurement year 2023.

BMA Comments:

Better Medicare Alliance commends CMS for its efforts in understanding how beneficiaries are screened for social risk factors. While many health plans do currently screen beneficiaries for social risk factors, further incentivizing health plans to conduct or implement screening will help ensure beneficiaries have access to the care and services they need. As this measure is further conceptualized, we urge CMS to consider the variety of methods and tools health plans, providers, and community partners have developed in recent years to collect beneficiary data related to social risk factors. There is a robust data ecosystem that now exists among stakeholders, so it is pertinent that current tools and methods are accounted for as a collection tool for purposes of this measure. The level of sophistication employed in collecting this data varies, ranging from traditional pen and paper to integrated, software platforms that providers, community partners, and health plans can access. For example:

- Healthify developed a platform that identifies social needs, finds local services, enables bi-directional referrals, and coordinates care with an accountable network community-based organization (CBO) to address the social needs. This platform can be integrated into health plan and provider clinical systems, further easing the burden of logging into multiple systems and allows stakeholders across the continuum of care to follow beneficiaries.[30]
- Community-based organizations like Meals on Wheels America and their local affiliates partner with health plans for their core meal delivery service. However, health plans recognized the value of Meals on Wheels having regular contact with and access to beneficiaries and worked with Meals on Wheels to develop their data capabilities in order to collect additional information about beneficiary needs. That information is then shared back to health plans to inform what their members' needs are and the type of services that may be offered to address the needs.[31]
- SCAN Health Plan, a non-profit plan serving over 220,000 Medicare beneficiaries in California, is a leader in addressing social risk factors in its beneficiaries. The health plan has roots in social service and currently incorporates questions related to SDOH into its HRA. The SDOH information collected in the HRA is then used to assign beneficiaries to the appropriate care management tier based on their risk, and various interventions are deployed depending on risk tier and targeted based on needs identified.[32]

For a comprehensive picture of the many data collection tools and methods developed by stakeholders, we recommend CMS engage with and conduct outreach to further inform the development of a measure for Stars. Further engagement with stakeholders and CMS provides the opportunity to align current data collection efforts by working within established tools and the standardized questions put forth in the CY 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs ("Proposed Rule").

Moreover, we support actions that incentivize and promote screening and interventions on behalf of the beneficiary to address unmet needs. Better Medicare Alliance requests additional information on how CMS intends to measure whether a referral was made for beneficiaries that screen positive for an unmet need. During qualitative interviews for recent research and as shared by our Allies, stakeholders have expressed concern that even when a need is identified, more harm results because the community lacks the resources necessary to properly address the unmet need.[33] As such, we are concerned that if the measure necessitates beneficiaries receiving services through referral, health plans will be unfairly penalized for lack of resources in the community. We request CMS continue engaging with stakeholders as it considers developing a measure based on NCQA's work for screening and referring for unmet social needs.

[30] Center for Innovation in Medicare Advantage, Case Study Report: Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, January 2022. Available at: https://bettermedicarealliance.org/publication/case-study-report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries-2/
[31] *Id*.
[32] *Id*.
[33] *See* Center for Innovation in Medicare Advantage, Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, August 2021. Available at: https://bettermedicarealliance.org/publication/report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries/

Value-based Care (Part C)

Better Medicare Alliance is a strong proponent of value-based care and believes the Medicare Advantage model offers the foundation necessary for success in a value-based care model. Transitioning to value-based care is an extensive and continuous process. As such, we offer considerations for CMS as it contemplates a measure assessing value-based care in Medicare Advantage.

CMS is considering a measure that assesses what percent of providers in Medicare Advantage are in a value-based care arrangement and what those arrangements entail. CMS solicits feedback as it considers this new measure.

