BETTER MEDICARE ALLIANCE

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

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

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

January 5, 2024

Re: CMS-4205-P, Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

Better Medicare Alliance is pleased to submit the following comments on the proposed Contract Year 2025 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs ("Proposed Rule") on behalf of our Alliance and the more than 31 million beneficiaries enrolled in Medicare Advantage. Better Medicare Alliance is a diverse coalition of over 200 Ally organizations and more than 1 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, affordable option for current and future Medicare beneficiaries.

We appreciate your ongoing commitment to preserving and strengthening Medicare Advantage as a critical choice for Medicare beneficiaries, and we look forward to continued engagement on our shared goals. Seniors and individuals with disabilities eligible for Medicare choose and trust the value-driven, affordable, quality, and innovative health care available in Medicare Advantage. Through value-based payment and care coordination that results in improved health outcomes, extra benefits, and lower costs for beneficiaries, 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 51 percent of all eligible Medicare beneficiaries, and it is estimated 33.8 million beneficiaries will be enrolled in Medicare Advantage in 2024.[1] Beneficiary access to Medicare Advantage is nearly universal (99.7 percent), and the average Medicare Advantage monthly premium remains low at approximately $18 in 2024.[2] Moreover, nearly all beneficiaries have access to a $0 premium plan with prescription drug coverage (MA-PD plan) and a health plan that offers dental, vision, hearing, or fitness benefits not available in Fee-for-Service (FFS) Medicare.[3] All the while, approximately three-quarters of beneficiaries are enrolled in an MA-PD plan

[1] Centers for Medicare & Medicaid Services, "Medicare Advantage and Medicare Prescription Drug Programs to Remain Stable in 2024," September 26, 2023. Available at: https://www.cms.gov/newsroom/press-releases/medicare-advantage-and-medicareprescription-drug-programs-remain-stable-2024.
[2] Kaiser Family Foundation, "Medicare Advantage 2024 Spotlight: First Look," November 15, 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/; Centers for Medicare & Medicaid Services, "Medicare Advantage and Medicare Prescription Drug Programs to Remain Stable in 2024," September 26, 2023. Available at: https://www.cms.gov/newsroom/press-releases/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-2024
[3] Kaiser Family Foundation, "Medicare Advantage 2024 Spotlight: First Look," November 15, 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/

with a 4 Star rating or higher in 2024.[4] A recent analysis finds Medicare Advantage beneficiaries report spending over $2,400 less in premiums and out-of-pocket costs compared to FFS Medicare beneficiaries.[5] Medicare Advantage beneficiaries are also highly satisfied with their care, earning a 94 percent satisfaction rating in a recent poll.[6]

We recognize and value your focus on Medicare beneficiaries. As programmatic changes are implemented, as well as continued implementation of significant changes finalized in the CY 2024 Rate Announcement, we want to emphasize the need for stability and further understanding of the impact recent changes have on beneficiaries to ensure successful implementation and minimal disruption to beneficiaries in receiving care.

Further, Better Medicare Alliance appreciates CMS' efforts in the areas addressed here and the intent of the policies in this Proposed Rule, as they aim to create a positive environment for Medicare Advantage beneficiaries and the innovative, high-quality, affordable care that improves health care experiences and outcomes. We agree there are opportunities for continued modernization and support the direction and intent of this Proposed Rule. We remain concerned CMS' proposed approach will not fully achieve the intended goals of the policies and potentially negatively impacts beneficiaries. We highlight our comments briefly below and detail fully in the attachment, which aim to meet our shared goal of delivering high-quality, affordable health care to beneficiaries.

Medicare Advantage and Prescription Drug Plan Marketing and Communications
Better Medicare Alliance shares CMS' goal and broadly supports efforts to ensure beneficiaries have the tools and access to complete and accurate information that is necessary to identify and choose the health plan that best meets their needs. However, we are concerned the proposals do not fully address the concerns CMS seeks to resolve and offer recommendations to meet our shared goal:

1. We strongly urge CMS maintain the current regulatory framework as it relates to agents and brokers and not pull administrative payments within the established compensation limit. Rather, we recommend CMS first expand its oversight authority to third party marketing organizations (TPMOs).
2. We ask CMS clearly define the types of administrative services health plans can compensate TPMOs for.
3. We recommend CMS establish a fee cap for the range of administrative services TPMOs engage in and perform on behalf of beneficiaries and health plans and encourage CMS engage the appropriate stakeholders to develop and adopt a cap for administrative services.
4. We reaffirm our support of prohibiting TPMOs from distributing beneficiary contact information.

