BETTER MEDICARE ALLIANCE

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

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

February 13, 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: CMS-4201-P, Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Administrator Brooks-LaSure:

Better Medicare Alliance (BMA) is pleased to submit the following comments on the proposed Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs ("Proposed Rule") on behalf of our Alliance and the 30 million beneficiaries enrolled in Medicare Advantage. 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.

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] 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

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[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
[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.*

or higher in 2023.[6] A recent analysis finds Medicare Advantage beneficiaries report spending nearly $2,000 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]

We commend CMS' work on delivering this comprehensive Proposed Rule and appreciate the agency's engagement with stakeholders across the health care spectrum ahead of the rulemaking process. At the same time, we strongly urge CMS to consider the broader Medicare Advantage policy environment and recognize the net impact of the proposals in this Proposed Rule along with other proposed policy changes, most especially the payment and policy changes proposed in the CY 2024 Advance Notice.[10]

Better Medicare Alliance has serious concerns that these proposed payment cuts would raise costs and reduce benefits for 30 million Medicare Advantage beneficiaries.[11] Therefore, we urge CMS to maintain stability and predictability in the regulatory and payment environment in order to avoid disruptions and maintain high-quality care for beneficiaries. Better Medicare Alliance has comments on several provisions, briefly highlighted below, and detailed fully in the attachment.

- **Promote health equity in Medicare Advantage by finalizing policy changes to ensure the delivery of culturally competent care, improve digital health literacy, and reduce health disparities by building on and strengthening Medicare Advantage quality improvement programs.** Better Medicare Alliance supports these policy changes as a way to continue progress in closing gaps in care and reducing racial and ethnic disparities in Medicare Advantage. In particular, Medicare Advantage quality improvement programs provide an effective mechanism for reducing disparities in health and health care for Medicare beneficiaries.

- **Strengthen and expand access to mental and behavioral health in Medicare Advantage by increasing access to specialists and requiring care coordination of community, social, and behavioral health services.** CMS' proposed policies will improve access to comprehensive mental and behavioral health services to address the needs of millions of Medicare beneficiaries with mental health conditions.

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[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 Outperforms Fee-for-Service 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
[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 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/01/BMA_Seniors-on-Medicare-Memo_final3.pdf
[10] Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. February 1, 2023. Available at: https://www.cms.gov/files/document/2024-advance-notice.pdf
[11] Better Medicare Alliance. Statement on Proposal to Cut Medicare Advantage. February 2, 2023. Available at: https://bettermedicarealliance.org/news/bma-statement-on-cms-proposal-to-cut-medicare-advantage/

- **Modernize and reform the prior authorization process in Medicare Advantage to ensure timely and clinically appropriate access to care for beneficiaries.** Better Medicare Alliance supports efforts to modernize and streamline the prior authorization process in Medicare Advantage. Specifically, we appreciate CMS' proposed steps to ensure timely access to care by adopting continuity of care requirements and ensuring that utilization management and prior authorization are aligned and consistent with Medicare coverage rules and widely used clinical treatment guidelines.

- **Protect Medicare beneficiaries by strengthening oversight over Medicare Advantage marketing materials and communications to ensure that consumers have access to accurate and complete information about their Medicare coverage choices and options.** Better Medicare Alliance appreciates CMS' efforts to address and protect consumers from misleading advertising by including new requirements on third-party marketing organizations and strengthening the role of Medicare Advantage plans in monitoring agent and broker activity to ensure compliance with CMS requirements.

- **Support CMS' efforts to promote continued improvement in quality, including for high-performing Medicare Advantage plans, and providing incentives for reducing health disparities through the Star Rating System.** However, Better Medicare Alliance has concerns about the cumulative impact of these changes to the Star Rating System and encourages CMS to take steps to mitigate the potential for disruption, including potential changes to the hold harmless policy.

Better Medicare Alliance shares the Administration's commitment to Medicare Advantage policies that ensure the program remains a critical part of promoting value-based, person-centered care for Medicare beneficiaries. Continued support for Medicare Advantage has led to increased enrollment, higher provider engagement in value-based payment arrangements, new relationships with community partners, lower consumer costs, and widespread support from policymakers. CMS' support for this integrated care model has driven innovation in financing and care delivery for millions of Medicare beneficiaries.

We appreciate your efforts, and we look forward to continued engagement and partnership to ensure Medicare Advantage continues offering high-quality and affordable care and extra benefits tailored to meet the needs of current and future Medicare beneficiaries.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

Attachment A

Healthy Equity in Medicare Advantage

Better Medicare Alliance has long supported efforts to advance health equity and reduce disparities in outcomes and access to coverage and care throughout the health care system, and we appreciate CMS' continued efforts in this area. As a diverse community of Allies and partners, Better Medicare Alliance strongly supports efforts to advance health equity by expanding access to care, reducing disparities, and closing gaps in care for underserved 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 social determinants of health (SDOH), typically by offering supplemental benefits tailored to the specific needs of patients and beneficiaries. As such, Better Medicare Alliance appreciates CMS' proposals in this proposed rule to further advance health equity though we urge CMS to further contemplate all current proposals, including the Advance Notice, related to Medicare Advantage to ensure each proposal advances health equity and is not counter to the Administration's broader efforts in reducing health care disparities.

- **Ensuring Equitable Access to MA Services (§ 422.112)**

Better Medicare Alliance shares CMS' commitment to ensuring equitable access to care and supports expanding the list of examples of underserved populations to whom a Medicare Advantage Organization (MAO) must ensure services are provided in a culturally competent manner and promote equitable access to services.

CMS proposes to clarify the list of examples of underserved populations to whom an MAO must ensure services are provided in a culturally competent manner and promote equitable access to services. The proposed new list will include: people with limited English proficiency or reading skills; people of ethnic, cultural, racial, or religious minorities; people with disabilities; people who identify as lesbian, gay, bisexual, or other diverse sexual orientations; people who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; people who live in rural areas and other areas of high deprivation; and people otherwise adversely affected by persistent poverty or inequality.

