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March 7, 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: CMS-4192-P, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs**

Administrator Brooks-LaSure:

On behalf of our Alliance and the 28 million beneficiaries enrolled in Medicare Advantage, Better Medicare Alliance (BMA) is pleased to submit the following comments on the proposed Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs ("Proposed Rule").

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,

[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/

hearing, or fitness benefits,[5] and the percentage of plans offering Special Supplemental Benefits 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 Proposed Rule aims to create a positive 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. 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 policy changes in the Proposed Rule. Below are highlights of our comments which are further detailed in the attachments.

[5] *Id*.
[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

- **Improving the quality of care for 12.2 million dually eligible beneficiaries:** Better Medicare Alliance shares the Administration's goal of reducing fragmentation for dually eligible beneficiaries by integrating care and improving the overall experience for the more than 12 million beneficiaries eligible for both Medicare and Medicaid.

- **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 the other programs. Specifically, we support CMS' efforts to standardize collection and reporting of social risk factor data for beneficiaries enrolled in a Special Needs Plan (SNP). Standardization will better ensure beneficiary needs are systematically identified as well as enable SNPs to develop and implement models of care to address those needs.

- **Enhancing consumer protections in Medicare Advantage:** Better Medicare Alliance appreciates CMS' efforts to improve consumer protections in Medicare Advantage by increasing transparency and reducing beneficiary confusion, thereby leading to beneficiaries who are empowered when making their enrollment and health plan selection choices.

- **Implementing changes to the maximum out-of-pocket (MOOP) limit:** Better Medicare Alliance asks CMS to consider the impact this change in tracking amounts paid toward the MOOP limit will have on Medicare Advantage beneficiaries, particularly because the risk adjustment model does not incorporate the MOOP limit. While health plans may increase bids to offset the shift in spending, plans could also reconsider, and reduce, the benefits currently offered to account for the shift in spending away from Medicaid and to the health plans. We encourage CMS to consider this impact and the potential reduced access to robust and innovative benefits.

- **Pharmacy price concessions:** We appreciate CMS' efforts to reduce the financial burden for Medicare beneficiaries at the pharmacy counter. However, given the considerable operational complexities and uncertain financial impact on plans, Better Medicare Alliance recommends that CMS delay the implementation of this provision for at least one year.

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.

Moreover, CMS' support for this integrated care model has driven innovation in financing and care delivery for millions of Medicare beneficiaries. We appreciate these 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.

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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**
**Better Medicare Alliance's Comments on Proposed Policy Changes**

**Improving Experiences for Dually Eligible Individuals**

Better Medicare Alliance is pleased by the comprehensive proposals related to dual eligibles in Medicare Advantage. Many of our Ally organizations provide care to dual eligible beneficiaries or advocate for a stronger, more integrated program for the millions of beneficiaries eligible for both Medicare and Medicaid.

We appreciate CMS' consideration of our Allies' work in the proposals it puts forth in this Proposed Rule. Specifically, the SNP Alliance, an organization dedicated to improving policy and practice for frail, disabled, and chronically ill beneficiaries and whose member organizations serve over 2.1 million Medicare Advantage beneficiaries, has recommended many of the included proposals in their policy and advocacy work over the years.[12] With extensive expertise, recommendations, and best practices, we encourage CMS to continue engaging with the SNP Alliance and other stakeholders diligently working to further integrate and improve the Medicare and Medicaid experience for dual eligible beneficiaries.

We share the Administration's goal of reducing disparities and advancing health equity, and Medicare Advantage is uniquely positioned to continue the work to meet this goal. A greater proportion of Medicare Advantage beneficiaries are dually eligible for Medicaid relative to Fee-for-Service (FFS) Medicare beneficiaries, 23 percent and 17 percent, respectively, and among all dual eligible beneficiaries in Medicare, 44 percent choose to enroll in Medicare Advantage.[13] Moreover, duals in Medicare Advantage report higher rates of having a usual source of care relative to duals in FFS Medicare – 91 percent (MA, enrolled in a SNP), 93 percent (MA, not enrolled in a SNP), and 86 percent (FFS Medicare).[14] To that end, Better Medicare Alliance encourages CMS to consider the importance of ensuring that the policy changes work as intended and work effectively to improve care and reduce disparities among the over 12 million dual eligible beneficiaries.

