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

January 27, 2025

Re: CMS-4208-P, Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Acting Administrator Wu:

Better Medicare Alliance is pleased to submit the following comments on the proposed Contract Year 2026 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 34 million beneficiaries enrolled in Medicare Advantage. Better Medicare Alliance is a diverse coalition of over 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, affordable option for current and future Medicare beneficiaries.

Medicare Advantage is now the primary form of Medicare coverage in the U.S. Fifty-five percent of Medicare beneficiaries choose Medicare Advantage for high-quality, comprehensive care that costs them less on average than Fee-for-Service Medicare. The program also serves Americans nationwide, across geographies, and attracts a diverse population of beneficiaries, with Latino, Black, and Asian and Pacific Islander Americans enrolling at higher rates than Fee-for-Service.[1] Beneficiaries rely on Medicare Advantage for affordable health coverage, with the average beneficiary spending over $2,500 less in premiums and out-of-pocket costs compared to Fee-for-Service Medicare beneficiaries.[2] Seniors and individuals with disabilities choose and trust the affordable, quality, and innovative health care available in Medicare Advantage that delivers better outcomes, with an estimated 35.7 million beneficiaries choosing Medicare Advantage this year.[3]

After two years of cuts to Medicare Advantage, and as the program continues to adjust to significant policy changes implemented in recent years, promoting stability for beneficiaries is critical. As you are aware, millions of beneficiaries have experienced widespread plan closures, higher costs, and reduced benefits for 2025. A stable Medicare Advantage enables widespread access to care and supplemental benefits, significant cost savings on premiums and out-of-

[1] Better Medicare Alliance, Medicare Advantage Enrollment Map. Available here; Better Medicare Alliance, State of Medicare Advantage 2024. Available here.
[2] Better Medicare Alliance, Medicare Beneficiary Spending 2024. Available here.
[3] Analysis of the Centers for Medicare & Medicaid Services Monthly Enrollment Files, June 2024; CMS Announcement, September 2024, Available here.

pocket costs for beneficiaries, and high-quality care with better outcomes, including fewer avoidable hospitalizations and greater use of preventative care services.[4] As such, we urge CMS to not finalize this Proposed Rule unless specifically mandated by statute until a careful review of the proposals has taken place. Should CMS move forward with this Proposed Rule, we provide further comments in the attached with the goal of promoting a seamless, easy to navigate care experience for well-informed beneficiaries.

Better Medicare Alliance is committed to preserving and strengthening Medicare Advantage as a critical choice for Medicare beneficiaries. We appreciate the opportunity to submit comments and look forward to working with this Administration to ensure stability and identify opportunities to strengthen the program.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

[4] Better Medicare Alliance, Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-for-Service Medicare, December 2020. Available here.

ATTACHMENT

Coverage of Anti-Obesity Medications

Better Medicare Alliance recognizes the ongoing importance of addressing obesity in the U.S. and the role the federal government could play in doing so. That said, we are not commenting on the overall proposal of coverage of anti-obesity medications (AOMs) in Part D and Medicaid and instead focus our brief comments on the operational impact and potential consequences of AOM coverage.

Better Medicare Alliance asks CMS to consider the unintended consequences that could arise if this proposal is finalized, for example, adverse implications for how certain quality measures are captured and measured and ensuring the appropriate population is recognized.

The rule proposes reinterpreting the statutory exclusion of weight loss agents, thereby allowing Part D coverage of AOMs for weight loss or chronic weight management when treating individuals with obesity. The proposed reinterpretation would expand the coverage of AOMs under both Part D and Medicaid. CMS will continue to exclude AOMs from coverage under Part D and Medicaid for individuals who do not have obesity.

BMA Comments

There are early concerns that there could be unintended consequences in parallel efforts if CMS finalizes the proposal to cover AOMs for beneficiaries that have obesity. For example, there could be implications for how certain quality measures are captured and measured should the administration expand coverage to beneficiaries with obesity but not diabetes. In other words, inclusion of beneficiaries without diabetes could have a significant impact on the diabetes medication adherence measures if the certain AOM intended for beneficiaries *with* diabetes automatically includes non-diabetics using the drug in the measure denominator. If CMS moves forward with this proposal, meaures like this must be corrected to ensure the appropriate population is captured for condition-specific measures.

Additionally, BMA shares concerns regarding the operational impact of this proposal and wants to make sure all the necessary pieces are in place for this proposal to be a success. CMS should ensure Part D plans and state Medicaid agencies have the time and information necessary to implement AOM coverage without disruption to the overall benefit design.