BMA Comments

Better Medicare Alliance supports efforts to explicitly define the underserved populations MAOs must provide care and services to, as this sets clear intentions and reaffirms not only the Administration's commitment to advancing health equity but also those across the health care community. Currently, Medicare Advantage serves an increasingly diverse and low-income population. Approximately 60 percent of Latino Medicare beneficiaries and 58 percent of Black Medicare beneficiaries are enrolled in Medicare Advantage.[12] Further, over half of all Medicare Advantage beneficiaries (52.7 percent) live below 200 percent of the federal poverty level

[12] Analysis of CMS Master Beneficiary Summary File. March 2022.

(FPL).[13] Enrollment in Medicare Advantage also reaches across the diverse communities in America, including counties with extreme access considerations (CEAC). While participation in Medicare Advantage in CEAC and rural geographies are approximately 24 percent and 38 percent, respectively, access to Medicare Advantage in these specific, and more rural communities, is high.[14] Lastly, Medicare Advantage beneficiaries are more likely to live in socially vulnerable counties relative to FFS Medicare beneficiaries; 38 percent of Medicare Advantage beneficiaries live in the top quartile of socially vulnerable counties compared to 33 percent in FFS Medicare.[15]

Certain flexibilities granted in Medicare Advantage enable health plans and their partners to deliver comprehensive care and services, particularly to underserved populations. Supplemental benefits are a critical tool in Medicare Advantage to address both health-related and non-health-related needs of beneficiaries. Following CMS' guidance relaxing the definition of "primarily health-related" and the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI), health plans have significantly increased their supplemental benefit offerings each year and as a result, these benefits are nearly universal.[16] Year over year, health plan offerings of supplemental benefits, including expanded primarily health-related and SSBCI offerings, increase. Specifically, offerings around food and produce benefits, transportation for non-medical needs, and general supports for living have seen the most growth.[17] Not only have health plans increased their offerings, but they have also developed innovative solutions and partnerships to address social determinants of health with the supplemental benefits offered.[18]

In sum, Medicare Advantage is uniquely positioned to deliver high-quality care and services to underserved populations, and data supports that many already choose to enroll in Medicare Advantage. By defining and reinforcing the underserved populations MAOs must provide care and services to, the innovative care being delivered will continue with the aim of advancing health equity for these populations and all Medicare Advantage beneficiaries.

- **MA Provider Directories (§ 422.111)**

Better Medicare Alliance appreciates CMS' goal to better identify providers with cultural and linguistic capabilities offered by the provider or someone in their office as well as identifying and increasing access to providers that offer medications for opioid use disorder (MOUD) and support these efforts. However, we do note that there may be general challenges around

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[13] Better Medicare Alliance. Medicare Advantage Outperforms Fee-For-Service 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

[14] Analysis of CMS Master Beneficiary Summary File. March 2022.

[15] *Id*.; The Social Vulnerability Index (SVI) ranks counties from most to least vulnerable, using 16 factors that relies on 4 themes, including socioeconomic status, householder characteristics, racial and ethnic minority status, and housing type and transportation.

[16] *See* Milliman. Overview of Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2022 Offerings. March 2022. Available at: https://bettermedicarealliance.org/news/study-99-9-of-medicare-advantage-plans-offering-supplemental-benefits-in-2022/; *see also* Milliman. Review of Contract Year 2023 Medicare Advantage Expanded Supplemental Healthcare Benefit Offerings. November 2022. Available at: https://bettermedicarealliance.org/wp-content/uploads/2022/11/Milliman-Issue-Brief-CY-2023-MA-EPHR-Supplemental-Benefits-final.pdf

[17] *Id*.

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

collecting and maintaining timely data and records and further recognize recent legislative changes that potentially render the designation of prescribers of MOUDs a non-issue.

CMS proposes to require MAOs to include providers' cultural and linguistic capabilities and identify certain providers waived to treat patients with MOUD in their provider directories by codifying best practices.

BMA Comments

Better Medicare Alliance supports CMS' proposal to require certain designations in provider directories as codifying these best practices recognizes the diverse needs of the Medicare Advantage population and aims to be more inclusive and accessible in delivering health care to the entire population. By requiring the identification of providers with cultural and linguistic capabilities in provider directories, beneficiaries are empowered with the information necessary to choose the correct health care and network of providers that meet their needs. This is particularly important in the Medicare Advantage population, where beneficiaries are more likely to identify as a racial or ethnic minority, as mentioned above, or speak a language other than English at home or not at all when compared to FFS Medicare beneficiaries. Sixteen percent of Medicare Advantage beneficiaries speak a language other than English at home compared to 10 percent of FFS Medicare beneficiaries, and the share increases as beneficiary income decreases.[19] Data also finds that Medicare Advantage beneficiaries with incomes between 100 and 199 percent of the FPL are more than twice as likely as FFS Medicare beneficiaries to not speak English well or at all.[20] As such, including providers' cultural and linguistic capabilities in the provider directory is a critical step in ensuring the diverse Medicare Advantage population receives the health care they need and deserve.

Nevertheless, it is important to also recognize potential limitations regarding the data to populate provider directories. Health plans maintain provider directories based on self-reported data from providers and providers must typically provide the necessary data to multiple health plans. First, self-reported data is helpful as it relies on how the individual reporting identifies, whether it is race and ethnicity or cultural and linguistic capabilities, and they are best positioned to offer that data. However, there may be reservations around sharing this information, amongst all individuals and populations, and specifically providers as the proposal requires. Second, providers experience varying cadences of providing updated data to health plans to maintain up to date provider directories, which may create unnecessary administrative burdens for both providers and health plans. Thus, assessing opportunities to potentially streamline this process and reduce any administrative burdens may be helpful in enabling the data sharing required to maintain provider directories. Better Medicare Alliance encourages CMS to further assess how to best address these limitations amongst the various stakeholders that contribute to producing up to date provider directories, and we look forward to working with the Administration in addressing such limitations.