BMA Comments:

Value-based care models are widely recognized as a leading model to support whole person care and better health outcomes, and Better Medicare Alliance supports the transition to value-based care. We also believe Medicare Advantage, and the capitated payment framework, provides the foundation necessary to be successful in developing value-based care arrangements. According to the most recent Health Care Payment Learning & Action Network (HCP-LAN) APM Measurement Efforts results, Medicare Advantage leads in risk-based and value-based arrangements relative to other public and private programs and lines of business, with approximately 58 percent of Medicare Advantage payments in 2020 tied to alternative payment models (APMs), with nearly 30 percent representing two-sided risk arrangements.[34] The percent of payments tied to APMs has increased since HCP-LAN first began measuring and reporting results for Medicare Advantage in 2017.[35]

We appreciate CMS' efforts to understand the extent of value-based care in Medicare Advantage. Nevertheless, the transition to a value-based care model requires extensive time, leadership, capital, and infrastructure. We ask CMS to consider that not all providers or health plans have the resources necessary to fully adopt and support a value-based care model. For example, it took the Vancouver Clinic, a Better Medicare Alliance Ally, several years to establish and refine their value-based care model and develop the infrastructure and partnerships necessary to be successful. Moreover, the transition is a continuous process, adapting to the needs of providers, the health plans, and beneficiaries served.[36] We ask CMS to continue engaging with stakeholders to wholly understand the barriers to adopting value-based care models, and if CMS moves forward with a measure related to assessing value-based care, that it provides adequate assistance to support the stakeholders involved in the transition.

CAHPS (Part C and D)

Better Medicare Alliance supports the introduction of a web survey for the MA and PDP CAHPS survey. We are pleased by CMS' exploring additional topics for the survey, though we request clarification on what the content will include and that additional topics can be directly impacted by health plans and are relevant to patient experience in Medicare Advantage.

[34] Health Care Payment Learning & Action Network, APM Measurement Effort 2020-2021, December 2021. Available at: https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/
[35] Health Care Payment Learning & Action Network, APM Measurement Effort 2018, October 2018. Available at https://hcp-lan.org/workproducts/apm-infographic-2018.pdf
[36] Better Medicare Alliance, Vancouver Clinic Spotlight on Innovation, January 2022. Available at: https://bettermedicarealliance.org/publication/spotlight-on-innovation-vancouver-clinic/

CMS is testing response rates and survey scores of the CAHPS survey by piloting a web-based survey and testing a new protocol for conducting the survey using mixed modes. The results of this test will inform a future transition to a web-based survey mode. CMS is also considering updating the survey content and using the test to inform potential updates.

BMA Comments:

Better Medicare Alliance supports a pilot for a web-based CAHPS survey, with the intent to move towards a permanent online format. Our previous research supports and recommends an online survey format to ease beneficiary burden in completing the survey and improve response rates. Since 2010, response rates for the CAHPS survey have steadily declined from 61.7 percent in 2010 to 38.4 percent in 2019.[37] A potential reason for the steady and significant response rate decline may be due to the survey method; 76 percent of beneficiary respondents stated they prefer an online format, with 30 percent reporting by mail and 54 percent reporting by phone as their *least* preferred survey method.[38]

Adopting an online survey format will also support surveys offered in additional languages, to recognize the increasingly diverse Medicare Advantage population. Among lower income Medicare Advantage beneficiaries, 45 percent speak a language other than English at home, and 26 percent report speaking English "not well" or "not at all."[39] While transitioning to an online survey format will more easily expand access to the survey in appropriate languages, CMS should consider the additional barriers created by utilizing internet to conduct the survey because not all beneficiaries have access to internet or devices that connect to the internet. As such, CMS must ensure there are pathways to adequately capture responses by beneficiaries that do not have adequate access to internet or devices necessary to complete an online survey.

