BETTER MEDICARE ALLIANCE

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

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

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

August 31, 2022

Re: CMS-4203-NC, Medicare Program; Request for Information on Medicare

Administrator Brooks-LaSure:

On behalf of our Alliance and the over 29 million beneficiaries enrolled in Medicare Advantage, the Better Medicare Alliance (BMA) is pleased to submit the attached response on the Centers for Medicare & Medicaid Services (CMS) Request for Information regarding various aspects of the Medicare Advantage program and organized by the five pillars prioritized by CMS.

Better Medicare Alliance is a diverse coalition of 180 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 shares a deep commitment to ensuring Medicare Advantage remains a high-quality, cost-effective option for current and future Medicare beneficiaries.

Better Medicare Alliance applauds CMS' efforts to engage partners and solicit stakeholder input on ways to strengthen the Medicare Advantage program and improve access to coverage and care for the 29 million Medicare beneficiaries it serves. We strongly agree with the Administration that "Medicare Advantage is a critical part of CMS' vision to advance health equity; expand access to affordable coverage and care; drive high-quality, person-centered care; and promote affordability and sustainability of Medicare."[1] Moreover, we appreciate the Administration's interest in better understanding how care innovations in Medicare Advantage impact beneficiary outcomes and costs.

Through value-based payment and care management that results in improved outcomes, extra benefits, and lower costs for beneficiaries and the federal government, Medicare Advantage is addressing the needs of today's beneficiaries. With growing enrollment and high consumer satisfaction, Medicare Advantage is building the future of Medicare.

Medicare Advantage's coordinated care model—which emphasizes prevention, early detection and management of chronic disease, and whole-person and comprehensive care—is strongly positioned to advance continued progress in each of the areas included in CMS' Strategic Pillars.

By addressing longstanding disparities in care, improving beneficiary access and affordability, and promoting innovation in payment and care delivery, Medicare Advantage has a

[1] Centers for Medicare & Medicaid Services, "CMS Seeks Public Feedback to Improve Medicare Advantage," July 28, 2022. Available at: https://www.cms.gov/newsroom/press-releases/cms-seeks-public-feedback-improve-medicare-advantage

demonstrated track record of success in providing high-quality and affordable care to over 29 million beneficiaries.

By building on the experience of care innovations in Medicare Advantage, we can make continued progress in closing gaps in care, expanding access, promoting affordability, and improving health outcomes for all beneficiaries. As CMS continues to explore public policies to further advance these shared goals, BMA looks forward to collaborating and partnering with the Administration on advancing progress in these critical areas. We also put forth policy recommendations for CMS' consideration in meeting these shared goals and priorities.

- **Advance health equity through public policies that help better identify and address social needs and risk factors to reduce gaps in care.** In addition to improving data collection and utilizing new tools to better identify Medicare beneficiaries' social risk factors and needs, BMA also supports CMS' efforts to address the social determinants of health and advance health equity within Medicare Advantage. As CMS continues to develop new policies—such as considering new quality measures and establishing a health equity index—we encourage CMS to continue engaging stakeholders on important design elements so that they can work effectively in meeting the needs of beneficiaries.

- **Improve access to telehealth and virtual care in Medicare and Medicare Advantage by extending or making permanent flexibilities tied to the public health emergency.** Both telehealth and virtual care have been instrumental to preserving and expanding access to care for Medicare beneficiaries during the public health emergency. Medicare Advantage worked effectively during the pandemic to expand the availability of telehealth and virtual care, and CMS can further build on this success by permanently authorizing many of the waivers permitted during the public health emergency.

- **Expand and permanently authorize the MA-VBID model so Medicare Advantage can continue to offer tailored and innovative benefits that meet the whole health care needs of Medicare beneficiaries.** The MA-VBID model has played an important role in providing beneficiaries with expanded access to non-medical benefit offerings that effectively address the needs of this patient population and has helped reduce disparities in care. BMA recommends that CMS consider expanding model participation to include all Medicare Advantage plans, including Employer Group Waiver Plans (EGWPs). In addition, CMS should also consider permanent authorization at the end of the demonstration in order to promote continued investment in the innovations that require multi-year continuity for effectiveness.

- **Support bipartisan policies to strengthen Medicare Advantage, including increasing flexibility for plans to address social determinants of health and reforms to streamline and improve prior authorization.** As CMS considers changes to improve Medicare Advantage, BMA also supports bipartisan legislative efforts to strengthen MA and the care it provides to over 29 million beneficiaries. To expand availability of supplemental benefits to more at-risk and vulnerable beneficiaries, we support H.R. 4074, *Addressing Social Determinants in Medicare Advantage Act*, bipartisan legislation that would allow Medicare Advantage plans to offer certain supplemental benefits that are currently only available to chronically ill enrollees. By permitting Medicare Advantage plans to provide targeted supplemental benefits to low-

income seniors and people with disabilities, this legislation would significantly expand the availability of supplemental benefits to more beneficiaries who will benefit from these tailored and targeted benefit offerings. We also support efforts to streamline and improve the prior authorization process in Medicare Advantage and have endorsed H.R. 3173/S. 3018, the *Improving Seniors' Timely Access to Care Act*. Prior authorization is an important tool to ensure access to clinically appropriate care and reduce waste and unnecessary costs in the system, but reforms are necessary to streamline and improve the process for both patients and providers. By establishing an electronic prior authorization process and ensuring prior authorization and other medical management processes adhere to evidence-based medical guidelines, this legislation represents an important step in assuring beneficiary access to clinically appropriate care.

- **Codify the 2016 best practices proposed in the CY 2016 Rate Announcement and Final Call Letter for in-home health risk assessments, which are critical in identifying and addressing unmet medical and social needs among beneficiaries.** In-home health risk assessments are an essential element of the high-quality, value-based clinical care model deployed in Medicare Advantage, and all in-home health risk assessments should provide clinical care that meets beneficiary needs through a holistic approach. Codifying the best practices further promotes the stability and program integrity of Medicare Advantage, while simultaneously raising the bar on the quality of these in-home clinical visits.