Further, Better Medicare Alliance supports CMS' goal of identifying and increasing access to providers that offer medications for opioid use disorder, however, recent legislative action that

[19] Analysis of CMS Master Beneficiary Summary File. March 2022.; *See* Better Medicare Alliance. Social Risk Factors are High Among Low-Income Medicare Beneficiaries Enrolled in Medicare Advantage. September 2020. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/09/BMA-Q3-Data-Brief-FIN.pdf

[20] *Id.*

occurred after this Proposed Rule was published may impact the relevancy and feasibility of finalizing this proposal. The Consolidated Appropriations Act (CAA) of 2023, signed into law on December 29, 2022, included the Mainstreaming Addiction Treatment (MAT) Act, which removes the requirement that providers prescribing drugs for maintenance treatment or detoxification treatment, including buprenorphine, must separately register with the Drug Enforcement Agency (DEA) to receive a special waiver and are limited to the number of patients they are able to prescribe buprenorphine to.[21]

Removal of this waiver requirement effectively opens the door for all providers eligible to prescribe scheduled drugs such as MOUDs and increases access to the number of patients able to receive such medications because providers are no longer limited in the number of patients they are able to prescribe to. Thus, identifying providers that offer MOUDs is unnecessary, as providers no longer need to receive a special waiver from the DEA to prescribe. It is also an important step in normalizing treatment for OUD and Better Medicare Alliance appreciates CMS' thoughtful proposal to take these steps. Nonetheless, informing beneficiaries of this change and that they no longer have to seek out providers that specialize in addiction treatment services is essential to meeting the goal of increasing access to providers that offer MOUDs. The legislative change is welcome, yet work remains to share this important development and Better Medicare Alliance looks forward to partnering on this effort.

- **Digital Health Education for MA Enrollees Using Telehealth (§ 422.112)**

Better Medicare Alliance appreciates and shares CMS' goal of increasing digital health literacy, particularly in light of the increased amount of care that is delivered using telehealth since the onset of the COVID-19 pandemic. We agree a flexible approach to come into compliance with this proposed requirement is necessary and welcome as MAOs pilot initiatives in communities. We further request additional clarification on how CMS is defining "low digital health literacy" and the process for implementing a digital health literacy education program that complies with the proposed new paragraph (9) at § 422.112(b).

CMS proposes to require MAOs to have procedures to identify enrollees with low digital health literacy, implement a digital health literacy education program and offer to identified enrollees, and make information about the identification, administration, and evaluation of the program to CMS upon request.

BMA Comments

Better Medicare Alliance appreciates CMS' goal of increasing digital health literacy and enabling beneficiaries to better understand their telehealth options and utilizing them, and we agree that identifying beneficiaries with low digital health literacy is the first step in meeting this goal. To effectively meet this requirement, Better Medicare Alliance requests additional clarification on how stakeholders, including MAOs, will meet this proposed requirement.

[21] Public Law No: 117-328. Consolidated Appropriations Act of 2023. December 29, 2022.; *See* Doyle S. and Baaklini V. "President Signs Bipartisan Measure to Improve Addiction Treatment." Pew. December 30, 2022. Available at: https://www.pewtrusts.org/en/research-and-analysis/articles/2022/12/30/president-signs-bipartisan-measure-to-improve-addiction-treatment

Importantly, we appreciate the flexibility CMS proposes to appropriately identify beneficiaries and offer them programs to improve literacy, but additional clarity on the components of this proposed requirement is helpful. First, it is necessary to understand what "digital health literacy" means and what CMS perceives as "low" digital health literacy. Establishing a standard definition or criteria will be helpful in identifying beneficiaries who do have low digital health literacy so appropriate next steps can be taken. Similarly, clarification on whether there may be specific screening requirements as a means to identify beneficiaries with low digital health literacy will be helpful as MAOs develop processes to be compliant with this proposed requirement.

Second, Better Medicare Alliance requests additional clarification or guidance on 3 items. First, further understanding and expectations of what an offered digital health literacy program that is compliant with this requirement will be helpful as MAOs contemplate how to best develop and implement pilots and programs for their enrollees across all markets. Second, CMS is proposing that upon request, MAOs will share information, including evaluation of effectiveness of the programs. We request additional information on how CMS will determine whether programs are effective and the implications of that determination for MAOs. Lastly, CMS may, under this proposal, request additional information regarding an MAOs digital health literacy program. It may be helpful for both MAOs and CMS to initially know the parameters of what data may be requested and to what level of granularity the request may be. As MAOs will need to collect the data, initial parameters around the data collection will help MAOs better develop programs and mitigate non-compliance with any information request and proposed requirement.

Digital health literacy programs are already underway and being piloted in the community. For example, in partnership with the Texas Association of Area Agencies on Aging, Aetna Medicaid invested in closing the gaps in digital literacy among people over 60 and their caregivers in Texas. This partnership supports seniors in learning about and accessing telehealth and telemedicine and is especially critical for dual eligible beneficiaries in Medicare and Medicaid. Moreover, the partnership and similar efforts further supports a flexible approach to pilot, develop, and scale digital literacy programs across the country and markets, as working within the community with partners is vital to identifying and reaching the beneficiaries that may benefit most from the programs.[22]

Accordingly, Better Medicare Alliance requests further information and clarification on this proposal. We further encourage CMS to consider the resources, including administrative, financial, and operation, expended to first screen and identify beneficiaries and subsequently develop and implement programs to offer to beneficiaries. To allow proper development of screening protocols and the development and implementation of education programs, we request the implementation of this proposed requirement be delayed by at least one year, and no earlier than CY 2025, if finalized.

- **Quality Improvement Programs (§422.152)**

Better Medicare Alliance supports CMS' proposal to incorporate activities that reduce health and health care disparities into broader quality improvement (QI) programs, as this will further embed health disparity reduction strategies and initiatives into the delivery of health care and

[22] CVS Health Completes Rollout of Time Delay Safes in Three Southern States. September 13, 2022. Available at: https://www.cvshealth.com/news/community/a-commitment-to-community-aetna-empowers-local-organizations-to.html

advance health equity. We further appreciate the proposed flexibility in the type of activity that must be implemented, as this offers MAOs the ability to tailor the activity to their enrollees' needs and overall population.

CMS proposes to require MAOs to incorporate one or more activities into their overall QI program that reduce disparities in health and health care among enrollees.