We appreciate CMS and the efforts to explore additional CAHPS content. As CMS considers additional content, we request further engagement with stakeholders to ensure the new content addresses topics important to beneficiaries when enrolling in and selecting their health care coverage, represent the diverse Medicare Advantage population, and are within a health plan's control to directly impact. Moreover, research conducted by RAND in 2019 suggests a shorter survey length and fewer supplemental questions have a strong, positive relationship with response propensity.[40] Thus, CMS should contemplate the length of the survey if additional content is developed and the impact that may have on response rates. Better Medicare Alliance applauds CMS' efforts to modernize the CAHPS survey and looks forward to being an active partner as CMS pilots a web-based survey and explores ways to further modernize CAHPS.

[37] Center for Innovation in Medicare Advantage, Measuring Patient Experience of Medicare Advantage Beneficiaries: Current Limitations of the Consumer Assessment Tool and Policy Recommendations, January 2021. Available at: https://bettermedicarealliance.org/publication/measuring-patient-experience-of-medicare-advantage-beneficiaries-current-limitations-of-the-consumer-assessment-tool-and-policy-recommendations/
[38] *Id*.
[39] Better Medicare Alliance, Social Risk Factors are High Among Low-Income Medicare Beneficiaries Enrolled in Medicare Advantage, September 2020. Available at: https://bettermedicarealliance.org/publication/data-brief-social-risk-factors-are-high-among-low-income-medicare-beneficiaries-enrolled-in-medicare-advantage/
[40] Q. Burkhard, N. Orr, J. Brown et al., Associations of Mail Survey Length and Layout With Response Rates, Medical Care Research & Review, November 2019. Available at: https://pubmed.ncbi.nlm.nih.gov/31747849/

BETTER MEDICARE ALLIANCE

1411 K Street NW, Suite 1400
Washington, DC 20005
202.735.0037 (office)
202.885.9968 (fax)

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

ATTACHMENT B

Analysis of Enrollment of Beneficiaries with ESRD Enrolled in Medicare, June 2021

	Number of MA Enrollees with ESRD	Number of Non-MA Enrollees with ESRD in Plans (i.e., PACE*, Cost, Demo)	Number of FFS Enrollees with ESRD	All Beneficiaries with ESRD	Percent of All Beneficiaries with ESRD in MA
All Core Based Statistical Areas (CBSAs)	**161,728**	**10,466**	**285,854**	**458,048**	**35%**
Dual Status					
Full Duals	49,682	9,743	101,553	160,978	31%
Partial Duals	22,312	61	24,435	46,808	48%
Non-Duals	89,647	640	159,509	249,796	36%
Race/Ethnicity					
White	69,666	3,874	132,815	206,355	34%
Black	62,506	4,523	93,312	160,341	39%
Hispanic	13,765	1,153	23,611	38,529	36%
Asian	6,703	446	12,903	20,052	33%
Native American	888	31	3,507	4,426	20%
Other	5,526	202	10,910	16,638	33%
Unknown	2,674	237	8,796	11,707	23%
All Rural Areas (Non-Metro or Micro)	**7,782**	**322**	**20,883**	**28,987**	**27%**
Dual Status					
Full Duals	2,321	108	6,814	9,243	25%
Partial Duals	1,531	11	2,246	3,788	40%
Non-Duals	3,926	203	11,813	15,942	25%
Race/Ethnicity					
White	4,195	260	12,783	17,238	24%
Black	3,166	41	4,874	8,081	39%
Hispanic	135	<11	638	779	17%
Asian	20	<11	511	531	4%
Native American	143	<11	1,214	1,365	10%
Other	57	<11	460	520	11%
Unknown	66	<11	403	473	14%

Under a research-focused data use agreement with the CMS, Avalere Health examined June 2021 data from CMS's Medicare Beneficiary Summary File for beneficiaries with Medicare Part A and Part B coverage. Beneficiaries were identified as having ESRD if they had a Medicare status of 11 (Aged with ESRD), 21 (Disabled with ESRD), or 31 (ESRD only) as of June 2021.

*PACE - Program of All-inclusive Care for the Elderly