As CMS looks ahead to the CY 2024 rate and policy setting process, we also appreciate the Administration's commitment to Medicare Advantage policies that promote stability and predictability, which is critically important to ensuring that Medicare Advantage continues providing the high-quality and affordable care that beneficiaries rely on.

We look forward to continued partnership and collaboration with CMS and other policymakers and stakeholders to best achieve the vision of ensuring that all Medicare beneficiaries receive equitable, high-quality, and person-centered care that is affordable and sustainable.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

BETTER MEDICARE ALLIANCE

ATTACHMENT

Better Medicare Alliance's Detailed Response to CMS' Request for Information to Strengthen Medicare Advantage

Advancing Health Equity

BMA appreciates CMS' continued focus on ways to advance health equity and reduce disparities in outcomes and access to coverage and care throughout the health care system. As a diverse community of Allies and partners, BMA strongly supports efforts to advance health equity by expanding access to care, reducing disparities, and closing gaps in care for vulnerable populations. Medicare Advantage's coordinated care model—which emphasizes prevention, early detection and management of chronic disease, and whole-person and comprehensive care—is strongly positioned to address longstanding health, racial, and ethnic disparities, as well as disparities related to income, geography, gender, and sexual identity and orientation. Through investments in addressing social risk factors, Medicare Advantage is also leading the way in innovations to address the social determinants of health (SDOH), typically by offering supplemental benefits tailored to the specific needs of patients and beneficiaries.

We appreciate CMS' interest in learning more about promising interventions to reduce disparities while also exploring public policy changes that will further advance the goal of health equity so that all Medicare beneficiaries—including Medicare Advantage beneficiaries—receive the high-quality care and support they need to achieve optimal health and thrive in their communities.

Medicare Advantage enrollment continues to grow rapidly—currently covering 29 million beneficiaries and is soon projected to approach half of the total Medicare population.[2] As beneficiary preference for Medicare Advantage grows, Medicare Advantage is also covering an increasingly diverse population and supporting improved access to care.

- Enrollment among minority and dual eligible beneficiaries has grown 111 percent and 125 percent, respectively, since 2013.[3]
- Nearly 50 percent of Black Medicare beneficiaries and 53 percent of Latino Medicare beneficiaries are enrolled in Medicare Advantage.[4]
- Twenty-two percent of Medicare Advantage beneficiaries are dually eligible for Medicare and Medicaid.[5]

[2] 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, June 2022. Available at: https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf
[3] 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
[4] 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/wp-content/uploads/2021/06/BMA_2021-Q2-Data-Brief_6.15.21.pdf
[5] Better Medicare Alliance, Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Moderate-Income Populations, March 2021. Available at: https://bettermedicarealliance.org/wp-content/uploads/2021/03/BMA-Data-Brief-March-2021-FIN.pdf

- Over half of Medicare Advantage beneficiaries live on annual incomes of less than $24,500 and are 37 percent more likely to be under 200 percent of the Federal Poverty Level (FPL) compared to FFS Medicare beneficiaries.[6]

- Medicare Advantage has a 63 percent higher rate of beneficiaries who are eligible for and enroll in Medicare due to a disability.[7]

The value of Medicare Advantage in providing coverage and care to vulnerable populations is demonstrated by its high-quality ratings[8] and also by increasingly offering supplemental benefits to meet the health care and social needs of Medicare's most underserved populations. By serving an increasingly diverse and lower income population, the experience to be learned from Medicare Advantage's coordinated care model can provide important insights in how to best serve some of the most vulnerable and underserved populations.

A recent study by CMS Office of Minority Health detailed important findings about how Medicare Advantage is making progress in closing longstanding disparities in care. For example, the study found "substantial reductions" in what were very large inequities for Black and Latino beneficiaries on access to preventive care, including the annual flu vaccine, while also documenting "substantial progress in the reduction of inequities in the patient experience for Black beneficiaries."[9]

Medicare Advantage is further leading to improved health outcomes for minority populations as the same report found "substantial improvement for Black and Hispanic beneficiaries in the area of clinical care, both absolutely and relative to white beneficiaries." Similar to trends in accessing preventive care, these trends resulted in "substantial reduction in what were large inequities on almost all clinical care measures analyzed."[10]

Separate research from ATI Advisory found that Black and Latino beneficiaries are more likely to enroll in Medicare Advantage and tend to be more socioeconomically disadvantaged than their counterparts who enroll in Fee-for-Service (FFS) Medicare.[11] In addition, racial and ethnic minority beneficiaries who enroll in Medicare Advantage are more likely to receive important preventive care services and have lower patient out-of-pocket costs than minorities who enroll in FFS Medicare.

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[6] Better Medicare Alliance, Medicare Advantage Outperforms FFS Medicare on Cost Protections for Low-Income and Diverse Populations, April 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FINv2.pdf; ATI Advisory, Responding to the CMS Request for Information: Medicare Advantage Data and Policy Insights, August 22, 2022. Available at: https://atiadvisory.com/wp-content/uploads/2022/08/Medicare-Advantage-RFI-Data-Insights.pdf

[7] Avalere Health, Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to FFS Medicare, July 2018. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf

[8] 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

[9] Centers for Medicare & Medicaid Services, Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018, December 2021. Available at: https://www.cms.gov/files/document/trends-inequities-medicare-advantage-2009-2018.pdf

[10] *Id.*

[11] 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/wp-content/uploads/2021/06/BMA_2021-Q2-Data-Brief_6.15.21.pdf

Deploying Supplemental Benefits in Medicare Advantage

An important way Medicare Advantage has been working to advance health equity is through innovations and investments in addressing SDOH and offering an expanded array of supplemental benefits.

Researchers at NORC at the University of Chicago conducted an in-depth examination of the myriad ways Medicare Advantage is working to address beneficiaries' social risk factors and unmet needs in the areas of nutrition, transportation, and caregiver and in-home supports.[12] By effectively addressing social risk factors, Medicare Advantage is working to fill critical social and health needs that are crucial to the long-term health and wellbeing of Medicare beneficiaries.