BMA Comments

Better Medicare Alliance appreciates and supports CMS' proposal to incorporate activities to reduce health disparities into QI programs, as inclusion supports health equity efforts across the continuum of care and engages the business more broadly. Moreover, inclusion of these activities in QI programs acknowledges that health equity should be discussed under a quality framework and that QI programs are an effective pathway and tool for reducing disparities. Better Medicare Alliance commends CMS' leadership in advancing health equity in the Medicare Advantage population and across the broader agency, and we look forward to continued partnership in meeting our shared goals.

Behavioral Health in Medicare Advantage

Better Medicare Alliance supports CMS' goal to improve access to behavioral health services and outcomes for people with behavioral health care needs and applauds recent efforts to meet this goal. Over one-third of Medicare Advantage beneficiaries have a mental health condition, and 14 percent have serious mental illness, and these rates are similar among FFS Medicare beneficiaries.[23] As the behavioral health needs of Medicare beneficiaries outpace current public policy and infrastructure, Better Medicare Alliance is encouraged to see proposals addressing some of the challenges present within the current health care system.

- **Behavioral Health Specialties in MA Networks (§§ 422.112 and 422.116)**

Better Medicare Alliance appreciates and supports CMS' proposal to add new provider specialty types, including clinical psychology, clinical social work, and prescribers of MOUDs to further improve access to behavioral health care services for beneficiaries. We request additional implementation time of the expanded specialty types, continued flexibility in meeting network adequacy standards, and further assessment of processes to best identify prescribers of MOUDs in light of recent legislative action and to ensure well-informed networks for beneficiaries. Better Medicare Alliance also appreciates and supports CMS' proposal that all new specialties will be added to the list of providers that receive a 10 percent credit towards the MAO's contracted network, but request further assessment as detailed below.

CMS proposes to add three new provider specialty types subject to network adequacy evaluation to include clinical psychology, clinical social work, and prescribers of MOUDs, which includes providers with waivers under the Controlled Substances Act and opioid treatment programs (OTPs). CMS further proposes base time and distance standards and a minimum number of in-person providers in each county type for these new specialty types. Lastly, CMS proposes to add all these new specialty types to the list that will receive a 10 percent credit if the

[23] Better Medicare Alliance. Approaches to Meet Behavioral Health Needs in Medicare Advantage. November 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

MAOs contracted network of providers include one or more telehealth providers that provide additional telehealth benefits for covered services.

BMA Comments
Better Medicare Alliance supports the addition of the behavioral health specialty types to networks in Medicare Advantage, as this will further increase access to behavioral health care and services. As discussed above, the recently enacted CAA removes the requirement that providers prescribing drugs for maintenance treatment or detoxification treatment separately register and receive a special waiver from the DEA, meaning all providers may prescribe and without limitations on the number of patients. As such, we encourage CMS review its proposal to add prescribers of MOUDs to the list and determine how to best move forward in light of the CAA enactment, while maintaining the intent of expanding access to behavioral health specialties in networks and ensuring there are no residual or carryover administration challenges for providers now as they are able to prescribe MOUDs.

We further appreciate CMS' proposal of base time and distance standards and minimum number of in-person providers for each new specialty to ensure access to the expanded network of providers. However, we request CMS maintain a flexible approach as contracts with the newly proposed specialists are established and recognize the difference across counties as it relates to available provider and specialist types.

In addition, Better Medicare Alliance supports the 10 percent credit towards MAO networks for the new specialties but request further assessment and overall information to better understand the interaction between the expansion of Medicare telehealth coverage and the telehealth services offered via supplemental benefits. As a matter of mitigating further health disparities and impeding the advancement of health equity for both Medicare Advantage and FFS Medicare beneficiaries, we believe CMS should first consider the current gaps in covered telehealth services and how to best close those gaps to ensure equitable access.

- **Behavioral Health Services in MA (§§ 422.112 and 422.113)**

Better Medicare Alliance shares CMS' goal of integrating behavioral health services in the care coordination plan and the recognition that overall health and wellbeing includes mental and behavioral health and should therefore be managed similarly to physical health and in circumstances such as an emergency.

CMS proposes to ensure access to behavioral health services by adding behavioral health services to the types of services which an MAO must have programs in place to ensure continuity of care and integration of services. CMS proposes to further codify its interpretation of what qualifies as an "emergency medical condition" to include conditions of both physical and mental nature.

BMA Comments
Better Medicare Alliance appreciates CMS' efforts to better coordinate behavioral health services by intentionally including behavioral health services in a beneficiary's care coordination plan. At the foundation of Medicare Advantage is care coordination, which involves connecting beneficiaries to care, services, and resources across the health care community to promote health and wellbeing. The inclusion of behavioral health services in care coordination, to the

extent it is not already, will further improve the care and experience beneficiaries receive to live a healthy and fulfilled life. Nevertheless, we do request CMS delay the implementation of this proposed requirement by at least one year, and to take effect no earlier than CY 2025, as this provides adequate time to fully include behavioral health services into care coordination plans for beneficiaries.

Further, Better Medicare Alliance appreciates CMS' proposal to codify its interpretation used to determine a condition that qualifies as an "emergency medical condition" to include a condition that is mental in nature as it relates to prior authorizations and provider networks. The codification of this interpretation acknowledges that a beneficiary's health and wellbeing is more than physical health and supports the inclusion of mental health in this proposal. We do request that CMS consider a defined set of behavioral health services that meet the prudent layperson definition to further clarify the variation of behavioral health symptoms that necessitate emergency care.

- **MA Access to Services: Appointment Wait Time Standards (§ 422.112)**

Better Medicare Alliance appreciates CMS' goals to increase and enhance access to equitable behavioral health services and its commitment to aligning how beneficiaries access needed behavioral and physical health care services as outlined in its Behavioral Health Strategy but share concerns about finalization of this proposal in the current environment.

CMS proposes to codify the appointment wait times as standards for primary care services as described in the Medicare Managed Care Manual and extend the standards to behavioral health services.