[4] Centers for Medicare and Medicaid Services, "Biden-Harris Administration Prepares to Kick Off Medicare Open Enrollment and Releases 2024 Medicare Advantage and Part D Star Ratings," October 13, 2023. Available at: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-prepares-kick-medicare-open-enrollment-and-releases-2024-medicare
[5] ATI Advisory. Medicare Advantage Beneficiaries Spend less on Health Care Premiums and Out-of-Pocket Costs than Fee-For-Service Beneficiaries. March 6, 2023. Available at: https://atiadvisory.com/resources/https-atiadvisory-com-resources-wp-content-uploads-2023-03-ma-cost-protections-data-brief-2023-pdf/
[6] Better Medicare Alliance and Morning Consult Poll on Satisfaction with Medicare Advantage, January 2023. Available at: https://bettermedicarealliance.org/wp-content/uploads/2023/02/BMA_Seniors-on-Medicare-Memo_final_R1.pdf

Improvements for Special Needs Plans

We appreciate CMS' goal and efforts to improve the experiences and outcomes of dual eligible beneficiaries through integration. We support CMS' proposal to limit D-SNP look-alike plans and lowering the threshold if partial dual eligible beneficiaries are excluded from the threshold assessment in order to promote beneficiary choice, as we have previously stated and reaffirm our support. Additionally, we are concerned the totality of CMS' remaining proposals could significantly limit beneficiary choice and disrupt care, particularly those around the expanded and new Special Enrollment Period (SEP) and limitations in enrollment in non-integrated health plans. We offer the recommendations below to meet our shared goal of improved coordination of Medicare and Medicaid for dual eligible beneficiaries:

1. We request CMS continue to preserve the Medicare Advantage choice for dual eligible beneficiaries as the coordinated care delivers value to this population that could benefit most.
2. In lieu of limiting enrollment in non-integrated health plans, we suggest focusing on and improving efforts on how the potential value of aligned enrollment is conveyed to beneficiaries in order to allow them to choose the health care option that best meets their needs.
3. We encourage CMS further explore how the proposals around further integration impacts the physician and provider community, and specifically, providers that deliver care to a significant number of dual eligible beneficiaries.

Supplemental Benefits in Medicare Advantage

Supplemental benefits are a critical aspect of Medicare Advantage for beneficiaries to access benefits that address health-related and non-health related needs. Better Medicare Alliance commends CMS' dedication to ensuring beneficiaries receive access and information to better understand their valuable supplemental benefits. We are concerned proposals such as the mid-year notification will not adequately meet this goal. We offer our support of and recommendations below to CMS' proposals related to supplemental benefits in order to best meet our shared goal:

1. We are supportive of CMS' proposal regarding the evidence to support offering Special Supplemental Benefits for the Chronically Ill (SSBCI). In support of this proposal, Better Medicare Alliance is uniquely positioned to aggregate the evidence of supplemental benefits and the impact these offerings have on beneficiary health. As such, we intend to collaborate with our Allies and partners invested in promoting and strengthening supplemental benefits for beneficiaries to develop a catalog or comprehensive resource that supports the offering of SSBCI.
2. We encourage CMS to explore expanded use of preexisting channels of communication and mechanisms that beneficiaries could be notified of their supplemental benefit offerings and availability that are already a part of the Medicare Advantage plan experience and communications.
3. We further reaffirm our support for our recent policy recommendations to further enhance supplemental benefit data collection and evaluation with the broader goal of strengthening and improving Medicare Advantage for beneficiaries.

Better Medicare Alliance thanks you again for your commitment to Medicare Advantage. We appreciate the opportunity you have provided to submit comments. We look forward to continued engagement and partnership with CMS on shared goals to ensure Medicare Advantage continues to offer high-quality, affordable health 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

Expanding Network Adequacy Requirements for Behavioral Health

Better Medicare Alliance supports CMS' goal to improve access to behavioral health services and outcomes for people with behavioral health care needs. 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 Fee-for-Service (FFS) Medicare beneficiaries.[7] 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.

Better Medicare Advantage supports improving access to behavioral and mental health through the inclusion of additional provider types through a new facility-specialty.

CMS proposes the addition of Outpatient Behavioral Health as a new type of facility-specialty and adding Outpatient Behavioral Health to the time and distance requirements, which can include Marriage and Family Therapists (MFT), Mental Health Counselors (MHC), Community Health Centers, or outpatient mental health and substance use treatment facilities.

CMS also proposes adding the new Outpatient Behavioral Health facility-specialty type to the list of specialty types that receive a 10-percentage point credit if the Medicare Advantage Organization's (MAO's) provider network includes one or more telehealth providers of that specialty type that provide telehealth benefits.

BMA Comments

We appreciate and support CMS' proposal to add new provider specialist types, including Marriage and Family Therapists, Mental Health Counselors, and Community Health Centers. Adding a new facility-specialty type of Outpatient Behavioral Health will continue to improve beneficiary access to necessary behavioral health services.

However, Better Medicare Alliance asks that CMS consider how to best implement this policy in a manner that minimizes beneficiary confusion. For example, by listing these new additions as a facility-specialty type rather than as provider specialists it might make navigating the provider directory more confusing for beneficiaries, particularly as they transition into Medicare Advantage from other types of health plans. Rather, CMS could expand the existing category of clinical social workers to also include these providers. We applaud efforts to make behavioral health more accessible. Nevertheless, beneficiaries need to be able to easily navigate available providers if they are to benefit from this proposal. We further encourage CMS consider aligning the standards with time and distance standards for all outpatient behavioral health services to create more uniformity.