Compared to individuals enrolled in Medicare only, dual eligible beneficiaries in Medicare Advantage are:

- More likely to be under the age of 65 (40 percent of dual eligible beneficiaries are under age 65 compared to 8 percent of Medicare-only (non-dual) beneficiaries)
- More likely to live in rural areas (11 percent compared to 9 percent)
- Four times as likely to have high food insecurity needs (49 percent compared to 12 percent)
- Three times as likely to speak a language other than English at home (27 percent compared to 9 percent)
- Twice as likely to have depression (44 percent compared to 22 percent)

[12] The SNP Alliance is a BMA Ally organization. For more information, visit https://live-snp-alliance.pantheonsite.io/
[13] Better Medicare Alliance, Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections When Enrolled in Medicare Advantage, December 2021. Available at: https://bettermedicarealliance.org/publication/dual-eligible-beneficiaries-receive-better-access-to-care-and-cost-protections-when-enrolled-in-medicare-advantage/
[14] *Id*.

- Nearly three times as likely to have cognitive impairment (39 percent compared to 14 percent)[15]

We offer our comments on select proposals related to dual eligible beneficiaries and look forward to working with CMS to continue this important work.

- **Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment (§ 422.101)**

*Better Medicare Alliance supports CMS' efforts to standardize collection and reporting of social risk factor data for beneficiaries enrolled in a Special Needs Plan (SNP). Standardization will better ensure beneficiary needs are systematically identified and enable SNPs to develop and implement models of care to address the needs identified.*

CMS proposes to require all SNPs to include in the health risk assessment (HRA) at least one standardized question on topics including housing stability, food security, and access to transportation. CMS will determine the standardized questions in sub-regulatory guidance for flexibility and easier modification over time. The requirements are to take effect in 2024.

**BMA Comments:**

Better Medicare Alliance supports CMS' efforts to standardize collection and reporting of social risk factor data for beneficiaries enrolled in a SNP, and we appreciate CMS for recognizing the capabilities and value of HRAs as a pathway to collect and report social risk factor data. While there are established mechanisms to collect and report social risk factor data on the topics proposed by CMS, including housing stability, food security, and access to transportation, this proposed requirement provides the opportunity for more timely, detailed data about beneficiary needs that health plans can use to develop appropriate interventions.

The proposed topic areas for the standardized questions are relevant. Research has found that beneficiaries in Medicare Advantage, including dual eligible beneficiaries, report needs in the areas of housing, food, and transportation. Forty-nine percent of MA duals report food insecurity compared to 12 percent of MA Medicare-only beneficiaries, and 40 percent of MA duals report being driven to the doctor compared to 15 percent of MA Medicare-only beneficiaries,[16] indicating a possible transportation need. Moreover, beneficiaries in Medicare Advantage are more likely to report renting their home than FFS Medicare beneficiaries, and the likelihood of a beneficiary renting their home increases as income decreases, meaning dual eligible beneficiaries are more likely to rent their home. Fifty-two percent of Medicare Advantage beneficiaries with income less than 100 percent of the Federal Poverty Level rent their home.[17]

While we know these needs exist among MA duals through various survey data and innovative partnerships among community-based organizations, providers, and health plans, standardized questions will provide more systematic and potentially granular information for SNPs and

[15] *Id*.
[16] *Id*.
[17] 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/

beneficiary needs that can be identified in a more timely manner. However, we ask that CMS consider the data ecosystem that currently exists as a result of these many stakeholders developing their own data collection tools and methods during recent years and in the course of their partnerships. For example:

- 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.[18]
- 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 social determinants of health (SDOH) into its HRA. Because health plans with a SNP must attempt to complete a HRA for its enrollees, SCAN has high success in performing HRAs, with over 80 percent of FIDE-SNP beneficiaries and close to 80 percent of C-SNP beneficiaries with a completed HRA. SCAN then uses the SDOH information collected in the HRA to assign beneficiaries to the appropriate care management tier based on their risk, and various interventions are deployed depending on risk and targeted based on needs identified.[19]

Better Medicare Alliance encourages CMS to explore ways to integrate the established tools before relying solely on the HRA as the tool to collect responses to the standardized questions. HRAs are not just a data collection tool and have proved effective in identifying unmet needs and coordinating care to close gaps in both medical care and social needs. Adapting established tools created for the purpose of collecting these precise responses ensures best practices are not lost in the transition and offers the flexibility necessary if this proposal is adopted across the Medicare Advantage program. By working within the tools already established, the data collection efforts can be easily scaled and recognize the various actors participating in the collection efforts. Lastly, we encourage CMS to engage with stakeholders when developing the standardized questions to avoid redundant questions, as many are collecting information on these topics already. Working in partnership with stakeholders facilitates informed question development reflective of experience collecting SDOH data and best practices.

