BETTER MEDICARE ALLIANCE

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

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

March 6, 2023

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

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Administrator Brooks-LaSure:

On behalf of the Better Medicare Alliance (BMA) and the 30 million beneficiaries enrolled in Medicare Advantage, we are pleased to submit the following comments on the Advance Notice of Methodological Changes for CY 2024 for MA Capitation Rates and Part C and Part D Payment Policies ("Advance Notice").

Better Medicare Alliance is a diverse coalition of 200 Ally organizations and more than one million 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.

Better Medicare Alliance appreciates CMS' continued efforts to strengthen the Medicare Advantage program and improve access to coverage and care for the 30 million Medicare beneficiaries it serves.

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 key priority areas included in CMS' Strategic Pillars. We look forward to continuing to collaborate and partner with the Administration on advancing progress in these critical areas.

Seniors and individuals with disabilities eligible for Medicare choose and trust the value-driven, affordable, high-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.

Today, Medicare Advantage accounts for 46 percent of all eligible Medicare beneficiaries, and it is estimated that nearly 32 million beneficiaries will be enrolled in Medicare Advantage in 2023.[1]

[1] Medicare Board of Trustees. 2022 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. June 2022. Available at: https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf

Access to Medicare Advantage is nearly universal, and beneficiaries are able to choose from almost 4,000 health plans across the country.[2] For 2023, the average Medicare Advantage premium is $18,[3] a 16-year low, and 99 percent of beneficiaries have access to a $0 premium plan with prescription drug coverage (MA-PD plan).[4] In addition, 97 percent of beneficiaries have access to a health plan that offers dental, vision, hearing, or fitness benefits.[5] All the while, approximately three-quarters of beneficiaries are enrolled in an MA-PD plan with a 4 Star rating or higher in 2023.[6]

A new analysis finds Medicare Advantage beneficiaries report spending $2,400 less on out-of-pocket costs and premiums annually than their Fee-for-Service (FFS) Medicare counterparts.[7] 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.[8] Medicare Advantage beneficiaries are also highly satisfied with their care, earning a 94 percent satisfaction rating in a recent poll; 93 percent also say protecting Medicare Advantage funding should be a priority for the Biden-Harris Administration.[9]

However, Better Medicare Alliance has serious concerns about several proposed policies included in the Advance Notice that would reduce payments to Medicare Advantage, raise costs, and reduce benefits for beneficiaries. As explained in a recent Avalere analysis, "CMS estimates the net growth in Medicare Advantage (MA) plan revenue for 2024 to be -2.27%, a lower growth rate compared to last year's net change of 5%. The change is due to a lower effective growth rate for MA county benchmarks, the expiration of a COVID-19 related adjustment to the 2023 Star Ratings, and changes to the MA risk adjustment model."[10]

We are especially concerned about proposed changes to the risk model which could negatively impact Medicare beneficiaries, especially those with chronic conditions, those who are low income, and those who are dually eligible for Medicaid. As a result, these changes place at risk the substantial progress made in improving care and outcomes for Medicare beneficiaries.

---

[2] Kaiser Family Foundation. Medicare Advantage 2023 Spotlight: First Look. November 2022. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look

[3] Centers for Medicare & Medicare Services. "Biden-Harris Administration Announces Lower Premiums for Medicare Advantage and Prescription Drug Plans in 2023." September 29, 2022. Available at: https://www.cms.gov/newsroom/press-releases/biden-harrisadministration-announces-lower-premiums-medicare-advantage-and-prescription-drug-plans

[4] Kaiser Family Foundation. Medicare Advantage 2023 Spotlight: First Look. November 2022. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look

[5] *Id*.

[6] Centers for Medicare & Medicaid Services. "2023 Medicare Advantage and Part D Star Ratings." October 6, 2022. Available at: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings

[7] Better Medicare Alliance. Medicare Advantage Beneficiaries Spend Less on Health Care Premiums and Out-of-Pocket Costs than Fee-for-Service Beneficiaries. March 2023.