Better Medicare Alliance also supports CMS' proposal that all new specialties be added to the list of providers that receive a 10 percent credit towards the health plan's contracted network.

[7] 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

Supplemental Benefits in Medicare Advantage

Supplemental benefits are a critical aspect of Medicare Advantage for beneficiaries to access benefits that address health-related and non-health related needs. Following CMS' guidance expanding 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.[8] 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.[9] This is especially important because Medicare Advantage beneficiaries have more social risk factors that impact their health. Compared to beneficiaries in FFS, Medicare Advantage enrollees are more likely to live below 200% of the federal poverty level, live in socially vulnerable counties, and have completed less than a high school degree.[10]

- **Evidence as to Whether a Special Supplemental Benefit for the Chronically Ill Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee (§ 422.12(f)(3)(iii)-(iv) and (f)(4))**

Better Medicare Advantage believes that the flexibility health plans currently have in designing and offering SSBCI is essential for addressing social determinants of health and health disparities. We are supportive of this proposal and reaffirming the SSBCI offered in Medicare Advantage have a reasonable expectation of improving beneficiary health.

CMS proposes that MAOs offering SSBCI provide evidence that the item or service has a reasonable expectation of improving the health of an enrollee. This proposed rule shifts the responsibility onto the MAO and requires it to:

- Establish, by the date on which it submits its bid, a bibliography of "relevant acceptable evidence" related to the item or service that it would offer as an SSBCI during the applicable coverage year
- Follow its written policies for determining eligibility for an SSBCI when making such determinations
- Document denials of SSBCI eligibility rather than approvals

The rule also proposes codifying CMS' authority to decline to accept a bid due to the SSBCI the MAO includes and to review SSBCI offerings annually for compliance, considering the evidence available at the time.

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[8] *See* Kaiser Family Foundation, "Medicare Advantage 2024 Spotlight: First Look," November 15, 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/; *see also* ATI Advisory. Metro and Non-Metro Medicare Advantage Plan Offerings of Nonmedical Supplemental Benefits. September 2023. Available at: https://atiadvisory.com/resources/wp-content/uploads/2023/09/Metro-and-Non-Metro-Medicare-Advantage-Plan-Offerings-of-Nonmedical-Supplemental-Benefits-Databook.pdf

[9] 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/

[10] ATI Advisory. Comparing Medicare Advantage and FFS Medicare Across Race and Ethnicity. July 2023. Available at: https://atiadvisory.com/resources/comparing-medicare-advantage-and-ffs-medicare-across-race-and-ethnicity/

BMA Comments
Better Medicare Alliance commends CMS' dedication to ensuring that beneficiaries receive the intended benefits of their supplemental benefits. Supplemental benefits available in Medicare Advantage improve Medicare beneficiaries' access to care and address social determinants of health.

We also appreciate CMS' understanding that data regarding SSBCI may be limited, and thus not requiring that the bibliography be limited to only studies concerning certain chronic conditions. As stated in the Proposed Rule, doing so "would discourage the development of new SSBCI." Allowing this flexibility in the evidence criteria is critical and could lead to additional studies of supplemental benefits, encouraging more awareness of how they benefit beneficiaries and showing new areas of improvement. We recognize the importance of ensuring accuracy in what Medicare Advantage beneficiaries are offered and choose, and we believe this proposal will improve the knowledge and understanding of how SSBCIs serve beneficiaries.

In support of this proposal, Better Medicare Alliance is uniquely positioned to aggregate the evidence on supplemental benefits and the impact these offerings have on beneficiary health. As such, we intend to collaborate with our Allies and partners invested in promoting and strengthening supplemental benefits for beneficiaries to develop a catalog or comprehensive resource that supports the offering of SSBCI. We see this as an opportunity to engage a wide range of stakeholders, including community-based organizations, providers, and researchers for collaboration. Better Medicare Alliance looks forward to exploring this opportunity to support the delivery of SSBCI and enable health plans in supporting and meeting the unique health and social needs of beneficiaries.

We do ask that CMS continues engagement with other stakeholders to ensure appropriate engagement on this proposal.

- **Mid-Year Notice of Unused Supplemental Benefits (§§ 422.111(l), 422.2267(e)(42))**

Better Medicare Advantage supports CMS' goal of beneficiaries having an improved understanding of their available and unused supplemental benefits. However, we are concerned the mid-year notification as proposed will not adequately address this goal.

CMS proposes that MAOs providing supplemental benefits must notify enrollees who have not yet accessed their supplemental benefits. The proposal requires MAOs to mail a mid-year notice annually, between June 30 and July 21 of the plan year, to each enrollee with information pertaining to supplemental benefits that the enrollee has not yet used. MAOs must list each covered mandatory benefit and optional supplementary benefit that the enrollee is eligible for in the notice they send.