Partnerships with community-based organizations are essential to the success of these interventions, and health plans take a variety of approaches in these new collaborations. Expanded supplemental benefits available through Medicare Advantage are a promising way to improve access to care, address unmet social needs and improve health care outcomes for Medicare beneficiaries.

The proliferation of supplemental benefit offerings is well-documented, and health plans are increasingly focused on improving access to services and care for vulnerable patient populations, including those with chronic conditions and unmet social needs.

- A report by Milliman found that the number of health plans offering supplemental benefits grew in 35 of the 41 categories measured, including 16 out of the 19 Special Supplemental Benefits for the Chronically Ill (SSBCI) categories. Overall, the number of health plans offering SSBCI benefits increased 38 percent from 2021 to 2022.[13]

- A study by Avalere found that more health plans offer non-medical supplemental benefits in 2022 compared to 2021, with increases in plans offering meals, transportation, nutrition, and in-home support services. The report also found that more plans offer meals, transportation, nutrition, or in-home support at a $0 premium for 2022.[14]

- ATI Advisory found that 34 percent of health plans offer at least one non-medical supplemental benefit while 42 percent of Medicare Advantage Special Needs Plans (SNPs) offer SSBCI benefits.[15]

[12] 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/
[13] Milliman, Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2022 Offerings, February 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/03/MA-Supplemental-Benefits-Milliman-Brief_20220225.pdf
[14] T. Kornfield, A. Fix, R. Duddy-Tenbrunsel, et al., More Medicare Advantage Plans Will Offer Non-Medical Benefits in 2022, Avalere Health, October 19, 2021. Available at: https://avalere.com/insights/more-medicare-advantage-plans-will-offer-non-medical-benefits-in-2022
[15] A. Rizer & L. Benzing, Filling the Gaps: The Role and Value of Supplemental Benefits in Medicare Advantage, *Health Affairs,* August 5, 2022. Available at: https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage

As the offerings of supplemental benefits continue to grow and proliferate, policymakers can learn from some of the early experiences and identify best practices and promising approaches that can lead to improved beneficiary experience, lower costs, and improved outcomes. Case studies and other published reports have identified promising interventions and improved outcomes as a result of expanded supplemental benefit flexibilities and offerings, but policy experts also note that the full impact of these efforts will likely take years to develop.[16] As health plan supplemental benefit offerings increase and Medicare Advantage gains more experience in designing these expanded benefits, additional data, research, and evaluation will be critical as policymakers seek to better understand the impact of these interventions and identify promising strategies for improving care for Medicare beneficiaries.

Medicare Advantage has proven its ability to advance health equity, evidenced through increased enrollment in the program, an increasingly diverse and lower income population served, and a growing focus on addressing unmet medical and social needs through benefit offerings. Nevertheless, more can be done to address gaps in care, remove barriers to access, and improve health equity despite the important and significant role Medicare Advantage has played in reducing disparities. BMA applauds CMS for moving forward with public policies to better address SDOH and advance health equity, including standardizing the collection of social risk factors data for beneficiaries enrolled in SNPs. We also appreciate the consideration of other potential ways for Medicare Advantage to advance health equity, including modifications to the Star Ratings System and to risk adjustment models. BMA supports a number of policy recommendations for CMS' consideration to further advance the shared goal of improving health equity in Medicare Advantage.

- **Improve data collection by establishing standards and processes for the collection of race, ethnicity, gender, and additional SDOH information in partnership with stakeholders.** Standardization will ensure consistency in the data elements collected and allow for more robust analysis and evaluation. SDOH information collected may address food insecurity, housing instability, financial insecurity, and social connection. Moreover, standardizing information will ensure accurate and timely data and enable the communication of beneficiary needs between health plans and providers across the health care and social service sectors.

- **Promote the use of Z codes to help better identify Medicare beneficiaries' social needs.** The most recent data show less than 2 percent of Medicare beneficiaries had their social needs tracked using Z codes.[17] Incentivizing providers to use Z codes with trainings, guidance on follow-up referrals, and possible financial incentives will help in identifying beneficiaries that could benefit from additional non-health related services.

- **Identify and adopt appropriate quality measures addressing SDOH and incorporate into Medicare Advantage Star Ratings (e.g., health equity index).** BMA supports CMS' efforts to address SDOH and advance health equity in Medicare Advantage and across other programs under CMS' purview. We especially appreciate the number of thoughtful proposals to better address screening for social risk factors and provide incentives for health plans to drive continued improvements in reducing

[16] *Id.*
[17] NORC at the University of Chicago, "Few Physicians Document Social Needs of Older Adults," September 30, 2021. Available at: https://www.norc.org/NewsEventsPublications/PressReleases/Pages/few-physicians-document-social-needs-of-older-adults.aspx;

disparities and closing gaps in care. As CMS continues to flesh out details on new proposed policies, such as considering new quality measures and establishing a health equity index, we encourage CMS to continue engaging stakeholders on important design elements so that they can work effectively. In addition, we look forward to partnering with CMS on supporting access to accurate and comprehensive SDOH data that is crucial to advancing these proposals and priorities.

- **Support bipartisan legislation (H.R. 4074, *Addressing Social Determinants in Medicare Advantage*) to allow Medicare Advantage plans to offer certain supplemental benefits that are currently only available to chronically ill enrollees.** Legislative and regulatory flexibility provided in recent years has allowed Medicare Advantage to continue to innovate in the areas of benefit design and care management to improve the health of Medicare beneficiaries, particularly those with chronic conditions and other vulnerable patient populations. To further improve access to care and reduce disparities, BMA supports bipartisan legislation that would further expand such flexibility and enable more Medicare beneficiaries to benefit from expanded benefits. By permitting Medicare Advantage plans to provide targeted supplemental benefits to low-income seniors and people with disabilities, in addition to those at high-risk for developing chronic conditions, this legislation would significantly expand the availability of supplemental benefits for at-risk and vulnerable beneficiaries.

- **Explore innovative models for closing gaps in care and reducing health disparities.**

Expanding Access to Coverage and Care

BMA strongly supports and shares CMS' commitment to providing high-quality and affordable care for all Medicare beneficiaries. Medicare Advantage is strongly positioned to continue providing affordable and high-quality coverage to beneficiaries. As enrollment continues to grow, Medicare Advantage is delivering on the promise of providing high-quality care to over 29 million beneficiaries.