Supplemental Benefits in Medicare Advantage

Supplemental benefits are a critical tool in Medicare Advantage to identify care gaps and address both beneficiaries' medical and non-medical needs. Following CMS' guidance relaxing the definition of "primarily health-related" and the creation of Special Supplemental Benefits for the Chronically Ill (SSBCI), health plans significantly increased their supplemental benefit offerings as new pathways for delivery became available. Recently, this growth has started leveling off, and in some instances, declined in response to policy actions that are shifting the supplemental benefit landscape.

Additionally, the CMS Innovation Center (CMMI) announced its decision to terminate the Value-Based Insurance Design (VBID) program at the end of 2025. As the only Medicare Advantage specific model, this decision removes unique flexibilities and innovative opportunities for health

plans and will further destabilize the supplemental benefits landscape. Given the uncertainty in supplemental benefits, we encourage CMS to promote stability in this space and ask for at least one more year of VBID to ensure a smooth transition for beneficiaries and to explore alternative options to incorporate successful aspects of the model into Medicare Advantage more broadly. We ask that the choice to extend the model be made as soon as possible and before April, so that key decisions necessary for the bid process can be made with an appropriate amount of time for both CMMI and health plans.

- **Administration of Supplemental Benefits Coverage Using Debit Cards**

Better Medicare Alliance is committed to making sure beneficiaries understand and receive their intended supplemental benefits.

The rule proposes codifying existing guidelines to include the use of debit cards to administer plan-covered benefits and adds clarifying language to require health plans to make beneficiaries aware of their covered supplemental benefits and ways to access them.

BMA Comments
Better Medicare Alliance commends CMS' dedication to ensuring that beneficiaries receive the intended benefits included in their plans. Supplemental benefits available in Medicare Advantage improve Medicare beneficiaries' access to care and address care gaps, including non-medical drivers of health. However, it is important that beneficiaries understand the benefits included in their health plan and how to access them. Increasing transparency around supplemental benefits will help fully inform beneficiaries on supplemental benefits included in their plan, empowering them with important information regarding specifics of their plan. Better Medicare Alliance is supportive of measures that will support beneficiaries in making informed decisions regarding their health care, including how to best utilize resources included in their health plan and ask CMS is thoughtful in their approach to ensure any additional requirements align with overall goals of plan benefit design.

- **Non-allowable Supplemental Benefits for the Chronically Ill**

Better Medicare Alliance is committed to bolstering high-value supplemental benefits and is supportive of codifying items and services that do not advance healthy living.

The rule proposes to codify a list of non-primarily health related items or services to not be offered as SSBCI, including procedures that are solely cosmetic in nature, alcohol, tobacco, and cannabis products, funeral expenses, life insurance, hospital indemnity insurance, and broad membership-type programs, including providing discounts.

BMA Comments
Better Medicare Alliance is supportive of high-value supplemental benefits. These benefits, both medical and non-medical, promote better health for beneficiaries. Supplemental benefits enable providers and health plans to deliver comprehensive care and address the physical, behavioral, social, and environmental needs that affect beneficiary health and wellbeing. These benefits are critical in Medicare Advantage's approach to addressing needs in the community and providing holistic health care for beneficiaries.

We agree that the proposed listed items and services above do not advance healthy living. In order to support the continued integrity and value of supplemental benefits, we support codifying this list of items and services that do not meet the standards for covered benefits. This will increase transparency around supplemental benefits and clarify what is covered for beneficiaries and bolster their value.

- **Eligibility and Technical Changes for the Definition of Chronically Ill Enrollee**

Better Medicare Alliance recognizes the importance of better identifying beneficiaries with chronic conditions. However, we ask that implementation be gradually phased in to minimize potential disruptions for beneficiaries.

The rule proposes specifying that an individual who is chronically ill meets the following criteria: 1) has one or more complex chronic condition that is life threatening or significantly limits the overall health of the enrollee, and 2) a high risk of hospitalization or other adverse health outcomes. A health plan must demonstrate that an enrollee meets these criteria through an objective process and publish the objective criteria on their website.

BMA Comments
Chronic conditions are highly prevalent within the Medicare population,[5] and health care spending for beneficiaries with chronic conditions is higher than beneficiaries without one or more chronic condition.[6] As such, the identification of chronic conditions is critical to properly manage and deliver care to beneficiaries and reduce health care spending. Better Medicare Alliance appreciates efforts to appropriately and efficiently identify beneficiaries that have unaddressed care needs within Medicare Advantage so that health plans may better connect beneficiaries with the care they need.