[8] Milliman. Value to the Federal Government of Medicare Advantage. October 2021. Available at: https://bettermedicarealliance.org/wp-content/uploads/2021/10/3400HDP_Value-to-the-federal-government-of-Medicare-Advantage.pdf

[9] Morning Consult & Better Medicare Alliance. Survey Results: Annual Seniors on Medicare Survey. January 2023. Available at: https://bettermedicarealliance.org/wp-content/uploads/2023/02/BMA_Seniors-on-Medicare-Memo_final_R1.pdf

[10] Avalere Health. "Proposed MA Plan Payment Changes May Impact Premiums and Benefits." February 15, 2023. Available at: https://avalere.com/insights/proposed-ma-plan-payment-changes-may-impact-premiums-and-benefits

Moving forward with the risk model changes would negatively impact Medicare Advantage and the 30 million beneficiaries it serves by:

- Increasing Medicare Advantage beneficiaries' out-of-pocket costs by increasing premiums and/or reducing benefits by an average of $540 per beneficiary per year, according to an independent analysis;[11]

- Negatively impacting health care providers, physician organizations, and health systems that provide comprehensive and coordinated care to the most vulnerable Medicare beneficiaries, thereby threatening beneficiary access to high-quality providers; and

- Placing care innovations that provide high-quality care to beneficiaries with chronic conditions, including through value-based care arrangements at risk.

For all these reasons, **we urge CMS not to move forward with these proposed changes to the risk adjustment model for CY 2024** and instead work with stakeholders on clinically based revisions to the model, with appropriate time for analysis and implementation.

We are also concerned with the impact associated with the one-time technical adjustment CMS is making to the calculation of the growth rate. When combined with the changes to the risk model and Star Ratings, we believe these changes will result in significant payment reductions to Medicare Advantage, which will increase costs and/or reduce benefits for Medicare beneficiaries. Therefore, Better Medicare Alliance recommends that the changes CMS has incorporated into the calculation of the annual growth rate should also be phased-in to minimize disruption and maintain stability in the Medicare Advantage program.

Better Medicare Alliance provides further comment on several provisions, including the risk model changes, which are detailed fully in the attachment.

We appreciate your consideration of these comments and recommendations and look forward to engaging 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

[11] *Id*.

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

Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2024

- **CMS-HCC Risk Adjustment Model for CY 2024**

Better Medicare Alliance urges CMS to not move forward with the proposed changes to the risk adjustment model.

CMS is proposing to update the Medicare Advantage CMS Hierarchical Condition Categories (HCC) risk adjustment model. CMS estimates that the combined impact of the risk adjustment changes, including the proposed normalization factor, would result in a 3.12% reduction to 2024 payment to Medicare Advantage plans.

These proposed updates include a clinical reclassification of the HCCs using the ICD-10-CM codes. CMS assessed conditions that are coded with more frequency in Medicare Advantage as compared to Fee-for-Service (FFS) Medicare. As a result of this assessment, CMS proposes to add additional constraints and remove several HCCs to reduce the impact of coding intensity on risk scores. Specifically, CMS proposes to remove 2,269 unique codes from the HCC model, impacting conditions such as major depressive disorder, diabetes with chronic conditions, cardiovascular disease, and rheumatoid arthritis. Other proposed changes by CMS include:

- Implementing a model that uses ICD-10 codes to create HCCs for the first time;
- Increasing the number of payment HCCs and renumbering HCCs;
- Updating data years used for calibrating the model; and
- Other technical changes, including updating the denominator year used for determining the average per capita predicted expenditures.

BMA Comments

Better Medicare Alliance has serious concerns about CMS' proposed changes to the Medicare Advantage risk adjustment model, particularly the proposed removal of 2,269 unique codes from the HCC model.

Better Medicare Alliance supports the goal of updating the risk adjustment model to ensure that Medicare Advantage plans are incentivized to provide high-quality care that meets the needs of all patient populations. However, Better Medicare Alliance is concerned that these proposed changes to the risk model would negatively impact Medicare Advantage beneficiaries, especially those with chronic conditions, those who are low-income, and those who are dual eligible beneficiaries.[12]

[12] *See* Milliman. High-Level Impacts of the Proposed CMS-HCC Risk Score Model on Medicare Advantage Payments for 2024. February 2023. Available at: https://us.milliman.com/en/insight/analysis-of-2024-cms-proposed-hcc-model

These proposed changes counteract with the goals of the risk adjustment program, which are to ensure that payment incentives are properly aligned so that Medicare Advantage plans can provide coverage and care to meet the health care needs of all populations, especially Medicare beneficiaries with chronic conditions. As a result, these changes could jeopardize the substantial progress made in improving care and outcomes for beneficiaries.