BMA Comments
As supplemental benefit offerings increase year over year, Better Medicare Alliance acknowledges the challenges this may bring beneficiaries in understanding the full extent of benefits and services available to them and remain committed to supporting beneficiary education and support. Further, the expansion of supplemental benefits has led to new, innovative partnerships and organizations and vendors operating in this space in order to better serve beneficiaries and deliver care and services.[11]

[11] 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/wp-content/uploads/2022/01/SDOH-Case-Studies-NORC-Report-Jan-2022.pdf

A result of this expansion and development of new partnerships focused on local delivery and engaging a variety of organizations and vendors are data challenges. Better Medicare Alliance has long focused on identifying the challenges and opportunities to enhance supplemental benefit data collection and evaluation and believe there are alternative steps and actions that will aid beneficiaries in understanding their benefits.[12]

We appreciate CMS' goal of beneficiaries having an improved understanding of their available and unused supplemental benefits and believe supplemental benefits are an important part of the Medicare Advantage beneficiary health care experience and support efforts to facilitate and promote access. However, we are concerned the mid-year notification to beneficiaries as proposed will not adequately address this goal. We believe the mid-year notification will ultimately create more confusion for beneficiaries as it may be incomplete or inaccurately present which supplemental benefits remain unused by beneficiaries due to lag in data reporting and overall data limitations. Because supplemental benefits are delivered in a variety of ways and with a range of organizations and vendors with different levels of data sophistication, the necessary information and data needed to develop the mid-year notification as proposed are limited. Better Medicare Alliance recommends the following adjustment to ensure the policy achieves its intended goal.

First, we encourage CMS to explore expanded channels of communication and mechanisms that beneficiaries could be notified of their supplemental benefit offerings and availability that are already a part of the Medicare Advantage plan experience and communications. For example, there are established touchpoints in place like care support services, patient portals, and mobile apps that could be leveraged by beneficiaries, providers and care teams, health plans, and care navigators. Focusing on these established channels and mechanisms recognize and support the variation in supplemental benefits and could further offer a more tailored and engaging experience for beneficiaries to ask questions, gain greater clarity of their benefits and options, and be connected to the appropriate services. Moreover, supplemental benefits are much like medical care in the sense that utilizing all supplemental benefits may not be necessary or appropriate based on an individual beneficiary's specific health and social care needs; the opportunity for additional dialogue could better serve beneficiaries in their understanding and access of benefits.

Second, Better Medicare Alliance reaffirms our support for our recent policy recommendations to further enhance supplemental benefit data collection and evaluation with the broader goal of strengthening and improving Medicare Advantage for beneficiaries. CMS could standardize language and descriptions for supplemental benefit categories to support beneficiary decision making. Further, we urge CMS to establish clear and robust guidance on which supplemental benefits health plans are permitted to offer. We also recommend that CMS, health plans, community-based organizations, and other stakeholders collectively work to collect standardized data on utilization of supplemental benefits (e.g., by creating new procedure codes). Together, these actions could create greater understanding and uniformity of benefits available across health plans and enable the evaluation of supplemental benefit use and impact on social, emotional, and physical health outcomes and tailoring offerings around high-value benefits.

[12] 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/wp-content/uploads/2021/08/Innovative-Approaches-to-Addressing-SDOH-for-MA-Beneficiaries-FINAL.pdf ; Better Medicare Alliance. Strengthening Medicare Advantage for Beneficiaries: Recommendations for Policymakers. October 2023. Available at: https://bettermedicarealliance.org/wp-content/uploads/2023/10/Strengthening_MA_Policy_Recommendations.pdf.

Upon consideration and should CMS move forward with a mid-year notification, we strongly urge CMS remain cognizant of the significant variation in how supplemental benefits are delivered and current data limitations and support flexibility when determining how beneficiaries must be notified. We underscore the importance that any notifications must accurately reflect the current environment for which benefits are delivered and data collected.[13] Therefore, we request CMS develop and disseminate a template of the mid-year notification to better guide the relevant stakeholders. Finally, we ask CMS to delay the proposed timeline for implementation to allow for adequate preparation and implementation.

BMA and CMS have a shared goal of advancing health equity and reducing disparities by improving the understanding and uptake of appropriate supplemental benefits available to beneficiaries to best meet their needs, and we look forward to further engagement on meeting this shared goal.

Annual Health Equity Analysis of Utilization Management Policies and Procedures

Better Medicare Alliance shares CMS' goal of ensuring timely and appropriate access to medically necessary care for beneficiaries enrolled in Medicare Advantage and appreciates CMS' focus on health equity in 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 appropriate utilization management and prior authorization ensures access to clinically appropriate care while reducing low-value care.[14]

Better Medicare Alliance shares CMS' ongoing commitment to advancing health equity and reducing health disparities among Medicare beneficiaries and generally support the inclusion of an individual with expertise in health equity on an MAO's Utilization Management Committee.