Last year, CMS announced that Medicare Advantage premiums will continue to decrease, to a 15-year low, while plan choices, benefits, and enrollment will increase for 2022.[18] Nearly 90 percent of beneficiaries currently enrolled in Medicare Advantage with prescription drug coverage (MA-PD) are in health plans with a rating of four or more stars in 2022, a record high.[19]

Medicare Advantage is also delivering cost savings for Medicare beneficiaries through lower patient cost-sharing and enhanced supplemental benefits. Recent research by ATI Advisory details the crucial role Medicare Advantage plays in protecting financially vulnerable Medicare beneficiaries with low- and moderate-incomes from out-of-pocket costs and premiums. This

[18] 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

[19] 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

latest report builds on earlier research by ATI Advisory and is based on 2019 MCBS data, the most recent available. The report finds, on average, that Medicare Advantage beneficiaries report spending nearly $2,000 less ($1,965) on out-of-pocket costs and premiums annually compared to FFS Medicare beneficiaries. The report's findings indicate an increase of $325 in consumer cost savings, compared to last year's report.[20]

Other notable findings from the report include:

- Medicare Advantage beneficiaries face lower cost burdens[21] than FFS Medicare beneficiaries. Approximately 13 percent of Medicare Advantage beneficiaries experience cost burden as compared to 20 percent of FFS Medicare beneficiaries.

- Medicare Advantage beneficiaries spend less than FFS Medicare beneficiaries across racial and ethnic groups, with Black Medicare Advantage beneficiaries spending $1,104 less in total health spending compared to FFS Medicare, while Latino Medicare Advantage beneficiaries see average savings of $1,421.

- For lower income beneficiaries, Medicare Advantage significantly reduces overall cost burden as compared to FFS Medicare. For example, nearly twice as many Medicare-only beneficiaries under 200 percent FPL experience cost burden in FFS Medicare as they do in Medicare Advantage (48.9% vs. 27.4%). Similarly, over twice as many dual-eligible beneficiaries in FFS Medicare are cost burdened compared to Medicare Advantage (28.4% vs. 12.2%).

- Medicare Advantage beneficiaries report high health care satisfaction and access, particularly as it relates to access to care, including receiving preventive screenings like flu shots and having a usual source of care, as well as ease of seeing their primary care physician and overall satisfaction with quality of care.

In addition to reducing beneficiary out-of-pocket costs and expanded access to care, Medicare Advantage is also delivering improved health outcomes for beneficiaries, especially for those with chronic conditions. Research from Avalere Health found that:

- Beneficiaries with hypertension, hyperlipidemia, and diabetes in Medicare Advantage experienced 33 percent fewer emergency room visits than their FFS Medicare counterparts.[22]

- Similarly, Medicare Advantage beneficiaries with hypertension, hyperlipidemia, and diabetes have nearly 29 percent fewer potentially avoidable hospitalizations, 41 percent fewer avoidable acute hospitalizations, and 18 percent fewer avoidable chronic hospitalizations than FFS Medicare beneficiaries.[23]

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[20] Better Medicare Alliance, Medicare Advantage Outperforms FFS Medicare on Cost Protections for Low-Income and Diverse Populations, April 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FINv2.pdf

[21] Cost burden is defined as spending over 20% of income on health care costs.

[22] Avalere Health, Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to FFS Medicare, July 2018. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf

[23] *Id.*

- Pneumonia vaccination rates among high-need, high-cost Medicare Advantage beneficiaries are as much as 52 percent higher than FFS Medicare vaccination rates.[24]

By providing coordinated care that emphasizes prevention, early detection, and effective management of chronic disease, Medicare Advantage is working to advance the health and well-being of all beneficiaries.

The Role of Telehealth

One important way that Medicare Advantage is working to expand access to care is through telehealth—the use of which has grown exponentially during the COVID-19 public health emergency. Research has documented that Medicare Advantage worked effectively to expand the availability of telehealth and virtual care in part by its leadership in quality improvement activities to offer virtual care solutions to beneficiaries.[25] Moreover, capitated payments from health plans to providers afforded them flexibility to deploy innovative solutions. Separate research also found that Medicare Advantage outperformed FFS Medicare on telehealth access and offers greater access to treatment for ongoing, chronic conditions.[26]

Both telehealth and virtual care have been instrumental to preserving and expanding access to care for Medicare beneficiaries during the public health emergency. Going forward, CMS should further build on this success by updating outdated payment policies and permanently authorizing many of the waivers permitted during the public health emergency.

Special Supplemental Benefits for the Chronically Ill

Expanding access to coverage and care has also been accomplished through health plans offering SSBCI benefits and participating in the CMS Innovation Center's Medicare Advantage Value-Based Insurance Design (V-BID) Model. Over 3 million beneficiaries[27] are enrolled in health plans providing additional supplemental benefits to individuals with chronic conditions and plans have increased their supplemental benefit offerings to this population by 38 percent last year. By providing meal delivery, nutritious food and produce, transportation for non-medical needs, and general supports for living, plans are effectively tailoring their benefits to meet the whole health needs of at-risk and medically complex beneficiaries.