By effectively reducing payments to plans and providers who deliver coordinated and comprehensive care to medically underserved and at-risk Medicare beneficiaries, these changes also run counter to the movement toward value-based care, particularly provider organizations that are in risk- and value-based contracts with Medicare Advantage plans.

Moving forward with these changes would have several detrimental impacts on Medicare Advantage and the 30 million beneficiaries it serves. Specifically, the risk model proposal would:

- Increase Medicare Advantage beneficiaries' out-of-pocket costs by increasing premiums and/or reducing benefits;

- Negatively impact health care providers, physician organizations, and health systems that provide comprehensive and coordinated care to the most vulnerable Medicare beneficiaries, thereby threatening beneficiary access to high-quality providers; and

- Place care innovations that provide high-quality care to beneficiaries with chronic conditions, including through value-based care arrangements at risk.

1. Increase Medicare beneficiaries' costs through higher premiums and/or reduced benefits

An analysis by Avalere Health found that CMS' proposed technical changes to the risk model, which would amount to a 3.12% reduction in Medicare Advantage plan payments next year would "have major implications if finalized" particularly as it relates to "beneficiary access and plan payment."[13]

A separate analysis by Avalere examined the impact of CMS' proposed payment policies on Medicare Advantage beneficiaries and found that the "decrease in payment to plans could result in less funding that plans use to offer supplemental benefits and lower premiums for enrollees. Avalere estimates that the decrease in payment could result in a $540 decrease in benefits per member per year."[14]

The estimated beneficiary impact is driven by CMS' Advance Notice payment reductions that could amount to a 29% nationwide reduction in average Medicare Advantage plan rebates, which plans use to fund additional benefits or reduce premiums for beneficiaries. Avalere concluded that if CMS finalizes the proposed changes, "beneficiaries could see plans reduce

[13] Avalere Health. "2024 Advance Notice Would Substantially Alter Risk Adjustment Model." February 2, 2023. Available at: https://avalere.com/insights/2024-advance-notice-would-substantially-alter-risk-adjustment-model
[14] Avalere Health. "Proposed MA Plan Payment Changes May Impact Premiums and Benefits." February 15, 2023. Available at: https://avalere.com/insights/proposed-ma-plan-payment-changes-may-impact-premiums-and-benefits

their 2024 benefits to keep premiums at their 2023 rate, increase their 2024 premiums to offer the same 2023 benefits, or a combination of both."[15]

2. Negatively impact providers that care for Medicare beneficiaries, especially for vulnerable patient populations

Better Medicare Alliance is concerned that the risk model changes would negatively impact health care providers, especially physician organizations and health systems that provide care to medically underserved and at-risk populations. The leading national association representing physician groups, America's Physician Groups, noted that their members "will face revenue cuts ranging from more than 10 percent to as much as 20 percent in caring for their Medicare patients enrolled in MA."[16]

As a result of these payment reductions, America's Physician Groups warns that many physician organizations could be forced to close outpatient facilities in underserved areas, including inner city and rural clinics and cause "thousands of vulnerable Medicare Advantage enrollees to lose needed access to care."[17]

3. Place innovative care coordination models and value-based care arrangements at risk

Medicare Advantage is a leader in value-based care arrangements, including risk and population-based models.[18] For the increasing number of physician organizations and health systems that enter into value-based arrangements and delegated risk arrangements with Medicare Advantage plans, the impact of these proposed risk model changes could have profound implications and create serious beneficiary access issues.

The proposed changes to the risk model, and the magnitude of the payment reductions, could cause physician organizations to reconsider these value-based arrangements. America's Physician Groups has cautioned that as a result of these proposed changes "delegated risk contracts and caring for disadvantaged Medicare Advantage enrollees will no longer be viable."[19] As a result, physician organizations could be forced to abandon these partnerships with Medicare Advantage and return to fee-for-service, with Medicare Advantage beneficiaries losing access to their providers and specialty group practices.

For all of these reasons, **Better Medicare Alliance urges CMS to not move forward with the proposed changes to the risk adjustment model for CY 2024** and instead work with stakeholders in a thoughtful, data-driven, and transparent process to consider clinically-based revisions to the risk model, with appropriate time for analysis and implementation. Any proposed changes to the risk adjustment model, developed with input from stakeholders and experts, should be appropriately phased-in to ensure successful implementation of clinically-based updates, stability, and predictability in the risk adjustment model.