- **Additional Opportunities for Integration Through State Medicaid Agency Contracts – Limiting Certain MA Contracts to D-SNPs (§ 422.107)**

*Better Medicare Alliance appreciates CMS' interest in better understanding D-SNP performance on the plan-level given the significant demographic, medical, and social needs differences in the dual eligible population. We are concerned about the greater impact separating contracts may*

[18] 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/
[19] *Id*.

*have on the Medicare Advantage population and therefore request additional analysis on the impact this proposal would have on Star Ratings and Medicare Advantage generally before moving forward.*

CMS proposes to allow States to require Medicare Advantage organizations to establish a D-SNP-only contract. The intent of this proposal is to ensure Star Ratings reflect only the D-SNP performance, which will improve assessment of D-SNP performance on Star Ratings relative to non-D-SNP contracts in the State.

**BMA Comments:**

Better Medicare Alliance has long advocated for beneficiaries to have the resources and information necessary to make an informed decision about their health care coverage. Allowing States to require D-SNP-only contracts is an additional step in providing beneficiaries with the information they need. This proposed policy could further increase transparency about health plan performance and enable beneficiaries to make an informed decision in the selection of and enrollment in a health plan. Moreover, the separation of D-SNPs may help beneficiaries, CMS, and other stakeholders assess population health. Currently, D-SNP contracts, which serve a medically and socially complex population, are assessed alongside non-D-SNP contracts, making it difficult to truly understand the population served by that specific contract. We support the intent of permitting D-SNP only contracts, as it will further facilitate an understanding of the D-SNP population's health, offer insight into health disparities, and unveil opportunities for interventions and improvements.

Nevertheless, we are concerned about the volatility and uncertainty that may result for the D-SNP contracts due to small population sizes compared to non-D-SNP contracts. We're also concerned about the greater impact separating D-SNP contracts from non-D-SNP contracts will have on the broader Medicare Advantage population. Separating D-SNP contracts for purposes of assessing Star Ratings may impact the remaining non-D-SNP contracts and their Star Ratings. Because Star Ratings are used, in part, to determine rebate dollars and therefore supplemental benefits offered and other cost-sharing benefits like reduced or zero premiums, we ask CMS to assess how separating D-SNP only contracts will impact Star Ratings, benefits, and premiums before allowing States to pursue and require D-SNP-only contracts. While this analysis is underway, we finally request a delay in codifying a pathway for States to require D-SNP only contracts.

- **Additional Opportunities for Integration Through State Medicaid Agency Contracts – Integrated Member Materials (§ 422.107)**

*Better Medicare Alliance shares CMS' goal of providing a more coordinated beneficiary experience and supports the proposal to codify a pathway requiring integrated Medicare and Medicaid beneficiary materials for certain D-SNPs. We request adequate time for health plans to make changes and develop integrated materials. Moreover, we request CMS provide a clear framework for implementing such materials.*

CMS proposes to codify a pathway to allow States to require D-SNPs with exclusively aligned enrollment to provide beneficiaries with certain integrated Medicare and Medicaid communication materials.

**BMA Comments:**

Better Medicare Alliance supports measures that empower beneficiaries to make an informed decision about their health care coverage and modernize the Medicare enrollment and health plan selection process. Further integrating certain communication materials supports this goal. While there is evidence that Medicare beneficiaries with higher health insurance literacy are more likely to enroll in Medicare Advantage, health insurance literacy remains low among beneficiaries with low socioeconomic status and those who may be enrolled in Medicaid due to annual income.[20]

These recent findings support an earlier report discussing the challenges Medicare Advantage beneficiaries experience during the enrollment and selection process.[21] One specific resolution to the challenge recommends redesigning, simplifying, and tailoring the notice of Medicare benefits; this simplification concept can be applied to the communication materials CMS has proposed. Moreover, CMS' own studies find integrated materials, particularly the model directory, were described as "clear," "simple," and "easy to read."[22] Thus, allowing States to require integrated materials for D-SNPs will reduce challenges beneficiaries experience during the enrollment and selection process and empower them to make an informed decision about their coverage.