BMA Comments

Better Medicare Alliance recognizes the interest in further integrating behavioral health care into physical health and the efforts underway to minimize the burden for beneficiaries and others in accessing care. Accordingly, we acknowledge the intent in aligning appointment wait times for primary care services and extending to behavioral health services. Nevertheless, we urge CMS to consider the impact of system wide workforce challenges, particularly in behavioral health, before codifying this proposal in regulation. In the current environment, codifying the primary care services appointment wait time standards guidelines and extending to behavioral health may further exacerbate the workforce challenges and negatively impact the care beneficiaries receive. To mitigate the potential impact due to current workforce challenges, we recommend CMS maintain the appointment wait time standards for primary care in guidance and within the Medicare Managed Care Manual rather than codify in regulation.

We further encourage CMS to examine primary care appointment wait times to better understand the factors that impact beneficiary preference and the times across different geographies and account for these factors when establishing and evaluating compliance with the standards. Following this examination, CMS can then apply their learnings to additional services like behavioral health.

Utilization Management Requirements

Better Medicare Alliance shares CMS' goal of ensuring timely and appropriate access to medically necessary care for all beneficiaries enrolled in Medicare Advantage and appreciates CMS' focus to modernize the prior authorization process. CMS' goal aligns with prior authorization efforts we support and have previously endorsed, including reforms to streamline and reduce administrative burdens on providers and ensure beneficiary access to clinically appropriate care. We also appreciate CMS' recognition that utilization management tools used in Medicare Advantage, including prior authorization, are an important means to coordinate care, reduce inappropriate utilization, and promote cost-efficient care. Research has shown that utilization management and prior authorization ensures access to clinically appropriate care while reducing low-value care.[24]

In addition to the utilization management requirement proposals put forth in this Proposed Rule, there are parallel and complementary efforts to further modernize and streamline prior authorization in Medicare Advantage and across health care more broadly. For example, Better Medicare Alliance continues to support bipartisan legislation that was introduced in the last Congress, the Improving Seniors' Timely Access to Care Act,[25] which would take a number of important steps to advance these same goals, including requiring greater transparency and ensuring prior authorization processes adhere to evidence-based medical guidelines and clinical practices. Moreover, there are the broader proposed electronic prior authorization and transparency requirements included in the recent Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations and other federal health care programs proposed rule that remains open for public comment.[26]

As these important regulations are finalized in the coming months, we encourage CMS to ensure coordination and alignment in the implementation and timelines of new prior authorization requirements, including the electronic prior authorization requirements and the consumer and patient protections included in this proposed rule.

- **Coverage Criteria for Certain Benefits**

Better Medicare Alliance commends CMS' efforts to reform and streamline the use of utilization management and prior authorization in Medicare Advantage to ensure beneficiaries have consistent access to medically necessary and clinically appropriate care, and we support ensuring that the application of utilization management and prior authorization aligns with Medicare coverage policies as well as current clinical guidelines.

CMS proposes to assure consistency in how Medicare Advantage plans apply prior authorization requirements so that they are aligned with Medicare coverage guidelines (e.g., national coverage determinations, local coverage determinations, and general coverage and benefit conditions included in FFS Medicare).

[24] Fendrick A.M. Reframe the Role of Prior Authorization to Reduce Low-Value Care. Health Affairs Forefront. July 11, 2022. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20220708.54139/
[25] Improving Seniors' Timely Access to Care Act, H.R. 3173/S. 3018, 117th Cong. (2022).
[26] 87 Fed. Reg. 76,238 (December 13, 2022).

BMA Comments
Better Medicare Alliance appreciates CMS' efforts to provide greater oversight and transparency in the utilization management and prior authorization processes, as it can help beneficiaries and providers better understand the criteria used for making medical necessity determinations and how these guidelines govern the application of utilization management tools, including prior authorization. We support efforts that not only bring greater transparency but also streamline the process.

As such, we support CMS' proposal to align general coverage and benefit conditions in Medicare Advantage and FFS Medicare, though we request CMS thoroughly examine if there are current circumstances in which Medicare Advantage has flexibility in making certain coverage decisions that may not be explicit in law, regulation, or guidance and that may change if this proposal is finalized.

For example, Medicare Advantage has the flexibility to cover skilled nursing facility stays that would not otherwise be covered in FFS Medicare. While this particular flexibility will remain in place if this proposal is finalized, there may be other similar circumstances that should be fully assessed before finalization that are not immediately clear. Moreover, we commend CMS for maintaining a health plan's authority to use step therapy for Part B drugs, as we believe this allows health plans to better manage beneficiary care and health care costs.

- **Continuity of Care**

Better Medicare Alliance generally supports the continuity of care provisions to ensure that any prior authorization process be valid for the entire course of treatment and that beneficiaries are provided a 90-day transition period when changing Medicare Advantage plans during the course of treatment. We encourage CMS to engage with all stakeholders to ensure operational readiness and successful implementation of this provision and request CMS consider aligning the timelines in the complementary Advancing Interoperability and Improving Prior Authorization Processes proposed rule. As such, we request a delay of implementation of no earlier than CY 2026.

CMS proposes new requirements that would ensure any prior authorization process be valid for the entire course of treatment to ensure continuity of care, including requiring health plans to provide a 90-day transition period when a beneficiary receiving treatment switches to a different Medicare Advantage plan.

BMA Comments
Better Medicare Alliance shares CMS' commitment to ensuring beneficiaries receive access to medically necessary care, including when beneficiaries choose to change their health care coverage during a course of treatment. The continuity of care provisions proposed here represent important patient protections, especially for beneficiaries undergoing treatment for complex and serious medical conditions. Similar protections exist in Medicare Part D related to the use of pharmacy management tools for Part D covered drugs, and these protections have worked to ensure continued access to medically necessary drugs and therapies for Medicare beneficiaries. Accordingly, we support these provisions but request a delay of implementation to further align with other proposed prior authorization rules to ensure operational readiness and successful implementation.

- **Mandate Annual Review of Utilization Management Policies by a UM Committee**

Better Medicare Alliance generally supports requiring annual review and oversight of utilization management practices as proposed in the Utilization Management Committee and encourage CMS to permit flexibility and allow MAOs to use existing committees to achieve the goals of the Utilization Management Committee. Moreover, we request CMS allow additional time to ensure MAOs have sufficient time to bring current review efforts into compliance with the requirements of this proposal and therefore ask for at least a one year delay with implementation beginning in CY 2025.