The V-BID model provides another opportunity for Medicare Advantage to offer enhanced supplemental benefits that address social needs, including food and nutrition, transportation,

[24] Better Medicare Alliance, Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-for-Service Medicare, December 2020. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf

[25] Better Medicare Alliance, Telehealth During a Time of Crisis: Medicare Experiences Amid COVID-19, July 2020. Available at: https://bettermedicarealliance.org/publication/telehealth-during-a-time-of-crisis-medicare-experiences-amid-covid-19/; Better Medicare Alliance, The COVID-19 Response: Differences in Medicare Advantage and FFS Medicare in Meeting Beneficiary and Provider Needs, November 2021. Available at: https://bettermedicarealliance.org/wp-content/uploads/2021/11/BMA-HMA-COVID-Response-Project_FIN.pdf

[26] Better Medicare Alliance, Medicare Advantage Sees Fewer COVID-19 Hospitalizations in Beneficiaries and Offers Greater Access to In-Person and Telehealth Non-COVID Care During Pandemic, October 2021. Available at: https://bettermedicarealliance.org/publication/telehealth-during-a-time-of-crisis-medicare-experiences-amid-covid-19/

[27] R. Duddy-Tenbrunsel, S. Donthi, J. Young & T. Kornfield, MA Enrollment in Plans with Extra Benefits for Chronically Ill Tripled in 2021, Avalere Health, February 5, 2021. Available at: https://avalere.com/insights/ma-enrollment-in-plans-with-extra-benefits-for-chronically-ill-tripled-in-2021

and in-home support services. BMA is pleased that model participation has grown significantly and is now projected to reach over 3.7 million beneficiaries this year.[28]

Whether under the authorities of SSBCI or through the V-BID model, the ability to offer tailored supplemental benefits is helping to close gaps in needed care and reduce longstanding health disparities. Medicare Advantage's success in expanding such offerings to an increasingly diverse patient population can serve as a model for expanded benefits in other insurance markets, including by public and private payers.

Prior Authorization and Medical Management

As CMS continues to examine ways to expand access to care, an important area of focus should be on streamlining and simplifying the prior authorization process in Medicare Advantage. While prior authorization and medical management play a critical role in ensuring access to clinically appropriate care and reducing low-value care,[29] BMA believes reforms are necessary to reduce burden on providers and ensure patient access to clinically effective care. For example, requiring electronic prior authorization will simplify the process and reduce patient and provider burden. Moreover, increasing transparency around prior authorization processes can help policymakers and stakeholders better understand the process and help ensure that prior authorization and medical management are based on the best available medical evidence and clinical best practice guidelines.

In sum, BMA recommends the following policy options as CMS considers additional steps to improve access to coverage and care for Medicare beneficiaries:

- **Expand access to telehealth in Medicare and Medicare Advantage by extending or making permanent flexibilities tied to the public health emergency.** For example, CMS should codify the flexibilities permitted during the COVID-19 pandemic, which allows data from audio-visual telehealth encounters to count towards risk adjustment.[30]

- **Preserve flexibility permitted in designing supplemental benefits.** Legislative and regulatory flexibility to design and offer supplemental benefits has expanded access and closed gaps in care for medically complex and vulnerable beneficiaries. As Medicare Advantage continues to focus on SDOH, supplemental benefits are an important tool for addressing care for the whole person and increasingly providing non-medical supplemental benefits to fill critical gaps in care.

- **Require disclosure of additional information about supplemental benefits on the Medicare Plan Finder.** Increasing transparency around supplemental benefit offerings may empower beneficiaries to make more informed choices about their benefit options and making changes to the Plan Finder represents an important way to educate beneficiaries about the availability of supplemental benefits.

[28] Centers for Medicare & Medicaid Services, Medicare Advantage Value-Based Insurance Design Model, last updated August 17, 2022. Available at: https://innovation.cms.gov/innovation-models/vbid
[29] A.M. Fendrick, Reframe the Role of Prior Authorization to Reduce Low-Value Care, *Health Affairs,* July 11, 2022. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20220708.54139/
[30] Department of Health & Human Services, Memo to MAOs, "Applicability of Diagnoses From Telehealth Services for Risk Adjustment," April 10, 2020. Available at: https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf; Department of Health & Human Services, Memo to MAOs, "Applicability of Diagnoses From Telehealth Services for Risk Adjustment - UPDATE," January 15, 2021. Available at: https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-update-1152021.pdf

- **Expand the successful Medicare Advantage V-BID model to include Employer Group Waiver Plans (EGWPs) and consider permanent authorization at the end of the demonstration.** The V-BID model has played an important role in providing beneficiaries with expanded access to non-medical benefit offerings that effectively address the needs of this patient population and reduce disparities. BMA recommends that CMS consider expanding model participation to include all Medicare Advantage plans, including EGWPs. In addition, CMS should consider permanent authorization at the end of the demonstration in order to promote continued investment in the innovations that require multi-year continuity for effectiveness.

- **Support legislative efforts (H.R. 3173/S. 3018, the *Improving Seniors' Timely Access to Care* bill) to streamline and improve the prior authorization process in Medicare Advantage by establishing an electronic prior authorization process and ensuring prior authorization and other medical management processes adhere to evidence-based medical guidelines.** BMA strongly supports bipartisan legislation to streamline and simplify the prior authorization process in Medicare Advantage. By requiring electronic prior authorization, this legislation represents an important step in reducing provider burdens while also ensuring greater transparency around the prior authorization process. Prior authorization is an important tool to ensure access to clinically appropriate care and reduce waste and unnecessary costs in the system. Through these targeted reforms, this legislation would streamline and improve the process for both patients and providers.

Driving Innovation to Promote Person-Centered Care

Better Medicare Alliance appreciates CMS' continued interest in driving innovation to promote person-centered care. Our response focuses on five areas, including the expansion of value-based contracting, the Star Ratings System, the V-BID model, in-home health risk assessments, and EGWPs.

Expansion of Value-Based Contracting

Value-based care models are widely recognized as a leading model to support person-centered care and better health outcomes, and Better Medicare Alliance supports the transition to value-based care. We also believe Medicare Advantage, and its 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.[31] The percentage of payments tied to APMs has increased since HCP-LAN first began measuring and reporting results for Medicare Advantage in 2017.[32]

[31] 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/
[32] Health Care Payment Learning & Action Network, APM Measurement Effort 2018, October 2018. Available at https://hcp-lan.org/workproducts/apm-infographic-2018.pdf

In value-based contracting, a one-size-fits-all approach is not conducive to supporting expansion because every stakeholder begins their transition to value-based care in a different place. For example, a provider may not have an interoperable system, or the capital to invest in a system, that will relay the necessary information to the health plan or community-based organization. For that reason, continued flexibility and stability is vital to expansion efforts as well as giving committed stakeholders the time and space to adequately develop, implement, modify, and evaluate efforts over the course of both the transition to value-based care broadly and within the Center for Medicare & Medicaid Innovation (CMMI) V-BID model. Moreover, transitioning to value-based care models requires extensive time, leadership, capital, and infrastructure, further supporting the continued need for flexibility and stability. As such, each stakeholder has a unique experience that requires flexibility to test, evaluate, and adapt their models that will meet the needs and capabilities of the local population and partner stakeholders.