Better Medicare Alliances asks CMS to provide adequate time so health plans can work with States requiring integrated communications to develop such materials. We also request CMS provide clear guidance and a framework for the integration process to facilitate an efficient implementation. For example, the framework may guide plans on what to do in the event enrollment is not aligned. Better Medicare Alliance appreciates CMS' work and goal of providing a more coordinated beneficiary experience.

- **Attainment of the Maximum Out-of-Pocket (MOOP) Limit (§§ 422.100 and 422.101)**

*Better Medicare Alliance asks CMS to further consider the impact this change in counting amounts paid toward the MOOP limit will have on Medicare Advantage beneficiaries. While health plans may increase bids to offset the shift in spending, plans could also reconsider, and reduce, the benefits currently offered to account for the shift in spending away from Medicaid and to the health plans. We encourage CMS to consider this impact and potentially reduced access to the robust and innovative benefits currently offered.*

[20] S. Park, B. Langellier & D. Meyers, Association of Health Insurance Literacy with Enrollment in Traditional Medicare, Medicare Advantage, and Plan Characteristics Within Medicare Advantage, *JAMA Network Open,* 2022:5(2). Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788633

[21] Center for Innovation in Medicare Advantage, Empowering Beneficiaries and Modernizing Medicare Enrollment, October 2020. Available at: https://bettermedicarealliance.org/publication/whitepaper-empowering-beneficiaries-and-modernizing-medicare-enrollment/

[22] Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 1842 (proposed Jan. 12, 2022) (to be codified at 42 C.F.R. pts. 422, 423).

CMS proposes to modify the method for calculating spending counted towards the beneficiary MOOP limit to include all costs for Medicare Parts A and B services, including cost sharing by secondary or supplemental insurers and any remaining unpaid cost sharing.

**BMA Comments:**

Better Medicare Alliance requests that CMS carefully consider the impact this methodology change for counting amounts paid towards the MOOP limit will have on benefits offered before finalizing the proposed policy change. We'd like to first note that a premise of the proposed change in methodology for the MOOP limits relies on the assumption that there is insufficient access to Medicare providers for dual eligibles. Better Medicare Alliance believes this is misplaced, as there are mechanisms such as network adequacy requirements that negate access to care concerns. Moreover, research shows dual eligibles in Medicare Advantage are more likely to have a usual source of care than dual eligibles in FFS Medicare, 91 percent and 86 percent, respectively.[23] We have three additional points for consideration related to the impact of this proposed policy change.

First, the proposed change is estimated to increase Medicare spending by $3.9 billion over 10 years, leading to increased spending by health plans. An early analysis estimates health plans will spend an additional $22.99 per member per month (PMPM).[24] When PMPM spending by health plans increases, rebate dollars decrease due to the bid-to-benchmark payment methodology in Medicare Advantage. As such, supplemental benefits like enhanced or extra benefits, reduced or zero-dollar premiums, and other cost protections may be modified or reduced due to fewer available rebate dollars. A reduction or modification in benefits would serve to offset an increase in spending due to this changed methodology for calculating the MOOP limit.

Supplemental benefits are a critical tool in Medicare Advantage to address both health-related and non-health-related needs of beneficiaries. Following CMS' guidance relaxing the definition of "primarily health-related" and the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI), health plans have significantly increased their supplemental benefit offerings each year and these benefits are nearly universal.[25] Of the 41 categories of supplemental benefits assessed, 35 categories saw growth in the number of health plans' offerings for 2022. Specifically, there was growth in 16 of the 19 categories of SSBCI assessed. In 2022, SSBCI offerings in Medicare Advantage increased 38 percent, with the largest increase among the food and produce benefit, covering nearly 3 million beneficiaries. Other benefits include meals beyond a limited basis, transportation for non-medical needs, general supports for living, and pest control.[26]

[23] Better Medicare Alliance, Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections When Enrolled in Medicare Advantage, December 2021. Available at: https://bettermedicarealliance.org/publication/dual-eligible-beneficiaries-receive-better-access-to-care-and-cost-protections-when-enrolled-in-medicare-advantage/
[24] ATI Advisory & Long-Term Quality Alliance, CY 2023 Medicare Advantage Proposed Rule: Impacts on Non-Medical Supplemental Benefits, January 2022. Available at: https://atiadvisory.com/wp-content/uploads/2022/01/CY-2023-Medicare-Advantage-Proposed-Rule-Impacts-on-Non-Medical-Supplemental-Benefits.pdf
[25] *See* Milliman, Overview of 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/
[26] *Id*.