CMS proposes that the recently established Utilization Management Committee must include one member with expertise in health equity. CMS further proposes requiring the committee conduct an annual health equity analysis of the use of prior authorization on enrollees who are dual eligibles or have a disability.

BMA Comments

Better Medicare Alliance is pleased with the proposals to address and improve health equity. Adding an individual with health equity expertise to an MAO's Utilization Management Committee will advance efforts to more intentionally bring health equity into decision making processes. Additionally, conducting an annual health equity analysis comparing prior authorization for dual eligibles and individuals with disabilities to those who are not duals or individuals with disabilities will better enable health plans to identify differences and opportunities for improvement to better serve beneficiaries.

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[13] Center for Innovation in Medicare Advantage. Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries. August 2021. Available at: https://bettermedicarealliance.org/wp-content/uploads/2021/08/Innovative-Approaches-to-Addressing-SDOH-for-MA-Beneficiaries-FINAL.pdf

[14] 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/

We do request clarification on whether the individual on the committee with health equity experience can be employed by the MAO. Permitting an individual internal and employed by the MAO so long as the individual has the proper, requisite expertise is preferred and we encourage CMS consider this option as necessary.

Lastly, we recognize the value of the analysis as it relates to prior authorization could be helpful in further advancing health equity, particularly for the stakeholders that interact with and deliver care to beneficiaries such as health plans. However, Better Medicare Alliance suggests that if the analysis is publicly available, it should be available with the requisite context and support to aid beneficiaries in fully comprehending its findings and impact. Additional context and support could mitigate any unnecessary confusion.

Medicare Advantage and Prescription Drug Plan Marketing and Communications

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 critical that beneficiaries have the tools and information they need to identify and choose the health plan that best meets their needs. Accurate and complete information and resources on all Medicare Advantage plans is essential for beneficiary education, empowered choices, and trust in the Medicare program. Better Medicare Alliance appreciates CMS' leadership and ongoing work in addressing marketing and communications practices in this Proposed Rule and aligns on many of the goals that these proposals seek to accomplish.

Further, Better Medicare Alliance recently developed policy solutions for policymakers designed to support and strengthen Medicare Advantage for beneficiaries and Medicare more broadly.[15] One area of focus developed with our Allies includes establishing marketing guidance that supports beneficiaries in making informed choices. Specific recommendations include enhancing ongoing enforcement of misleading marketing practices, establishing a code of conduct and best practices for third party marketing organizations (TPMOs) with continued oversight from health plans and CMS, prohibiting TPMOs from distributing beneficiary contact information, and enhancing oversight of companies engaging in misleading marketing practices. Better Medicare Alliance recognizes the important and varied role agents and brokers, as well as other entities such as TPMOs have in informing Medicare beneficiaries of their health care options, and we appreciate CMS' recognition of the role these stakeholders play.

Nevertheless, we remain committed to identifying and supporting solutions that support beneficiaries in making informed health care choices. We are concerned the proposals put forth in this Proposed Rule will not fully address the concerns that CMS seeks to resolve and offer more detailed recommendations below aimed at meeting our shared goals. Better Medicare Alliance further reaffirms its broad support of 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 could lead to beneficiary confusion.

[15] Better Medicare Alliance. Strengthening Medicare Advantage for Beneficiaries: Recommendations for Policymakers. October 2023. Available at: https://bettermedicarealliance.org/wp-content/uploads/2023/10/Strengthening_MA_Policy_Recommendations.pdf.

- **Limitation on Contract Terms**

Better Medicare Alliance appreciates CMS' consideration of and goal to eliminate incentives or bias that may create an environment where beneficiaries are not directed to or enrolled in an appropriate health plan and broadly support efforts to address this. We request clarification and additional guidance for the relevant and applicable contract terms.

CMS proposes to prohibit contract terms between MAOs and agents, brokers, or TPMOs that impact the agent or broker's ability to objectively recommend a health plan to a beneficiary.

BMA Comments
Better Medicare Alliance shares CMS' commitment to ensuring beneficiaries are enrolled in a Medicare Advantage plan that best meets their needs and broadly supports efforts aimed at eliminating incentives or biases during this process. As such, we appreciate the proposal to limit contract terms that may limit objectively recommending the most appropriate health plan to beneficiaries. We do request CMS provide clear definitions and guidance as well as additional examples of anti-competitive contract terms as offered in the Proposed Rule as it will further direct MAOs during the contracting process and better support compliance with the proposed regulations.

Additionally, we appreciate CMS' concern around contract language regarding enrollment quotas, however, it is important to distinguish "quotas" from other terminology such as "targets," which indicates MAOs are setting expectations for agents, brokers, and TPMOs through contracts. It could be helpful to take a flexible or broad approach to determine whether the intent of the contract language would incentivize beneficiary enrollment into a particular plan versus language setting expectations between two entities or individuals.

- **Compensation Rates and Administrative Payments**

Better Medicare Alliance shares CMS' goal and broadly supports efforts to ensure beneficiaries have the tools and access to complete and accurate information that is necessary to identify and choose the health plan that best meets their needs. However, we are concerned the proposals do not fully address the concerns CMS seeks to resolve and offer recommendations as a means to meet our shared goal.