The transition to value-based care, and the opportunities, successes, and challenges experienced along the way, is best captured by a Better Medicare Alliance Ally, the Vancouver Clinic. During the Vancouver Clinic's transition to value-based care, it took several years to establish and refine their model and develop the infrastructure and partnerships necessary to be successful. Moreover, the transition is a continuous process, adapting to the needs of providers, health plans, and beneficiaries served.[33]

Other Better Medicare Alliance Allies, including ChenMed and Iora Health, are establishing themselves as leaders in the value-based care space. As a physician-led, integrated care medical center, ChenMed provides patient-centered and coordinated care in dozens of practices across the country. By providing value-based care and leveraging rich patient data, ChenMed helps meet the social needs that impact its patients' health.[34] Iora Health demonstrates how Medicare Advantage's comprehensive care capabilities incentivize patient-centered and value-based care. Through its fully integrated and multidisciplinary primary care model, Iora Health keeps its patients happier, healthier, and more engaged in their own care.[35]

To further learn from and expand value-based care and contracting in Medicare Advantage and across CMS' programs broadly, it is critical that all stakeholders, whether it's a provider, health plan, community-based organization, or others, are closely involved in the planning process. This is particularly important when planning and modifying models at CMMI; by engaging stakeholders from the early conception phase to implementation and evaluation phases, barriers and burdens may be identified and addressed early on, leading to smoother adoptions and scaling.

In addition to stakeholder engagement, the expansion of value-based care cannot happen in silos; the transition and reform necessary to truly move towards a health care system rooted in

[33] Better Medicare Alliance, Vancouver Clinic Spotlight on Innovation, January 2022. Available at: https://bettermedicarealliance.org/publication/spotlight-on-innovation-vancouver-clinic/
[34] Better Medicare Alliance, Spotlight on Innovation – ChenMed: Patient-Centered Care for Medicare Advantage Beneficiaries, January 2018. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_ChenMed_Spotlight_2018_01_08.pdf
[35] Better Medicare Alliance, Iora Health Spotlight on Innovation, June 2016. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_Spotlight_06022016.pdf

value-based care must happen across both the public and private sectors and the various programs and populations served. Until the commitment to break down silos is fully realized, the incentives to make the transition are not present.

We appreciate CMS' efforts to further understand the extent of value-based care in Medicare Advantage and identify steps to support and expand value-based care across the program. In consideration with the above, Better Medicare Alliance recommends CMS:

- **Align incentives, metrics, and evaluation processes across demonstrations within CMMI.** Alignment may lessen the burden for participants in CMMI models and remove barriers to participation, particularly for those interested in more than one model.

- **Preserve the flexibility permitted in the V-BID model and other CMMI demonstrations to allow adequate time to pilot health care delivery innovations and expand to the broader Medicare Advantage program where possible.**[36]

- **Continue supporting the transition to value-based care across the Medicare program and CMS more broadly.** BMA appreciates CMS' focus on value-based care as a key lever to improving individual health outcomes, population health, and lowering health care costs both to the beneficiary and the federal government. By focusing on the quality of care provided, value-based care ensures that providers deliver primary and preventive care as well as addressing the unmet social needs of beneficiaries.

The Star Ratings System

Better Medicare Alliance appreciates CMS' interest in understanding the various perspectives and functions of the Star Ratings, as well as the most recent action of modernizing the CAHPS surveys (i.e. piloting a web-based survey method). We look forward to continued engagement as modernization efforts are implemented.[37] As the weight for patient experience and access measures increases from 2 to 4 for CY 2023 Star Ratings,[38] we remain committed to further modernizing the CAHPS surveys, as modernization will lead to more accurate, meaningful, and actionable measurement.[39]

With the growth in weight for patient experience measures, modernization of CAHPS surveys more broadly is necessary so that beneficiaries, providers, health plans, accrediting entities, quality organizations, and policymakers can better rely on the accuracy of the results and information to drive quality as defined by CMS. Our previous research identifies and supports

[36] *See* Department of Health and Human Services. Memo to MAOs "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits." April 27, 2018. Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/hpms%2520memo%2520primarily%2520health%2520related%25204-27-18_21.pdf; *see also* Department of Health and Human Services. Memo to MAOs "Implementing Supplemental Benefits for Chronically Ill Enrollees." April 24, 2019. Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

[37] Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," p. 108, April 4, 2022. Available at: https://www.cms.gov/files/document/2023-announcement.pdf

[38] *Id*. at 78.

[39] 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/

four policy recommendations aimed at resolving limitations in the CAHPS survey that impact patient experience and Star Ratings more generally. First, modernize patient experience measurement in Medicare Advantage by updating the survey language to reflect the diversity of today's beneficiaries, along with the evolution of the Medicare Advantage benefit offerings and how care is delivered today. Second, provide more granular CAHPS results to health plans while protecting beneficiary confidentiality to empower better health plan quality improvement. Third, remove MA-PD CAHPS questions from the patient experience Medicare Advantage Star Ratings that health plans cannot directly impact and continue modernizing the patient experience measurement as the weight increase is now finalized. Lastly, explore ways to reduce burden on the beneficiary survey respondent to improve response rates.[40]

In sum, addressing the limitations and further modernizing CAHPS in light of the weight increase for patient experience measures will improve beneficiary engagement, empower beneficiaries to be a partner in their health care decisions, and continue to enable the delivery of high-quality care to Medicare Advantage beneficiaries.

- **Further engage stakeholders when strengthening metrics in Medicare Advantage (e.g. considering patient experience measures in CAHPS).** Meaningfully engaging stakeholders will aid CMS in overcoming any barriers and limitations in establishing metrics and presenting thoughtful measures that empower beneficiaries to make fully informed decisions about their health care.