Not only have health plans increased their offerings, but they have also developed innovative solutions and partnerships to address social determinants of health with the supplemental benefits offered.[27] Additionally, the proposed policy will disproportionately impact health plans that enroll more full dual eligible beneficiaries. Considering Medicare Advantage beneficiaries, and dual eligibles especially, have more social risk factors than their FFS Medicare counterparts,[28] actions that may reduce supplemental benefits will negatively impact a population that benefit from the additional services and offerings in Medicare Advantage.

Lastly, CMS should consider whether this proposed policy change creates a disincentive for health plans to enroll dual eligible beneficiaries. Plans that serve large dual eligible populations will be disproportionately impacted by this proposed change due to the cost sharing limitations for dual eligibles. As mentioned earlier, dual eligibles are medically and socially complex beneficiaries, and Medicare Advantage serves a larger proportion of these beneficiaries than FFS Medicare. There is concern that this complex population may see a reduction in enhanced or supplemental benefits as a result of this proposed policy change, yet this population is one that needs the robust benefits and innovative supplemental benefits addressing social determinants of health the most. We ask CMS to consider how this methodology change to calculate the MOOP limit will impact the millions of beneficiaries that choose Medicare Advantage.

- **Amend MA Network Adequacy Rules by Requiring a Compliant Network at Application (§ 422.116)**

*Better Medicare Alliance shares CMS' priority for bid integrity and ensuring beneficiaries have access to adequate, high-value networks, however, we're concerned this additional requirement may impact beneficiary access to robust Medicare Advantage options if submitting the provider network at the point of application becomes administratively burdensome for some health plans and providers. Therefore, we request CMS considers the additional burden from this proposed requirement, especially for community and regional health plans, and the potential impact on beneficiary access to care.*

CMS proposes to require the submission of provider networks for review when submitting an application for a new contract or expanding an existing service area. With this new requirement, CMS proposes a 10-percentage point credit towards meeting the network adequacy requirements.

**BMA Comments:**

We request CMS further analyze the impact of requiring health plans to submit their networks for review at time of application. This is particularly important for community and regional health

[27] 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/

[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/

plans. Many contracts between providers and health plans depend on final benefit design features, which may not be known prior to updates made through rulemaking and the Advance Notice, thus delaying the finalization of contracts. Given the reliance on the most current data and information to develop high-value provider networks, the proposed requirement is incompatible with the timeframe and processes of when health plans are generally able to finalize their contracts with providers. Should this proposed requirement take effect, health plans may have to reopen contracts to reflect new information. Consequently, this creates an administrative burden for both providers and health plans if contracts have to be reopened.

Furthermore, this requirement and the burden created may disincentivize community and regional plans from expanding into new areas, thus reducing the variety of health plans offered for beneficiaries to select from. We therefore ask CMS to consider alternative ways for health plans to demonstrate adequate networks without submitting a complete provider network at time of application. For example, plans can submit non-binding letters of intent they have with providers to demonstrate adequacy. These alternatives will provide the flexibility health plans may need in order to utilize the most current data and information available to develop high-quality provider networks.

Better Medicare Alliance also supports expanding the list of specialty sites that will receive the 10 percent credit to include telehealth. We believe the inclusion of telehealth aligns with current approaches to care delivery, recognizes the changing landscape in response to the PHE, and offers additional flexibility for health plans as they build their provider networks.