---

[15] *Id*.
[16] APG Statement on 2024 Medicare Advantage and Part D Advance Notice." February 8, 2023. Available at: https://www.apg.org/news/apg-statement-on-2024-medicare-advantage-and-part-d-advance-notice/
[17] *Id*.
[18] HCP LAN. APM Measurement, Progress of Alternative Payment Models. 2022 Methodology and Results Report. November 2022. Available at: https://hcp-lan.org/apm-measurement-effort/2022-apm/
[19] APG Statement on 2024 Medicare Advantage and Part D Advance Notice." February 8, 2023. Available at: https://www.apg.org/news/apg-statement-on-2024-medicare-advantage-and-part-d-advance-notice/

There is precedent for CMS to phase-in new payment policies. The last time CMS made significant changes to the risk adjustment model, changes were incorporated over four years. Phasing in new policies allows stakeholders to incrementally implement changes over time in a way that minimizes disruption to beneficiaries.

Further, any proposed and substantive changes to the risk adjustment model such as those in this Advance Notice necessitate a longer comment period so that stakeholders have sufficient time to assess the impact of any changes to the risk model. CMS should allow for meaningful opportunities for dialogue and input from stakeholders as changes are considered.

- **Direct Graduate Medical Education and Indirect Medical Education Adjustments**

Better Medicare Alliance recommends that CMS delay the implementation for removing graduate medical education costs from the growth rate and not move forward with this technical change in CY 2024.

CMS noted that the growth rate is driven primarily by growth of FFS per capita cost. In addition, CMS proposes a one-time technical correction to account for removal of graduate medical education costs. CMS previously included these costs in the calculation of the growth rate and the removal of these costs lowers the FFS spending growth rate by 2.13%.

BMA Comments
Better Medicare Alliance recommends that CMS delay the implementation for removing graduate medical education costs from the growth rate and not move forward with this technical change in CY 2024. When combined with the changes to the risk model and Star Ratings, we believe these changes will result in significant payment reductions to Medicare Advantage, which will increase costs and/or reduce benefits for Medicare Advantage beneficiaries.

As an alternative, we recommend CMS finalize a phased-in approach for the removal of graduate medical education costs from the growth rate, in order to maintain stability in Medicare Advantage payments for 2024. A phase-in can be implemented similar to how CMS handled the original indirect medical education phase-out under § 1853(k)(4)(B)(ii) of the Social Security Act, and we recommend CMS phase-in this change over several years. The statutory maximum of 0.60% annually outlined in § 1853(k)(4)(B)(ii) is an example of how to provide more stability to beneficiaries for a technical change in methodology that results in a significant impact.

- **MA ESRD Rates**

Better Medicare Alliance appreciates CMS' continued analysis of the methodology for setting ESRD payment rates in Medicare Advantage, and we reaffirm our request for CMS to change Medicare Advantage ESRD rates to a sub-state level to ensure payment and policies enable Medicare Advantage plans and providers to offer high-quality care and treatment for beneficiaries with ESRD, without decreasing supplemental benefits or increasing premiums or the cost burden for all Medicare Advantage beneficiaries. We further request additional information on CMS' analysis to arrive at the decision to set ESRD rates at the state level.

Consistent with previous years, CMS proposes to set Medicare Advantage ESRD rates on the state level and use updated FFS costs, including reimbursement and enrollment data from 2017-2021 for beneficiaries receiving dialysis services.

BMA Comments

Better Medicare Alliance supports access to Medicare Advantage for beneficiaries with ESRD, with 2021 being the first year all Medicare beneficiaries with ESRD could choose and enroll in Medicare Advantage. In January 2021, over 40,000 beneficiaries with ESRD enrolled in Medicare Advantage. As a result, the share of beneficiaries with ESRD in Medicare Advantage grew from 22.7% to 30.3%.[20] As the share of beneficiaries with ESRD choosing Medicare Advantage increases, we urge CMS to ensure Medicare Advantage ESRD payment rates are accurate, stable, and sufficient. Better Medicare Alliance seeks to ensure beneficiaries with ESRD, as well as all other Medicare Advantage beneficiaries, do not see higher out-of-pocket costs, reduced benefits, or limited service areas as a result of increased enrollment of beneficiaries with ESRD in Medicare Advantage.