Value-Based Insurance Design Model

The public-private partnership foundational to Medicare Advantage leads to exciting innovations in delivering care to seniors and people with disabilities across the country, and Medicare Advantage has made great strides in deploying person-centered strategies and care models through CMMI models, as well as more broadly in the program.

Better Medicare Alliance has previously shared with CMS pathways to test and expand eligibility criteria in the V-BID Model to further address SDOH and advance health equity, including consolidating authorities to promote transparency and reduce confusion around plan offerings and eligibility criteria and allowing EGWPs to participate in the model. Moreover, additional insight into a beneficiary's eligibility and enrollment status in other federal programs like the Supplemental Nutrition Assistance Program (SNAP) may be helpful for both providers and health plans in having a deeper understanding of the populations served. As such, Better Medicare Alliance finds value in CMS working with other agencies and departments to share or link beneficiary eligibility status.

While the V-BID model is still underway and comprehensive evaluation remains outstanding, Better Medicare Alliance is hopeful V-BID will be a successful model, leading to permanent authorization at the end of the demonstration. Early findings show the model has a neutral impact on cost and beneficiaries report positive experiences if participating, and since these preliminary findings, the V-BID model has grown significantly to include other eligibility criteria

[40] *Id.*

for Medicare Advantage beneficiaries.[41] We therefore look forward to further evaluation on the impact the expanded flexibilities are having on beneficiaries as the model continues to promotes innovation and advance the commitment of delivering person-centered care.

In-Home Health Risk Assessments

Similarly, there are other aspects, care models, and tools deployed in Medicare Advantage that help identify and address unmet medical and social needs among beneficiaries. For example, health care is increasingly being delivered in the home and home-based services are often the only clinical touchpoint for many Medicare beneficiaries. During the initial months of the COVID-19 pandemic, in-office visits drastically declined, while telehealth and in-home visits increased,[42] further supporting the importance of an effective and reliable in-home clinical care model. Medicare Advantage leverages in-home clinical visits, also known as in-home health risk assessments, to deliver primary care and address a beneficiary's physical, mental, and functional needs. In-home health risk assessments manage care for acute and chronic conditions, identify and address unmet needs and diseases, and coordinate care by connecting beneficiaries to community resources, follow-up care, and care coordination programs.

In-home health risk assessments are essential to the high-quality, value-based clinical care model deployed in Medicare Advantage, and all in-home health risk assessments should provide clinical care that meets beneficiary needs through a holistic approach. Better Medicare Alliance recommends CMS:

- **Codify the 2016 best practices proposed in the CY 2016 Rate Announcement and Final Call Letter for health risk assessments, which are critical in identifying and addressing unmet medical and social needs among beneficiaries.**[43] Codifying the best practices further promotes the stability and program integrity of Medicare Advantage, while simultaneously raising the bar on the quality of these in-home clinical visits.

Employer Group Waiver Plans

EGWPs represent a successful public-private partnership that addresses the health care needs of an important segment of today's retirees. Roughly 5 million Medicare Advantage beneficiaries are covered by an EGWP product, more than doubling since 2010 and accounts for nearly 20 percent of the Medicare Advantage population.[44] 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. As stated earlier, Better Medicare Alliance supports

[41] Centers for Medicare & Medicaid Services, Center for Medicare & Medicaid Innovation, Synthesis of Evaluation Results Across 21 Medicare Models, 2012-2020, 2022. Available at: https://innovation.cms.gov/data-and-reports/2022/wp-eval-synthesis-21models; https://innovation.cms.gov/data-and-reports/2020/vbid-yr1-3-evalrpt

[42] University of Michigan National Poll on Healthy Aging, "Telehealth Use Among Older Adults Before and During COVID-19," August 17, 2020. Available at: https://www.healthyagingpoll.org/reports-more/report/telehealth-use-among-older-adults-and-during-covid-19; K. Gallagher, J. Gerhart, K. Amin, et al,. "Early 2021 Data Show No Rebound in Health Care Utilization," August 17, 2021. Available at: https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

[43] Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 6, 2015. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

[44] 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/

permitting EGWPs to participate in the V-BID model, as this will further expand access to care and deliver person-centered care to beneficiaries enrolled in EGWPs.

Supporting Affordability and Sustainability

We share CMS' commitment to ensuring beneficiaries have access to affordable, high-value health care options. Our response focuses primarily on risk adjustment and the Medical Loss Ratio (MLR), which CMS has expressed interest in better understanding.

Risk Adjustment in Medicare Advantage

Better Medicare Alliance recognizes the importance of an accurate and sustainable risk adjustment methodology. Accurate and sustainable risk adjustment enables providers, health plans, and others to have adequate resources to deliver the high-quality care and services Medicare Advantage beneficiaries rely on each year. Accurate risk adjustment further facilitates predictable and stable payments, ensuring health plans receive adequate resources to provide comprehensive care for both anticipated and unexpected beneficiary health care needs. Moreover, opportunities are created in Medicare Advantage to coordinate, manage, and deliver patient care in affordable, high-quality, and innovative ways. Accurate risk adjustment benefits the millions of beneficiaries that choose Medicare Advantage through early intervention and more personalized care, leading to improved health outcomes.

One methodology CMS should consider and that will contribute to accurate risk adjustment is codifying the flexibilities permitted during the COVID-19 pandemic which allow data from audio-visual telehealth encounters to count towards risk adjustment. As stated earlier, the use of telehealth during the early days of the pandemic and its further integration into care models since has increased significantly.[45] Moreover, Medicare Advantage beneficiaries have positive experiences and outcomes with telehealth.[46] Omitting the use of data obtained during audio-only telehealth visits unreasonably limits the use of available, timely, and clinically accurate data on these beneficiaries that could be used to provide the required information for millions of Medicare beneficiaries. Without this information, the data required by CMS to inform adequate and accurate payment based on health status will be incomplete and may impact payment stability for providers and health plans in subsequent years, as well as out-of-pocket costs and supplemental benefits for beneficiaries. As such, Better Medicare Alliance recommends CMS:

- **Collaboratively engage stakeholders and rigorously test proposals that may change Medicare Advantage payment to mitigate disruption and negative unintended consequences for beneficiaries**, as collaborative engagement will continue to support the current risk adjustment methodology and ensure a stable, adequate, and appropriate risk adjustment process year over year.