CMS proposes that health plans establish a Utilization Management Committee to review all utilization management practices to ensure consistency with Medicare coverage and guidelines. Under this proposal, health plans must utilize and make publicly available the clinical criteria so the application of utilization management and prior authorization is aligned with the current evidence in widely used treatment guidelines.

BMA Comments

Better Medicare Alliance shares CMS' goal of ensuring utilization management policies are reviewed and have the benefit of provider input. By creating a utilization management committee whose membership includes a majority of practicing physicians and chaired by the health plan's medical director, CMS can ensure that the utilization of medical management and prior authorization are aligned with clinical best practices. Moreover, the annual review process will ensure the clinical criteria reflects the most current medical and clinical practice guidelines, including standards of care for clinical specialties. Furthermore, requiring written documentation of the determination process will bring greater transparency to the decisions made by the committee as it relates to the application of utilization management and prior authorization in Medicare Advantage.

We therefore support establishing this committee but request CMS allow additional time to ensure MAOs have sufficient time to bring current review efforts into compliance with the requirements of this proposal and therefore ask for at least a one year delay with implementation beginning in CY 2025.

Medicare Advantage and Part D Marketing

Nearly all Medicare beneficiaries nationwide have multiple Medicare Advantage plan options from which to choose from. To support the best possible health care experience, it is crucial that beneficiaries have the tools and information they need to identify and choose the health plan that best meets their needs. Accurate marketing of Medicare Advantage plans is essential for beneficiary education, empowered choices, and trust in the Medicare program. Better Medicare Alliance appreciates CMS' leadership and work in addressing marketing practices in this Proposed Rule and aligns on many of the goals that these proposals seek to accomplish.

- **Marketing Materials and Communications Requirements**

Better Medicare Alliance appreciates and shares CMS' goal to strengthen its ability to ensure marketing to beneficiaries is not misleading, inaccurate, or confusing and support overall efforts to improve transparency in marketing materials and communications.

CMS proposes to require TPMOs to submit marketing materials developed for multiple MAOs and Part D Sponsors (with prior approval from each) to CMS; prohibit the use of the Medicare name, CMS logo, or official products in a misleading manner; prohibiting the use of superlatives in marketing materials unless supported by recent sources of documentation or evidence; prohibiting the advertisement of benefits that are not available in the service area where marketing occurs unless unavoidable in local markets; prohibiting the marketing of any product or plan, benefits, or costs unless the MAO's marketing name is identified; and prohibiting the inclusion of information about saving available that are based on typical expenses of uninsured individuals, unpaid costs of duals, or other unrealized costs.

BMA Comments
Better Medicare Alliance agrees that efforts to improve transparency in marketing materials and communications are necessary to protect and support beneficiaries while making decisions about their health care. We support CMS' proposal to require the submission of TPMO marketing materials for multiple MAOs to CMS for review, as this allows CMS to ensure marketing is not misleading, inaccurate, or confusing for beneficiaries, particularly those that live in areas where there are several Medicare Advantage options available to choose from. Moreover, Better Medicare Alliance requests CMS should routinely share examples of approved and denied marketing materials as a tool for stakeholders on best practices when developing their materials.

Regarding the proposal on prohibiting the use of the Medicare name, CMS logo, or official products in a misleading manner, we do request clarification around this prohibition, specifically if this exclusively applies to marketing materials or if this extends to education materials as well. Better Medicare Alliance strongly agrees that Medicare-related communications or advertising should not appear endorsed by the federal government and CMS when it has not, however, additional clarification on this proposed prohibition will be helpful when balancing the need to educate beneficiaries about all of their health care options.

We also share CMS' goal of minimizing any misleading information shared with beneficiaries about plan benefit design and supports CMS' proposals to achieve this. Lastly, we do request that if changes to the HPMS marketing review approval process are to be made, CMS include a comment and feedback period as well as implementation dates to allow for adequate time in responding and making any necessary modifications across stakeholders.

- **Contacting Beneficiaries**

Better Medicare Alliance supports efforts to improve guidance over contacting beneficiaries, including forms and processes around permission to contact as well as business reply cards (BRCs) and appreciates CMS' proposals seeking to address this.

CMS proposes to add contacting a beneficiary at their home to be considered door-to-door solicitation unless there is a previously scheduled appointment; require additional notice about a beneficiary's ability to opt out of being contacted about plan business; prohibit marketing events that take place within 12 hours of an educational event in the same location; require scope of appointments (SOAs) to be completed at least 48 hours before a marketing appointment; and limiting the validity of SOAs and BRCs to 6 months from signature or request for information by the beneficiary.

BMA Comments
Better Medicare Alliance supports thoughtful efforts that improve guidance around contacting beneficiaries, and we appreciate CMS' proposals. We share CMS' concern that beneficiaries attending an educational event immediately followed by a marketing event may feel persuaded to make a choice that very day. However, we request CMS consider whether prohibiting marketing events that take place within 12 hours of an educational event in the same location is the appropriate step to meeting the intended goal of creating sufficient time between events for the beneficiary to contemplate their options and make a decision without persuasion. This proposed prohibition may create additional burdens for beneficiaries that outweigh mitigating potential persuasion through this prohibition.

To mitigate and reduce concern that beneficiaries may feel persuaded to make an immediate or near immediate choice, there are certain safeguards we support and encourage CMS to consider. For example, the educational and marketing events can take place in two separate rooms or spaces, clear and explicit announcements can be made explaining the role of agents or brokers, and additional time between the educational and marketing events can be added to further distinguish the separate events.

We also believe there are circumstances where codifying the guidance of completing a SOA at least 48 hours before a marketing appointment without the additional language of "when practicable" may create unnecessary burdens and even disruption of care for some beneficiaries. For example, if a beneficiary does not begin reviewing their options until the end of the enrollment period, the proposed 48 hour requirement may overlap with the end of the enrollment period and impede the beneficiary from selecting their health care. As such, a disruption in care could occur for this beneficiary. We agree there are numerous circumstances where the inclusion of "when practicable" language in this proposal nullifies the purpose of adding a timeframe, however, we request CMS review whether this requirement that does not allow the circumstances of the beneficiary to be considered has the likelihood of negatively impacting beneficiaries more than supporting and maintaining "when practicable" in those circumstances.