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

We urge CMS to continue its consideration of changes to the methodology to calculate Medicare Advantage ESRD rates to reduce year-over-year volatility, reflect actual costs, and ensure accurate and adequate payments for the ESRD population. We appreciate CMS' further consideration since last year, particularly as it relates to the Area Deprivation Index (ADI), though we do request additional transparency on CMS' analysis and application of the ADI as it will help us better understand the differences across the country and impact the current and any future alternative methodologies may have on beneficiaries with ESRD.

Specifically, we request CMS provide additional information on the analysis conducted in the CY 2023 Advance Notice and what the change and impact was on ESRD payment rates in the medically underserved areas when assessed on the state and sub-state levels. Further, it will be helpful to know how many Medicare Advantage beneficiaries are located in these areas. Second, we request additional information on what the change and impact was on ESRD payment rates in Core-Based Statistical Areas (CBSAs) with a low ADI compared to a high ADI as noted in this Advance Notice. Moreover, understanding the range in variation will further help in understanding the magnitude of setting ESRD payment rates on a sub-state level versus a state level. Lastly, we request CMS provide the number of Medicare Advantage beneficiaries with ESRD that are located in the CBSAs with a low ADI, as assessed in this Advance Notice.

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

We appreciate any additional information on CMS' analysis conducted in preparation for this year's Advance Notice.

We maintain our concern that ESRD payment rates should be calculated on a sub-state level basis. A 2019 analysis comparing Medicare Advantage ESRD rates based on state level rates to actual costs in FFS Medicare finds FFS Medicare costs for beneficiaries with ESRD exceed the Medicare Advantage ESRD rates, and payment is lower for Medicare Advantage beneficiaries in certain geographic areas across the country.[21] This underpayment typically occurs in high-density metropolitan areas, likely resulting in payment not being adequate for beneficiaries residing in those specific areas.

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

In addition to Medicare Advantage plans receiving lower payments relative to FFS Medicare costs, there are other financial pressures when contracting for dialysis services. Due to the market concentration of dialysis providers, Medicare Advantage plans pay on average about 14 percent higher than FFS Medicare rates for dialysis services.[22] MedPAC estimates 15 percent of Medicare Advantage contracts "paid rates at or above 40 percent of FFS rates."[23] Because they are unable to negotiate rates closer to FFS Medicare rates, plans may "offset higher dialysis spending by reducing costs for other services provided to these enrollees (e.g. care coordination to reduce inpatient hospital and emergency room visits) or risk losses on ESRD enrollees."[24] As such, changing the methodology to a sub-state level rate may assist in lessening the financial pressures health plans face in delivering care to beneficiaries with ESRD and ensure critical benefits like care coordination are not reduced for this population.

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

[22] MedPAC, Report to Congress: Medicare Payment Policy, March 2021, 389-90. Available at: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf

[23] *Id.* at 390.

[24] *Id.* at 389.

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

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

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

Moreover, a change in payment methodology will reduce the disparities among beneficiaries with ESRD that live in urban or metropolitan areas relative to those that live in more rural areas of a state. One analysis shows the number of Medicare Advantage beneficiaries with ESRD living in urban settings greatly outnumbers those living in rural settings, 161,728 beneficiaries and 7,782 beneficiaries, respectively. Beneficiaries with ESRD living in urban areas enroll in Medicare Advantage at a higher rate than in rural areas, 35% and 27%, respectively. Higher representation among Medicare Advantage beneficiaries with ESRD in urban areas is consistent when comparing full dual, partial dual, and non-dual populations by geography. Furthermore, Black and Latino beneficiaries with ESRD living in urban areas enroll in Medicare Advantage at slightly higher rates than white beneficiaries with ESRD, 39% and 36%, respectively compared to 34%.[25] The table in Attachment B further shows beneficiaries with ESRD disproportionately live in urban areas. Because of the cost of care difference between

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

urban and rural areas, a methodology change will provide additional resources to adequately deliver high-quality care and further advance health equity, a goal Better Medicare Alliance and CMS share.

For the reasons stated above, Better Medicare Alliance supports adopting a sub-state level ESRD payment rate methodology to ensure payments are accurate, stable, and sufficient, and request further examination of this methodology and information around CMS' analysis leading to its conclusion that the current ESRD payment rates and methodology are sufficient to deliver care to this complex population.