CMS proposes to:

- Require all payments to an agent or broker that are tied to enrollment be included in the definition of compensation and clarify that administrative payments are included in enrollment-based compensation calculations
- Implement a standard compensation rate for agents and brokers across all plans and remove the reporting requirement for MAOs regarding rates and ranges of rates
- Eliminate separate payments for administrative services and increase the compensation rate by the fair market value of $31, beginning in 2025

Better Medicare Alliance firmly believes beneficiaries should have complete and accurate information during the Medicare education and enrollment process. As stated, we have engaged our Allies to identify a number of policy solutions aimed at establishing marketing guidance that supports beneficiaries in making informed choices. In accordance with these policy solutions, we strongly urge

CMS action as it relates to all TPMOs and not just agents employed by TPMOs. We have previously suggested that establishing clear guidance and best practices around all TPMOs will further advance CMS' goal of minimizing incentives and variability and ensure beneficiaries have complete and accurate information to make informed decisions.

We appreciate CMS' recognition of the various activities agents and brokers carry out over the course of the year on behalf of beneficiaries. Nevertheless, the current environment in which beneficiaries receive education and assistance enrolling in Medicare, including Medicare Advantage, has significantly changed over time. Currently, there are more recent stakeholders that interact with beneficiaries, such as TPMOs, and it is critical they also be considered in CMS' oversight efforts and included under the current regulatory framework. Failure to account for TPMOs to their full extent will not adequately address the concerns CMS raised and Better Medicare Alliance shares, including minimizing incentives to enroll beneficiaries in specific plans and ensuring beneficiaries are appropriately directed to a health plan that best meets their health care needs.

The relevant regulatory language proposed in this Proposed Rule is ambiguous as to whether TPMOs are included within the purview of CMS oversight. For the reasons stated above, TPMOs must be a part of CMS' oversight with regard to ensuring beneficiaries are fully informed and empowered to choose a health plan that best meets their needs and in a transparent manner. As such, Better Medicare Alliance has three recommendations that collectively, will more comprehensively address the outstanding concerns around marketing and sales practices of Medicare Advantage plans to beneficiaries.

First, we strongly urge CMS maintain the current regulatory framework as it relates to agents and brokers and not pull administrative payments within the established compensation limit. Rather, we recommend CMS first expand its oversight authority to TPMOs. Second, we ask CMS clearly define the types of administrative services health plans can compensate TPMOs for. Clearly articulating and exemplifying which services are allowed for compensation will better inform health plans and their services to beneficiaries. For example, CMS should define activities, including but not limited to those related to beneficiary support and enrollment and compliance. Lastly, we recommend CMS establish a fee cap for the range of administrative services TPMOs engage in and perform on behalf of beneficiaries and health plans. Better Medicare Alliance encourages CMS to engage the appropriate stakeholders to develop and adopt a cap for administrative services that is based on the fair market value of those services and creates a balanced environment for Medicare Advantage plans, whether larger or smaller in size.

In consideration of our comments and recommendations, Better Medicare Alliance looks forward to further conversation with CMS and other stakeholders to better ensure our shared goals of comprehensively addressing marketing and communications to Medicare beneficiaries as they navigate the enrollment process and selection of a health plan that best meets their needs successfully and in a transparent manner are met.

Improvements for Special Needs Plans

Medicare Advantage is unique in that health plans are able to offer tailored health plans to meet the special needs of beneficiaries through Special Needs Plans (SNPs). There are three types of SNPs, including dual eligible SNP (D-SNP), chronic condition SNP (C-SNP), and institutional SNP (I-SNP), which are designed to meet the unique and special needs Medicare beneficiaries may have. Better Medicare Alliance's comments focus specifically on CMS' proposals around D-SNPs and the dual eligible population. Nevertheless, we recognize the important roll C-SNPs and I-SNPs have in meeting the unique needs of Medicare Advantage beneficiaries and appreciate CMS' continued focus to ensure beneficiaries receive targeted, high-quality health care.

In the Medicare population, there are approximately 12 million dual eligible beneficiaries, or about 19 percent of the Medicare population.[16] Of those 12 million beneficiaries, nearly 60 percent choose Medicare Advantage to receive their Medicare benefits. A majority of dual eligible beneficiaries in Medicare Advantage are full duals compared to partial duals.[17] Within the three types of SNPs available in Medicare Advantage, duals enrolled in a D-SNP account for approximately 90 percent of all SNP enrollment, meaning D-SNPs are the more popular and widely selected SNP in Medicare Advantage.[18]

The dual eligible population includes a significant number of individuals that identify as a minority, are low-income, and are medically and/or socially complex.[19]