- **Provider Directory Requirements**

Better Medicare Alliance supports CMS' proposal to make provider directories searchable by every element. However, we share concerns over the data collection and cadence to maintain these directories and have offered additional detail in earlier comments and below.

CMS proposes to require MAO provider directories be searchable by every element, such as name, location, and specialty that is required in CMS' model provider directory.

BMA Comments
Better Medicare Alliance supports efforts that empower beneficiaries with the information necessary to choose the correct health care and network of providers that meet their needs, including proposals around provider directories that are in furtherance of these efforts. We appreciate CMS' proposal to require directories to be searchable by every element and are supportive of this endeavor. However, for the reasons stated above, we are concerned there are challenges around data collection to maintain provider directories. As such, we continue to encourage CMS to further assess how to best address the collection and cadence of self-

reported data used to populate provider directories amongst the various stakeholders that contribute to producing up to date directories and we look forward to working with the Administration in addressing such challenges and limitations.

- **Third Party Marketing Organization Requirements**

Better Medicare Alliance recognizes the importance of beneficiaries understanding all of their health care options and appreciates CMS' goal of ensuring beneficiaries have the information they need.

CMS proposes to require third party marketing organizations (TPMOs) to notify beneficiaries in their disclaimer that they may contact their local State Health Insurance Program (SHIP) for more information and require two additional disclaimers, dependent on whether the TPMO sells all or a select number of MAOs and Part D Sponsors in the service area.

BMA Comments

Better Medicare Alliance applauds CMS' commitment to providing beneficiaries with unbiased information and supports the inclusion of notifying beneficiaries they can contact their local SHIP for additional information and questions they may have about their health care. We also recommend CMS should extend marketing guidance between MAOs and providers to TPMOs and providers to create more consistent marketing among TPMOs with providers and further reduce confusion among beneficiaries.

- **Oversight and Monitoring of Marketing**

Better Medicare Alliance appreciates CMS' proposals around overall oversight and monitoring of marketing in Medicare Advantage, as the regulatory framework is complex. We believe consolidation of requirements, regulations, and guidance will promote consistency across all stakeholders.

CMS proposes a series of requirements for improved oversight and monitoring of marketing activity, including requiring MAOs establish and implement an oversight plan; that all agents and brokers go through a CMS-developed list of items that must be asked and/or discussed during the marketing and sale of a plan; limiting the TPMO calls that must be recorded to only calls regarding sales, marketing, and enrollment, including calls occurring via web-based technology (i.e. Zoom); and prohibiting personal beneficiary data collected by a TPMO to be distributed to other TPMOs.

BMA Comments

Better Medicare Alliance supports efforts to improve oversight and monitoring of marketing in order to reduce beneficiary confusion. In furtherance of these efforts, we appreciate and support CMS' clarification around limiting the calls TPMOs must record. As this recent requirement continues, we recommend CMS reassess the length of time that recorded calls must be kept and maintained. In addition to potential burden on the TPMOs, beneficiaries themselves may be reluctant in engage with these individuals if they are aware their conversation is maintained for so long. In turn, beneficiaries may not seek out the array of resources available to better understand their health care options.

Finally, we broadly support efforts to consolidate all marketing regulations and guidance for all stakeholders into a single source of information provided by CMS to minimize the possibility of stakeholders adopting differing interpretations that can lead to beneficiary confusion. We appreciate CMS' leadership and attention to this particular area of Medicare Advantage to ensure beneficiaries have the accurate information necessary to make informed decisions.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

Better Medicare Alliance appreciates CMS' efforts to promote enhancements to the Star Rating System for Medicare Advantage and Part D in order to drive quality improvement for all Medicare beneficiaries. The Star Rating System fosters quality improvement in Medicare Advantage. Stars provides beneficiaries with valuable and meaningful information about the quality of their coverage and is an important tool to ensure beneficiaries can make informed decisions about the Medicare coverage choices. Approximately three-quarters of beneficiaries currently enrolled in Medicare Advantage with prescription drug coverage are enrolled in a health plan with a rating of 4 or more stars in 2023.[27] While there are a number of positive changes included in the Proposed Rule, Better Medicare Alliance has concerns about some of the specific methodological changes as well as the potential overall cumulative impact of the proposed changes.

- **Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)**

Better Medicare Alliance shares CMS' commitment to continuing to improve the Part C and Part D Star Ratings System and that measures may be added, updated, and removed as a means to improvement. We comment specifically to share our support of expanding the age of colorectal cancer screenings to include beneficiaries between the ages of 45-49 years of age and pursuant to updated screening guidelines by the National Committee for Quality Assurance (NCQA).

CMS proposes a series of changes to specific measures in the Part C and Part D Star Ratings system, including both removing and updating established measures and adding new measures.

BMA Comments

In the CY 2023 Medicare Advantage Advance Notice,[28] CMS proposed following NCQA's updated screening guidelines and in accordance with the U.S. Preventive Services Task Force (USPSTF) to include screening individuals 45-49 years old for colorectal cancer. Better Medicare Alliance supported this proposal in the CY 2023 Advance Notice and appreciate CMS now formally proposing to update the screening measure in this Proposed Rule.

Colorectal cancer (CRC) is the second most common cancer death in the U.S., and over 52,000 people are expected to die from CRC in 2023.[29] Despite only 3.1 percent of Medicare

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[27] 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
[28] Advance Notice of Methodological Changes for Calendar Year 2023 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. February 2, 2022. Available at: https://www.cms.gov/files/document/2023-advance-notice.pdf
[29] American Cancer Society, Key Statistics for Colorectal Cancer, Last Revised January 2023. Available at: https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html

Advantage beneficiaries being under 50 years old in 2019,[30] including individuals 45-49 years old in the CRC screening measure may have a significant impact on health outcomes and further reduce disparities, especially for Black beneficiaries. CRC disproportionately impacts Black Americans who are about 20 percent more likely to be diagnosed with CRC than other populations and are 40 percent more likely to die from CRC.[31] Yet 60 percent of CRC deaths in the U.S. could be prevented with screening.[32] Better Medicare Alliance supports expanding CRC screening to individuals 45-49 years old because it can lead to earlier detection and intervention, decrease disparities, advance health equity, and result in fewer deaths from CRC and therefore appreciate CMS formally proposing this update to the CRC screening measure in Stars.