- **MA Employer Group Waiver Plans**

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

CMS proposes to continue the current payment methodology used in 2023 for CY 2024, as well as waiving Bid Pricing Tool bidding requirements. The policy permitting EGWPs to buy down Part B premiums will also continue. CMS again published preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice following inclusion in 2022.

BMA Comments
EGWPs represent a successful public-private partnership that addresses the health care needs of an important segment of today's retirees and accounts for nearly 20% of the Medicare Advantage population.[26] EGWPs successfully enable employers nationwide to maintain consistent benefits and manage costs for retirees' health coverage. Employers, state and local governments, and unions increasingly rely on Medicare Advantage to provide health benefits to retirees.

Accordingly, Better Medicare Alliance supports CMS' proposal to continue the current methodology and the Bid Pricing Tool for EGWPs for CY 2024, and we support the continuation of the policy permitting EGWPs to buy down Part B premiums. Furthermore, we appreciate CMS' intent to continue adjusting the individual plan bid-to-benchmark ratios to account for enrollment differences based on the timing of the Rate Announcement release and publishing preliminary bid-to-benchmark ratios ahead of the Final Rate Announcement. Providing the additional month supports EGWPs in what to expect for the upcoming year.

[26] Kaiser Family Foundation. Medicare Advantage in 2022: Enrollment Update and Key Trends. August 2022. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

Updates for Part C and D Star Ratings

- **Changes to Existing Star Ratings Measures for the 2023 Measurement Year and Beyond**

Better Medicare Alliance appreciates CMS sharing future Star Ratings meaures it is considering for implementation and the opportunity to share feedback. We are encouraged to see CMS considering a Universal Foundation of quality measures and offer comments specific to that consideration.

CMS is considering the implementation of a Universal Foundation of quality measures, which is a core set of quality measures aligned across CMS programs.

BMA Comments
Better Medicare Alliance appreciates CMS' commitment to ensuring high-quality care is delivered in Medicare Advantage and across all CMS programs, and we are supportive of CMS' intent to align standards across certain measure domains. The domains that CMS focuses on, including wellness and prevention, chronic conditions, behavioral health, care coordination, person-centered care, and equity are all domains Better Medicare Alliance recognizes as critical components of the Medicare Advantage model and where beneficiary impact is the greatest.

We further support the reasoning for establishing a core set of measures, including reducing the burden for stakeholders, espeically providers who typically navigate a variety of payers in a single day, promoting uniformity, and increasing the focus on outcomes-based measures. As CMS considers the core measures and program specific add-ons, we request it be done thoughtfully and with stakeholder input, and we look forward to engaging with the Administration on the identification and inclusion of a Universal Foundation in Stars.

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

Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures (Part C)
Better Medicare Alliance supports efforts to simplify the identification of chronic conditions. We appreciate NCQA's reevaluation efforts and support the potential change as proposed.

NCQA is evaluating how to identify beneficiaries with chronic conditions by incorporating clinical data, including simplifying the method, and CMS will consider updates for measurement year 2024 by adding clarifications.

BMA Comments
Chronic conditions are highly prevalent within the Medicare population[27] and health care spending for beneficiaries increases with the number of chronic conditions a beneficiary has.[28] As such, the identification of chronic conditions is critical to properly manage and deliver care to

[27] The Commonwealth Fund. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? October 2021. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ
[28] Centers for Medicare & Medicaid Services. 2018 Chartbook and Charts. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts

beneficiaries and reduce health care spending. Better Medicare Alliance appreciates efforts to simplify how chronic conditions are identified with clinical data and supports NCQA's consideration of the method to identify beneficiaries.

Social Connection Screening and Intervention (Part C)
Better Medicare Alliance supports efforts to better understand social connection among beneficiaries and applicable interventions. We're encouraged that NCQA is considering a measure and that CMS is interested in its potential use for display or in Stars.

NCQA is developing and CMS is considering a new measure to screen people 65 years and older for social isolation, loneliness, or inadequate social support using pre-specified instruments and identifying those that received the corresponding intervention if screened positive.