- Dual eligible beneficiaries are more likely than Medicare-only beneficiaries to be Black or Latino and duals in Medicare Advantage are more likely to be Black or Latino compared to duals in fee-for-service (FFS) Medicare. Among duals in a Medicare Advantage SNP, 56 percent are Black or Latino compared to 34 percent of duals in FFS Medicare.
- Medicare Advantage also serves a greater proportion of dual eligible beneficiaries that speak a language other than English compared to dual eligible beneficiaries in FFS Medicare, 30 percent and 25 percent, respectively.
- Dual eligible beneficiaries in Medicare Advantage report more chronic conditions and higher rates of specific conditions than dual eligible beneficiaries in FFS Medicare. Over two in three duals in Medicare Advantage report having three or more chronic conditions, which is 12 percentage points higher than duals in FFS Medicare. For duals enrolled in a Medicare Advantage SNP, nearly three-quarters of duals report having three or more chronic conditions.
- Dual eligible beneficiaries in Medicare Advantage are more likely to have a usual source of care compared to duals in FFS Medicare. Among duals in Medicare Advantage, 91 percent report a usual source of care compared to 86 percent in FFS Medicare. Duals in Medicare Advantage also report less difficulty getting health care, 11 percent, compared to 15 percent in FFS Medicare.
- Dual eligible beneficiaries in Medicare Advantage are more likely to report receiving preventative care services across multiple measures, including receiving mammograms, getting the flu shot, and having their blood cholesterol measured compared to duals in FFS Medicare.

[16] Medicare Payment Advisory Committee. Mandated Report: Dual-Eligible Special needs Plans. November 2, 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/03/D-SNPs-MedPAC-11.23.pdf
[17] *Id.*
[18] Analysis of CMS Monthly Enrollment File. September 2023.
[19] Better Medicare Alliance. Data Brief: Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections When Enrolled in Medicare Advantage. December 2021. Available at: https://bettermedicarealliance.org/wp-content/uploads/2021/12/BMA-Q4-Brief-2021.pdf

- Medicare Advantage delivers affordable care to dual eligible beneficiaries who spend less on premiums and out-of-pocket costs compared to duals in FFS Medicare.

With the growing dual eligible population in Medicare broadly and specifically within Medicare Advantage, the diversity of the population, and the complex medical needs, Medicare Advantage is well positioned to deliver high-quality care and support this population through its clinical care model and unique flexibilities like supplemental benefits. The data above suggests dual eligible beneficiaries in Medicare Advantage, including those enrolled in SNPs, receive better access to and affordable health care. As such, Better Medicare Alliance firmly believes the D-SNP model within Medicare Advantage is the appropriate model to deliver care to dual eligible beneficiaries and supports building on the D-SNP model and promoting coordinated care to continue serving this population.

- **Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization (§§ 422.503, 422.504, 422.514, 422.530, and 423.38)**
    i. Changes to the Special Enrollment Periods for Dually Eligible Individuals and other LIS Eligible Individuals
    ii. Enrollment Limitations for Non-Integrated Medicare Advantage Plans

Better Medicare Alliance appreciates CMS' goal and efforts to improve the experiences and outcomes of dual eligible beneficiaries through integration. However, we are concerned the proposals could significantly limit beneficiary choice and disrupt care.

CMS proposes to replace the current quarterly Special Enrollment Period (SEP) with a monthly SEP for dual eligible beneficiaries and LIS beneficiaries to elect a standalone PDP. CMS also proposes to create a new integrated care SEP to allow dual eligible beneficiaries to elect an integrated D-SNP on a monthly basis, limit enrollment in certain D-SNPs to those who are also enrolled in an affiliated Medicaid Managed Care Organization (MCO), and limit the number of D-SNP plan benefit packages an MAO may offer in the same service area as an affiliated Medicaid MCO.

BMA Comments
Better Medicare Alliance recognizes the complexities and potential confusion of navigating the health care system as a dual eligible beneficiary and commends CMS for its efforts over the years to improve this experience for beneficiaries. However, we are concerned that in totality, the proposals put forth in this Proposed Rule could significantly limit beneficiary choice and disrupt beneficiary care and offer the following comments for consideration.

First, we appreciate CMS' intent and goal to increase the percentage of beneficiaries in more integrated health plans. Currently, the evidence supporting fully integrated care is mixed, with a recent study finding that while dual eligible beneficiaries in a FIDE-SNP had improved use of Home and Community Based Services (HCBS), these beneficiaries did not experience other differences in care patterns.[20] Another recent study found that FIDE-SNPs did not perform better than non-D-SNP health plans on care coordination for the dual eligible beneficiary population.[21] As the evidence around the

[20] Eric T. Roberts, John Lovelace, et al, Changes in Care Associated with Integrating Medicare and Medicaid for Dual-Eligible Individuals. JAMA, December 21, 2023. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812751
[21] David J. Meyers, Kendra Offiaeli, Amal N. Trivedi, et al, Medicare and Medicaid Dual-Eligible Special Needs Plan Enrolment and Beneficiary-Reported Experience with Care. JAMA, September 8, 2023.Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2809284?resultClick=1

benefits of integrated care continues to be explored and developed, Better Medicare Alliance believes it is best to further identify opportunities to better coordinate health care for dual eligible beneficiaries within the current framework and pathways to deliver care to dual eligible beneficiaries.