[45] Better Medicare Alliance, The COVID-19 Response: Differences in Medicare Advantage and Fee-for-Service Medicare in Meeting Beneficiary and Provider Needs, November 2021. Available at: https://bettermedicarealliance.org/publication/the-covid-19-response-differences-in-medicare-advantage-and-fee-for-service-medicare-in-meeting-beneficiary-and-provider-needs/; Better Medicare Alliance, Telehealth During a Time of Crisis: Medicare Experiences Amid COVID-19, July 2020. Available at: https://bettermedicarealliance.org/publication/telehealth-during-a-time-of-crisis-medicare-experiences-amid-covid-19/

[46] Better Medicare Alliance, Medicare Advantage Sees Fewer COVID-19 Hospitalizations in Beneficiaries and Offers Greater Access to In-Person and Telehealth Non-COVID Care During Pandemic, October 2021. Available at: https://bettermedicarealliance.org/publication/telehealth-during-a-time-of-crisis-medicare-experiences-amid-covid-19/

- **Codify the applicability of diagnoses from telehealth services for risk adjustment flexibilities issued in CMS guidance from April 2020 and January 2021, in response to the COVID-19 pandemic.[47]**

Considerations for the Proposed Rule on the RADV Process

Better Medicare Alliance appreciates CMS' continued interest in the Risk Adjustment Data Validation (RADV) process and share the Administration's goal of ensuring program integrity. Given the pending final rule, we want to highlight our primary concerns about potential unintended consequences that may occur if the forthcoming RADV rule is finalized as proposed. Specifically, stakeholders have raised significant concerns that the rule as proposed has the potential to create disruption for plans and providers, which may, in turn, affect premiums and benefits for beneficiaries.[48]

Medical Loss Ratio

Better Medicare Alliance appreciates CMS' interest and recent action to better understand the MLR and identify ways to improve and ensure Medicare dollars are going towards beneficiary care. Specifically, certain flexibilities tied to a declared public health emergency that allow health plans to modify their benefit offerings mid-year to adapt to and meet beneficiary needs is valuable. Offering additional flexibility and ability to innovate when needs in the community change allows health plans, and in turn providers, to be more responsive to beneficiary needs and deliver more person-centered care.

As CMS continues its work improving the MLR, it should consider the significant investments stakeholders have made in identifying and addressing beneficiary social needs and how those investments can be accounted for in the MLR. Investments made to identify and address social needs not only improve beneficiary experience but lead to the delivery of more patient-centered care and better outcomes.[49] Because these innovative efforts result in spending on beneficiary care, CMS should begin considering proposals that account for the investments in the MLR.

Lastly, Better Medicare Alliance supports efforts to collect data to better understand supplemental benefits in Medicare Advantage and the role they play in supporting high-value, person-centered care. CMS recently finalized the proposal to reinstate the detailed MLR reporting requirements that were in effect CY 2014-2017 with a few modifications, including reporting expenditures for supplemental benefits.[50] This additional data may offer helpful insight on how resources are dedicated to supplemental benefits. Better Medicare Alliance

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[47] Department of Health & Human Services, Memo to MAOs, "Applicability of Diagnoses From Telehealth Services for Risk Adjustment," April 10, 2020. Available at: https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf; Department of Health & Human Services, Memo to MAOs, "Applicability of Diagnoses From Telehealth Services for Risk Adjustment - UPDATE," January 15, 2021. Available at: https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-update-1152021.pdf

[48] S. Creighton, C. Harris, C. Seals, et al., Overview and Implications of CMS's Proposed Changes to MA RADV, Avalere Health, August 23, 2022. Available at: https://avalere.com/insights/overview-and-implications-of-cmss-proposed-changes-to-ma-radv?utm_campaign=20220823_1661282488_MKEM_Insight%20Alert&utm_medium=email&utm_source=Eloqua&elqTrackId=393ad3a380b44ed3a349b0a693b8baeb&elq=1aeaa0cf2bd3469895c293b62fd5cd5f&elqaid=3010&elqat=1&elqCampaignId=4922

[49] *See* M. Canterberry, J. Figueroa, C. Long, et al., Association Between Self-Reported Health-Related Social Needs and Acute Care Utilization Among Older Adults Enrolled in Medicare Advantage, *JAMA Health Forum*, July 8, 2022. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2794134

[50] Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 27,704, 27,824, May 9, 2022 (to be codified at 42 C.F.R. pts. 417, 422, and 423).

recommends CMS establish clear guidance on the unit health plans are to use to capture and report supplemental benefit spending under the reinstated requirements. Given the nature of many supplemental benefits, a "claims-based" reporting framework may not be appropriate for all supplemental benefits. Rather, a per-member per-month (PMPM) framework may best capture the financing arrangements between the health plan and the partner contracted with for the benefit.

Clear and thoughtful guidance on how CMS would like to see the data captured may 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, guidance will help ensure spending is not reported differently across the different supplemental benefit categories.

Accordingly, Better Medicare Alliance recommends CMS:

- **Permit flexibilities tied to a declared public health emergency (e.g. mid-year benefit modifications) during a non-PHE time to continue meeting the changing needs of beneficiaries.** The ability to modify benefit packages mid-year and respond to changing communities and needs further supports beneficiaries and deliver patient-centered care.

- **Consider proposals to account for investments made in identifying and addressing beneficiary social needs in the MLR.**

- **Establish clear guidance on capturing and reporting expenditures on supplemental benefits as put forth in the MLR.**

Engaging Partners

As an Alliance of 180 diverse organizations and more than 600,000 beneficiary advocates, Better Medicare Alliance is uniquely positioned to convene the Medicare Advantage community, build consensus, and advance innovative solutions that improve the health and wellbeing of seniors and people with disabilities across the country. As the leading research and advocacy organization supporting Medicare Advantage, Better Medicare Alliance is a resource for all stakeholders, including policymakers, and we are eager to further engage with the Administration as it considers the responses to this RFI and prepares for the CY 2024 rate notice and regulatory cycle.