BMA Comments
Social isolation, loneliness, and inadequate social support is a growing concern in the U.S., especially over the last few years and during the pandemic. Between 2020 and 2022, severe loneliness among older adults increased 64% during initial screening by one organization and the prevalence of loneliness increased 5% since the beginning of the pandemic.[29] Loneliness in older adults also contributes to poorer health outcomes; older adults experience a higher risk of mortality and increased risk of heart disease, stroke, and dementia.[30] Moreover, data finds people who are lonely utilize more health care, including visits to the emergency department.[31]

Screening for social isolation, loneliness, and inadequate social support helps identify beneficiaries that already experience or are at risk for experiencing one or more of these needs, thus inclusion of this measure in Stars will further encourage health plans, providers, and the broader health care community to address gaps in supports among seniors and people with disabilities.

Similar to other screening and intervention proposals for social needs and supports, organizations are already innovating in this space and developing screening tools and initiatives to implement across markets and populations. We encourage CMS, and in turn NCQA, to conduct outreach with stakeholders to further inform the development of a measure for Stars. Further engagement between stakeholders and CMS provides the opportunity to align current screening and data collection efforts by working within established tools.

Moreover, we support actions that incentivize and promote screening and interventions on behalf of the beneficiary to social connection. Better Medicare Alliance requests additional information on how CMS intends to measure whether a beneficiary received an intervention when screened positive. During qualitative interviews for recent research and as shared by our Allies, stakeholders have expressed concern that even when a need is identified, more harm results because the community lacks the resources necessary to properly address the unmet

[29] Papa. Loneliness is a Public Health Crisis – And It's on the Rise. Available at: https://resources.papa.com/hp-infographic-loneliness-is-a-pandemic
[30] *Id.*
[31] Papa. How Social Support Improves Health Care Utilization. 2023. Available at: https://resources.papa.com/hp-researchbrief-social-support-health-care-utilization

need.[32] As such, we are concerned that if the measure necessitates beneficiaries receiving an intervention, health plans will be unfairly penalized for lack of resources in the community. We request CMS continue engaging with stakeholders as it considers developing a measure based on NCQA's work for social connection.

Better Medicare Alliance appreciates and supports NCQA and CMS' recognition of the impact social connection has on a beneficiary's health and wellbeing, as we believe this measure will promote improved health outcomes and beneficiary experience and engagement. We look forward to further engagement on this measure as it is developed and considered for future use.

Broadening the Mental Health Conditions Assessed by HOS (Part C)
Better Medicare Alliance shares CMS' goals of better understanding the prevalence of mental health conditions in the Medicare Advantage population and screen for mental health and support efforts in meeting this goal though we request additional information and consideration of the impact including these measures will have on beneficiaries.

CMS is considering adding the Generalized Anxiety Disorder (GAD-2) measure to HOS to enhance the survey's ability to screen for mental health access and is soliciting feedback on the value of adding the GAD-2 measure and if it fills gaps in HOS mental health measurement.

BMA Comments
Behavioral and mental health is an important issue in the Medicare population, with nearly half of Medicare beneficiaries experiencing a behavioral health need. Specifically, over a third of all Medicare Advantage beneficiaries have a mental health condition, and it is likely this is underreported due to longstanding reservations or hesitancy around disclosing a behavioral or mental health concern.[33] Better Medicare Alliance supports efforts to better screen for mental health conditions so beneficiaries can receive the care they need to live a healthy and fulfilling life. As CMS explores ways to broaden the screening for mental health conditions, we encourage CMS to consider the impact it will have on stakeholders and specifically beneficiaries, and if there are other ways to assess outside of HOS.

We ask CMS provide additional information on what will be done with the data once collected and how to best provide actionable data to Medicare Advantage plans, as they are currently limited in their ability to assess and identify immediate actions for addressing beneficiary needs. Additional information may include whether there will be appropriate follow up with the beneficiary, whether the same measures will be mandated in other tools and assessments such as the initial or annual health assessment, and whether treatment is necessary if screened positive through the HOS and what the implications are. Finally, Better Medicare Alliance requests CMS consider how this will contribute to the broader, ongoing mental health parity discussions. For example, HOS is limited to a sample of Medicare Advantage beneficiaries, and we believe it is important to better understand how including these measures on HOS may

[32] *See* Center for Innovation in Medicare Advantage, Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, August 2021. Available at: https://bettermedicarealliance.org/publication/report-innovative-approaches-to-addressing-social-determinants-of-health-for-medicare-advantage-beneficiaries/
[33] Better Medicare Alliance. Approaches to Meet Behavioral Health Needs in Medicare Advantage. October 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/11/BMA_Approaches-to-Meet-Behavioral-Health-Needs-in-Medicare-Advantage-Brief-FIN-1.pdf

impact overall understanding and strategies around addressing mental health parity across the country.