- **Past Performance (§§ 422.502, 422.504, 423.503, 423.505)**

*Better Medicare Alliance shares CMS' goal of ensuring beneficiaries receive high-quality care in Medicare Advantage and we support measures to meet this goal. However, CMS should consider whether any current and future proposed measures expanding the bases for contract denials will impact beneficiary access to care and health plan options. We request that if CMS moves forward with this proposed policy change that it apply the additional bases for denial at the contract level, not the organization level.*

CMS proposes expanding the basis for denying a Medicare Advantage or Part D contract. Additional proposed bases for denial include a Star Rating of 2.5 or lower, filed or is in bankruptcy proceedings, and has been issued compliance actions.

**BMA Comments:**

Better Medicare Alliance believes carefully reviewing applications for new contracts or an expanded service area protects beneficiaries and improves the level of high-quality care delivered in Medicare Advantage. Yet we believe the additional bases for application denial may negatively impact beneficiary access to care and health plan options as they are currently proposed.

CMS' found "[t]he low number of denials has not impacted access to care to MA plans nor do[es it] believe expanding the bases for denials will impact access."[29] While this may be true now, we request CMS examine the impact these additional bases will have, particularly when at the organization level as proposed. Better Medicare Alliance wants to ensure poor performance by a single or handful of contracts does not negatively affect a greater number of contracts at the organization level. Such occurrence would unduly impact access to care and health plan options for many beneficiaries. Accordingly, we request that if CMS moves forward with these additional bases that it apply the additional bases for denial at the contract level, not the organization level.

- **Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§§ 422.2260, 423.2260, 422.2267, 423.2267)**

*Better Medicare Alliance appreciates and supports CMS' proposals to enhance a beneficiary's decision-making power through the Multi-Language Insert and additional safeguards against Third-Party Marketing Organizations. We request a few clarifications to CMS' proposals and look forward to continuing our engagement with the Administration as an active partner seeking to further empower beneficiaries.*

CMS proposals include requiring a Multi-Language Insert (MLI) in all enrollee materials directing beneficiaries to translation services, defining Third Party Marketing Organizations (TPMO) to remove ambiguity around the roles and responsibilities of TPMOs, and requiring certain disclosures or disclaimers when TPMOs market Medicare Advantage and Part D plans.

**BMA Comments:**

Better Medicare Alliance supports reinstituting the Multi-Language Insert (MLI) and CMS' recognition of the changing demographics in Medicare Advantage, and Medicare more broadly. According to a recent analysis using the Medicare Current Beneficiary Survey (MCBS), 53 percent of Latino Medicare beneficiaries, 49 percent of Black Medicare beneficiaries, 34 percent of white Medicare beneficiaries, and 31 percent of Asian, American Indian, or Alaskan Native Medicare beneficiaries enroll in Medicare Advantage.[30] Further, 45 percent of lower income Medicare Advantage beneficiaries, those with incomes less than 200 percent of the Federal Poverty Level, speak a language other than English at home, and 26 percent report speaking English "not well" or "not at all."[31] The shifting demographics may contribute to the significant portion of Medicare Advantage beneficiaries that speak languages other than English, especially among lower income beneficiaries.

Reinstituting the MLI in enrollee materials will further empower beneficiaries with the tools and resources necessary for them to make informed decisions about their health care coverage. Moreover, beneficiaries that utilize the translation services may better understand their health care coverage, what benefits they have, and how to access the various benefits and services

[29] Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 1842 (proposed Jan. 12, 2022) (to be codified at 42 C.F.R. pts. 422, 423).
[30] 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/
[31] 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/

available. A better understanding of their coverage may help reduce disparities among beneficiaries whose primary language is not English, further advancing this Administration's goal of achieving health equity.

We commend CMS for its steps to increase access to translation services for critical enrollee materials, and Better Medicare Alliance supports increased access to these materials to accommodate the diversity of the Medicare Advantage population and the languages spoken by beneficiaries. We would like to see additional action by the Administration to further empower beneficiaries to make informed decisions about their health care coverage. For example, additional materials should be fully translated and printed in additional languages. We applaud the expansion of the Medicare & You Handbook to be available in Chinese, Korean, and Vietnamese as of this year. Additional steps like this are necessary to fully recognize the changing demographics in Medicare, and Better Medicare Alliance looks forward to continued engagement as an active partner to further empower beneficiaries.

In response to CMS' solicitation for comments on the proposed definition of TPMO and whether it is sufficiently broad, we believe the proposed definition is sufficiently broad to capture the activity CMS is targeting through this proposal.