- **Measure Weights (§§ 422.166(e) and 423.186(e))**

Better Medicare Alliance is pleased CMS reconsidered its position of increasing the weight of patient experience/complaints and access measures from 2 to 4 and supports the decision to reduce the weight of these measures back to 2. Given the impact of the weight increase for 2023 Star ratings, we recommend CMS accelerate the implementation timetable for reducing the weight for patient experience measures to promote stability and minimize disruption for beneficiaries.

CMS proposes to decrease the weight of patient experience/complaints and access measures from 4 to 2 beginning with the 2026 Star ratings.

BMA Comments

Better Medicare Alliance shares CMS' interest in identifying methodological enhancements to the Star ratings to drive continuous quality improvement for all Medicare Advantage beneficiaries. We further commend CMS for its reevaluation of the weight for patient experience measures and rebalancing with the weight of clinical outcome measures. As such, we support reducing the weight of patient experience measures in Stars, as it may potentially further shift the focus to patient outcomes, screenings, and preventative care. As CMS continues to receive feedback on this proposal, we recommend the implementation timetable for reducing the weight back to 2 be accelerated and before the 2026 Star ratings. We believe this acceleration will further promote stability in the program and minimize potential disruption to care and benefits for beneficiaries.

We also encourage CMS to further address limitations and modernize the CAHPS survey, with input from stakeholders and beneficiaries. Better Medicare Alliance has previously made recommendations around the current limitations of measuring patient experience in the Medicare Advantage CAHPS survey.[33] Recommendations include modernizing measurement by updating the survey language to reflect the diversity of today's beneficiaries, provide more

[30] 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

[31] Fight Colorectal Cancer, Facts and Stats, 2022. Available at: https://fightcolorectalcancer.org/about-colorectal-cancer/general-information/facts-stats/

[32] *Id*.

[33] 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/

granular survey results to health plans to empower better quality improvement, remove questions that health plans cannot directly impact, and explore ways to reduce burden on beneficiary survey respondents to improve response rates. CMS has taken steps to address these limitations, including piloting a web-based CAHPS survey method and we applaud CMS for their actions and look forward to further engagement on modernization efforts.

- **Guardrails (§§ 422.166(a)(2)(i) and 423.186(a)(2)(i))**

Better Medicare Alliance appreciates the goal of being responsive to changing industry performance on non-CAHPS measures but are concerned removing the guardrails will invite variability and volatility back into Stars.

CMS proposes to remove guardrails when determining measure-specific thresholds for non-CAHPS measures beginning for 2026 Star Ratings.

BMA Comments
Better Medicare Alliance appreciates CMS' goal of remaining responsive to changing industry performance as it relates to the non-CAHPS measures, however, we are concerned the removal of the guardrails will bring more variability and volatility back into the Star ratings, therefore acting in conflict with the overarching goal of improving stability and predictability in the quality rating system.

- **Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3))**

Better Medicare Alliance appreciates CMS' efforts to advance health equity in Medicare Advantage and for beneficiaries, however we have concerns about the proposed Health Equity Index in its current form and whether adoption in lieu of the current reward factor will meaningfully reduce health care disparities.

CMS proposes to add a health equity index to further incentivize MAOs and Part D plans to improve care for beneficiaries with social risk factors in their contracts.

BMA Comments
Better Medicare Alliance supports efforts to advance health equity across the Medicare Advantage program but has concerns with the Health Equity Index (HEI) as currently proposed. First, the HEI does not fully recognize the variation of social risk factors experienced by Medicare Advantage beneficiaries and that social risk is not exclusive to the populations identified in the proposal. Second, we are concerned MAOs that do not have a high share of enrollees that meet the criteria for the HEI, including individuals with low-income subsidies (LIS), are dually eligible for Medicare, or have a disability will be negatively impacted for reasons not within their control and have a potentially disproportionate impact across organizations and contracts. Lastly, we have concerns that the removal of the current reward factor would make it more challenging for plans to maintain and improve Star ratings.

An analysis by Wakely Consulting found that the removal of the current reward factor and corresponding addition of the HEI reward “could make it far more challenging for plans to maintain a 4.0 Star Rating.”[34]

We believe there are potentially more meaningful opportunities to reduce disparities among beneficiaries and recommend CMS fully consider other pathways to incentivize MAOs to reduce disparities across contracts. For example, CMS may consider maintaining the current reward factor and applying to contracts that do not meet the criteria for the HEI. Another consideration includes potentially phasing in the HEI to help mitigate any disruption to contract ratings and therefore potential care and services beneficiaries receive.

- **Improvement Measure Hold Harmless (§§ 422.166(g)(1) and 423.186(g)(1))**

Better Medicare Alliance shares CMS’ interest of encouraging continued improvement across all measures in Stars, including among high-performing health plans. However, we are concerned about the overall impact the proposed modification of this policy will have and therefore encourage CMS to take steps to mitigate the potential for disruption, including potential changes to the hold harmless policy, prior to this change being finalized and implemented in 2026.

CMS proposes to modify the hold harmless policy to apply the policy only to contracts with 5 Stars for their highest rating.

BMA Comments

Better Medicare Alliance recognizes the importance of promoting continued improvement across quality measures in Stars. Nevertheless, we are concerned about the proposed modification to the hold harmless policy, as it could have a “significant negative impact on Overall Star Ratings and corresponding Quality Bonus Payments for the market as a whole” when considered alongside CMS’ other proposed changes, including other methodological changes to Stars.[35]

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[34] Wakely. Written in the Stars: Proposed Changes to the Medicare Star Rating Program in the 2024 Contract Year Policy and Technical Rule. December 2022. Available at: https://www.wakely.com/sites/default/files/files/content/summary-2024-medicare-proposed-rule-star-rating-changesformatted0.pdf

[35] *Id*.