The proposals around the expanded and new SEP create an environment that unduly limits the opportunities for beneficiaries to join Medicare Advantage relative to the opportunities for beneficiaries to leave Medicare Advantage. By creating an imbalance in the number of opportunities for beneficiaries to choose FFS Medicare and leave Medicare Advantage, we believe the goal of improving the percentage of dual eligible beneficiaries in more coordinated health plans will be hindered. We request CMS preserve the Medicare Advantage choice for dual eligible beneficiaries, as the coordinated care delivers value to this population that could benefit most.

Next, we recognize the critical role states have in delivering care to the dual eligible population through Medicaid services and benefits and the robust activities carried out. However, we are concerned the proposal to limit enrollment in non-integrated, or unaligned, Medicare Advantage plans could effectively eliminate beneficiary choice as it relates to choosing their health care options and create additional confusion and complexity. This is especially concerning when there are a number of states that adopt an auto-assignment process for Medicaid beneficiaries, and it is understood that dual eligible beneficiaries could find themselves enrolled in a Medicaid plan and a D-SNP from the same organization without making any choice under this Proposed Rule. Moreover, this could be a significant shift for states that do not have implemented or explored aligned enrollment requirements.[22]

Better Medicare Alliance is supportive of promoting more coordinated care and empowering beneficiaries with the information they need to make their health care decisions. Effectively removing or limiting beneficiaries' Medicare choice impedes the advancement of these goals. As such, we suggest focusing on and improving efforts on how the potential value of aligned enrollment is conveyed to beneficiaries in order to allow them to choose the health care option that best meets their needs.

Third, this Proposed Rule and the focus around aligned enrollment could create disruption for beneficiaries and their health care. As states contract with Medicaid MCOs for a period of time, there could be variability in the options available to beneficiaries and subsequently impacting their Medicare options. Further, partial dual eligible beneficiaries may experience disruption to their care if enrollment in non-integrated D-SNPs becomes more limited. Much like full dual eligible beneficiaries, partial duals share many of the same medical and social complexities and benefit from the coordinated care and additional benefits and services available in Medicare Advantage.[23] These efforts to further align enrollment in Medicare and Medicaid could negatively impact the options available for partial dual eligible beneficiaries.

Lastly, we encourage CMS to further explore how the proposals around further integration impact the physician and provider community, and specifically, providers that deliver care to a significant number of dual eligible beneficiaries. Dual eligible beneficiaries experience a unique set of health and social

[22] Integrated Care Resource Center, Exclusively Aligned Enrollment 101: Considerations for States Interested in Leveraging D-SNPs to Integrate Medicare and Medicaid Benefits, May 4, 2022. Available at: https://integratedcareresourcecenter.com/sites/default/files/ICRC_EAE_101_FINAL_5.4.22_0.pdf

[23] ATI Advisory. A Profile of Medicare-Medicaid Dual Beneficiaries. June 2022. Available at: https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf

care challenges, with an increasing number of providers focusing on this particular population and developing trusted relationships with beneficiaries. If there are changes in a beneficiary's enrollment in and alignment with their Medicare and Medicaid benefits, their provider could also change and potentially disrupt beneficiary care if that particular provider does not have a relationship with both the Medicaid MCO and Medicare Advantage plan.

- **Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes (§ 422.514)**
    i. Reducing Threshold for Contract Limitation on D-SNP Look-Alikes

Better Medicare Alliance appreciates CMS' continued focus to limit D-SNP look-alike plans, and lowering the threshold is a proposal we have previously and reaffirm our support of if partial dual eligible beneficiaries are excluded from the threshold assessment.

CMS proposes to lower the threshold for D-SNP look-alike plans from 80% of total enrollment being dual eligible beneficiaries to 70% in 2025 and 60% in 2026.

BMA Comments
Better Medicare Alliance supports efforts to further integrate Medicare and Medicaid benefits for dually eligible beneficiaries, as this population can benefit from the care coordination and integrated benefit design available through a managed care plan tailored to meet their needs. In recent years, we have been supportive of CMS lowering the threshold of dual eligible beneficiaries enrolled in D-SNP look-alike plans, as we recognize these plans may undermine state and federal efforts to integrate the Medicare and Medicaid programs and are pleased to see this proposal in furtherance of CMS goals.

As CMS reviews this proposed policy change, we request it consider and appreciate the differences within the dual eligible population (full and partial duals) as well as the service areas across the country. The benefit of coordinated care and the additional services and items offered in Medicare Advantage extends to partial dual eligible beneficiaries who may not have a D-SNP available to choose from. It is important to preserve this choice for partial dual eligible beneficiaries to either continue or choose to enroll in Medicare Advantage and have a managed care option available to them. As such, we suggest CMS exclude partial dual eligible beneficiaries from the threshold assessment in order to promote beneficiary choice of health care options that best meet their unique care needs.