For the TPMO disclaimer and lead generating disclosure proposed by CMS, we ask for measures to offer clarity to and educate beneficiaries on the matter. Better Medicare Alliance suggests the following disclaimer to be used by TPMOs, as proposed in 42 CFR §§ 422.2267(e)(41), 423.2267(e)(41): "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. *Please visit Medicare.gov or call 1-800-MEDICARE* to get information on all of your options." (*Suggestion emphasized*). We believe this revision will further clarify the contact options for beneficiaries seeking information on all of their options. Moreover, the revision further distinguishes the option to visit a website or call a center and supports beneficiaries that may have lower technology literacy.

Better Medicare Alliance further requests additional guidance on phrases or sentences made by TPMOs that CMS considers misleading. In the Proposed Rule, CMS provides one example – "We will help pick the best plan for you" – however, we request additional guidance to better inform health plans and Part D sponsors on ensuring disclaimers are provided appropriately.

Lastly, we recommend CMS develop official supplemental materials to either share with beneficiaries or make available upon request about TPMOs and lead generating activities. Better Medicare Alliance shares CMS' goal of reducing beneficiary confusion, however, notifying beneficiaries of lead generating activities and disclosure by TPMOs that contact information will be shared with or transferred to licensed agents, as proposed, may create more confusion rather than reduce confusion. For example, beneficiaries may not know the role and responsibilities of TPMOs and how that may differ from licensed agents. Without proper education or understanding of the individuals or entities involved in the enrollment and selection process, further disclosure may create additional confusion among beneficiaries.

- **Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data (§§ 422.2460, 422.2490, 423.2460)**

*Better Medicare Alliance commends the Administration's goal to better understand supplemental benefits and supports the proposal to collect data to ascertain the level of resources expended by health plans by providing these extra benefits. We recommend CMS consider creating sub-categories within the "Non-Primarily Health Related Items and Services that are Special Supplemental Benefits for the Chronically Ill" category that align with other targeted areas like food, transportation, and housing. We also request CMS clarify how amounts paid for supplemental benefits will be captured and reported and to consider the potential impact additional data collection requirements will have on community-based organizations relative to larger, national organizations and the unintended consequences that may follow. Lastly, Better Medicare Alliance urges CMS to delay implementing the modified MLR reporting requirements to allow adequate time for health plans and their partners to sufficiently collect the required data.*

CMS proposes to reinstate detailed Medical Loss Ratio (MLR) reporting requirements that were in effect CY 2014-2017 with a few modifications, including reporting expenditures for supplemental benefits to take effect for CY 2023.

**BMA Comments:**

Better Medicare Alliance supports efforts to collect data to better understand supplemental benefits in Medicare Advantage and the role they play in supporting whole person health. The proposed types and categories of supplemental benefits to include in MLR reporting sufficiently capture those offered by health plans, with two recommendations. First, Better Medicare Alliance recommends including "Wellness" within the "Fitness Benefit" category, thus establishing a "Fitness and Wellness Benefit" category. This addition will further capture the programs that incorporate a more holistic approach to the health and wellbeing in the benefit offered.

We also recommend expanding the "Non-Primarily Health Related Items that are Special Supplemental Benefits for the Chronically Ill (SSBCI)" category. SSBCI encompasses a substantial number of benefits, so expanding the category to include a few other targeted areas will offer a more comprehensive understanding of the SSBCI benefits offered. For example, we propose sub-categories such as food, transportation, and housing, which align with the broader areas of focus for CMS and health plans. If CMS adopts sub-categories for SSBCI, there should also be a miscellaneous or other category to ensure SSBCI that do not fall squarely within a broader sub-category are still captured. We further recommend the 10 percent rule applicable to non-SSBCI supplemental benefits be applied to SSBCI benefits.

Better Medicare Alliance also seeks clarification on the unit health plans are to use to capture and report supplemental benefit spending. Given the nature of many supplemental benefits, a "claims-based" reporting framework may not be appropriate for all supplemental benefits. Rather, a PMPM framework may best capture the financing arrangements between the health

plan and the partner contracted with for the benefit. We request clarification on how CMS would like to see the data captured in order to mitigate differences in the payment frameworks and arrangements utilized for supplemental benefits. According to the most recent Community-Based Organization Health Care Contracting Survey, a FFS payment model is the most common model type used by CBOs when contracting with health care entities, with 78 percent of CBOs reporting FFS frameworks as a payment model used. However, PMPM or other capitation payment models are the second most common type reported at 30 percent. Therefore, we ask for clarification to ensure spending is not reported differently across the different supplemental benefit categories proposed by CMS.