Addressing Unmet Health-Related Social Needs on HOS (Part C)
Better Medicare Alliance supports efforts to better understand a beneficiary's needs, including social needs and believe the information gathered from this data collection will further inform the innovative initiatives already underway to address unmet social needs. Nevertheless, we encourage CMS to consider the current, robust data ecosystem and whether additional collection efforts are necessary or alternatively, whether there are alignment opportunities in data collection.

CMS is soliciting feedback on the value of collecting unmet health-related social needs information and if health plans use HOS to collect the information.

BMA Comments
In recent years, providers, community partners, and health plans have invested in and improved their data collection efforts around social risk factors and unmet needs. As a result, a robust data ecosystem now exists among stakeholders. While there is variability in whether the beneficiary's perception of their needs is captured, Better Medicare Alliance encourages CMS to engage with stakeholders to better understand the existing data around potential gaps in beneficiary social care in an effort to reduce reporting and collection redundancies. As CMS further examines questions around capturing this data, we look forward to working with CMS and stakeholders to develop questions resulting in rich and thoughtful data for the health care community.

- **CAHPS**

Better Medicare Alliance commends CMS for taking steps to modernize CAHPS, as we have long supported efforts to modernize the survey in order to increase response rates, reflect the current beneficiary experience, and include measures that health plans have direct actionability and influence over.

In the CY 2023 Medicare Advantage Advance Notice, CMS proposed piloting a web-based mode in administering the MA and PDP CAHPS surveys to test response rate. CMS found MA response rates increased 4 percent and found little change in the PDP responses. In an effort to continue improving response rates to CAHPS surveys and potentially contribute to long-term cost savings for health plans in administering the surveys, CMS plans to implement the web-based mode in the 2024 CAHPS survey implementation.

CMS also tested modifications to the Getting Appointments and Care Quickly measure, including removing the item around waiting more than 15 minutes and considering whether to remove the item from the question for the 2024 survey.

BMA Comments
Aligning with previous Better Medicare Alliance recommendations, implementing a web-based mode for the CAHPS survey recognizes the advancements in how people prefer and do interact

with the health care system broadly.[34] It further recognizes the growing diversity of the Medicare Advantage population and languages spoken and is a positive step in modernizing the CAHPS survey. We applaud CMS' work on piloting and moving forward with a web-based mode, though we reaffirm that beneficiaries may still experience additional barriers created by utilizing internet to conduct the survey, as not all beneficiaries have access to internet or devices that connect to the internet. As such, CMS must ensure there are pathways to adequately capture responses by beneficiaries that do not have adequate access to internet or devices necessary to complete an online survey.[35] We ask that CMS begin working with health plans and survey vendors on the introduction of this new survey method to better understand the digital tools and outreach methods that will be used.

Better Medicare Alliance further supports the removal of questions and meaures that health plans do not have direct actionability or influence over. Accordingly, we appreciate CMS' consideration of removing the question related to waiting for more than 15 minutes in the Getting Appointments and Care Quickly measure of the survey. While measuring ease of getting and receiving care in a timely manner is important, there are factors that are not within the direct control of a health plan, such as how long a beneficiary waits at the provider's office, and health plans and subsequently, beneficiaries, should not be penalized. Better Medicare Alliance applauds CMS' efforts to modernize and update the CAHPS survey and looks forward to being an active partner as CMS explores ways to further modernize CAHPS to reflect the current Medicare Advantage beneficiary experience.

[34] 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/wp-content/uploads/2021/01/BMA-Patient-Experience-Policy-Report-FIN.pdf

[35] *See* Better Medicare Alliance. Comment Letter on Advance Notice of Methodological Changes for CY 2023 for MA Capitation Rates and Part C and Part D Payment Policies. March 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/03/BMA-Comment-Letter-2023-Advance-Notice.pdf

BETTER MEDICARE ALLIANCE

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

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

ATTACHMENT B

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

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

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