Moreover, we ask CMS to consider the impact additional data collection on behalf of the health plan will have on CBOs relative to the larger, national organizations. Health care is local, and many communities have resources within the community itself or region, as evident by increased contracting with CBOs.

However, CBO data capabilities and infrastructure may not be as sophisticated as the national organizations, creating difficulties in providing the data necessary to meet the modified MLR reporting requirements. If CBOs are unable to provide the data necessary, we may see a shift in contracting entities, meaning health plans may seek contacts with national organizations that are able to meet the new reporting requirements rather than CBOs that understand the community and the beneficiaries that reside there. As such, we ask CMS to consider the role CBOs have in data collection for health plans and the partnerships developed over recent years by aligning the CBOs' capabilities with the proposed reporting requirements to ensure CBO and health plan partnerships continue.

Pursuant to our recommendations, Better Medicare Alliance asks CMS to provide additional time for health plans to establish processes with their vendors to ensure all necessary data is collected to meet the modified reporting requirements. As such, we request an additional year, with the proposed MLR reporting requirements as it relates to supplemental benefits to take effect in CY 2024.

- **Pharmacy Price Concessions in the Negotiated Price (§ 423.100)**

*Better Medicare Alliance urges CMS to delay the timeline before the amended "negotiated price" and additional "price concessions" definitions go into effect. We request at least 1 additional year, with an implementation date no earlier than CY 2024, if the proposed definitions are finalized.*

CMS proposes to amend the definition of "negotiated price" to eliminate the exception for contingent pharmacy price concession and add a regulatory definition for "price concessions."

**BMA Comments:**

The proposal to amend the term "negotiated price" and adopt the additional "price concessions" definition will impact standalone Part D products, as well as Medicare Advantage plans that include prescription drug coverage – MA-PD plans. Implementing these changes across both product lines is operationally complex, particularly for the integrated MA-PD products.

One consequence of the proposed policy change is an increase in beneficiary premiums. Due to the nature of integrated products and the option for health plans to offer a Medicare Advantage plan that includes prescription drug coverage, Medicare Advantage more broadly is impacted by changes in the Part D program. Health plans currently have the option to buy down Part D premiums for their enrollees as a supplemental benefit, with many resulting in a $0 premium. However, if Part D premiums increase, the number of MA-PD plans with a $0 premium may decrease, becoming more limited.

Based on 2021 offerings and enrollment, over 11 million Medicare Advantage beneficiaries were enrolled in an MA-PD plan with a $0 premium.[32] In 2022, 89 percent of all Medicare Advantage plans include prescription drug coverage, and 59 percent of the MA-PD plans have a $0 premium for beneficiaries.[33] Moreover, 98 percent of all Medicare beneficiaries have access to a MA-PD plan with a $0 premium.[34] The consequences of this proposed policy change are far reaching and can have a significant impact on $0 premium MA-PD plans and the millions of Medicare Advantage beneficiaries that choose to enroll in one of those plans each year.

Preserving access to high-quality, *affordable* care for beneficiaries is a priority for Better Medicare Alliance. If the proposed policy goes into effect, beneficiaries that currently have near universal access to a $0 premium MA-PD plan will likely decline. Looking at the Proposed Rule holistically, there are other proposed policy changes that could lead to fewer benefits, such as the MOOP limit proposal. We are concerned there will be a compound effect, leading to fewer benefits and affordable plan offerings and CMS should consider the greater impact of these discrete policy changes during its review. Given the operational complexity of incorporating pharmacy price concessions into the negotiated price, Better Medicare Alliance urges CMS for a delay of at least 1 year before the proposed policy takes effect so health plans have adequate time to thoughtfully implement this policy and limit the impact on beneficiaries.

[32] Kaiser Family Foundation, Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits, and Supplemental Benefits, June 2021. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/
[33] Kaiser Family Foundation, Medicare Advantage 2022 Spotlight: First Look, November 2021. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/
[34] *Id*.