Requiring health plans to post their objective criteria for identifying chronically ill beneficiaries online will make the process more transparent and easier to navigate for beneficiaries. Having the ability to easily check what criteria allows them to be considered chronically ill, and often eligible for additional supplemental benefits, empowers beneficiaries as it helps them better understand their care and prevents them from being caught off guard by their coverage. Better Medicare Alliance supports a consistent and transparent approach to identifying chronically ill beneficiaries, as this leads to better informed beneficiaries. That said, we recommend that if finalized, the implementation be delayed at least one year to allow adequate time to inform beneficiaries while minimizing any potential disruptions to care.

[5] The Commonwealth Fund. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? October 2021. Available here.
[6] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Health and Economic Costs of Chronic Diseases. Available here; Medicare Payment Advisory Committee. Improving Care for Beneficiaries with Chronic Conditions. May 14, 2015. Available here.

Adding Guardrails for Artificial Intelligence

Better Medicare Alliance strongly agrees health care should be provided equitably in Medicare Advantage, including when using artificial intelligence, and encourages CMS to engage all stakeholders in developing the guardrails in this proposal.

The rule proposes revising current regulation by adding language that requires Medicare Advantage organizations to ensure they provide services equitably regardless of whether they are provided by a human or an automated system. CMS notes that health plans are required to follow all relevant Medicare Advantage requirements when using artificial intelligence. Finally, the rule proposes definitions for terms such as "automated systems," "patient computing infrastructure," "patient care decision support tool," and "artificial intelligence."

BMA Comments
Better Medicare Alliance appreciates the ongoing commitment to ensuring equitable access to care under Medicare Advantage. As artificial intelligence use in the medical field grows, it has great potential to innovate the delivery of care. However, those achievements should be available equitably across Medicare Advantage. It is imperative that artificial intelligence tools follow the same rules that human providers must follow in Medicare Advantage. That said, we encourage CMS to work with stakeholders in developing these guardrails to fully realize the benefit of artificial intelligence and its positive impact on beneficiaries.

Promoting Community-Based Services

Community-based organizations (CBOs) and the services they deliver are vital to delivering local, tailored care to beneficiaries. The partnerships fostered by CBOs, health plans, and others are a critical component to Medicare Advantage and something Better Medicare Alliance seeks to encourage in our work and with our Allies. Through these partnerships, local, innovative interventions occur that further address and meet the need of beneficiaries. Better Medicare Alliance appreciates CMS' recognition that CBOs play a role in delivering care and services in Medicare Advantage.

- **Adding Definition for Direct Furnishing Entities**

Better Medicare Alliance supports the proposed definition of "direct furnishing entities."

The rule proposes to add a definition to the provider directory model for "direct furnishing entities" to include those that deliver or furnish covered benefits to enrollees.

BMA Comments
Better Medicare Alliance appreciates CMS clarifying the term "direct furnishing entity" and recognizes the importance of beneficiaries having the contact information for entities and providers that can reasonably be expected to deliver covered benefits and services. The proposed definition for "direct furnishing entity" sufficiently captures the individuals or entities that could reasonably provide benefits and services.

- **Including Direct Furnishing Entities in Provider Directories**

Better Medicare Alliance requests additional guidance on including direct furnishing entities of in-home supplemental benefit services in directories without overwhelming beneficiaries with information and supports the alternative approach to maintain this provider directory separate from the primary directory.

The rule proposes clarifying that health plans must include all direct furnishing entities in their provider directories, including those that provide in-home supplemental benefits or services or a hybrid of in-home and in-office. In addition, CMS proposes to require easily identifiable notations or filters to indicate in-home supplemental benefits providers and solicits comments on alternatives such as creating a separate list for in-home supplemental benefit providers.

BMA Comments
Better Medicare Alliance appreciates CMS' further clarification that current guidance and regulation establish the expectation that all direct furnishing entities be included in provider directories. We recognize the importance of beneficiaries having a comprehensive understanding of the entities, individuals, and providers that could deliver benefits and services as it will offer beneficiaries a more complete understanding of their Medicare Advantage plan and care options. Nevertheless, we caution CMS that codifying the "direct furnishing entity" definition and subsequent clarification that they be included in the provider directory could lead to expansive provider directories that a) become more cumbersome and difficult to navigate for beneficiaries, and b) lead to further inaccuracies of provider directories, hindering current efforts and progress by stakeholders in ensuring accurate and updated directories.

First, directories could become more lengthy and cumbersome, leading to difficulty navigating the full directory for beneficiaries. Under current CMS guidance on provider directories and in accordance with the model provider directory, health plans cannot "list a provider if the enrollee cannot call the phone number listed and request an appointment with that provider at the address listed."[7] In the proposed language, it could be interpreted that every individual, including those in medical facilities such as adult day centers that deliver supplemental benefit services, must be listed as they would have a phone number that beneficiaries could reach them at to request an appointment. The result could lead to an extensive list of providers that becomes unmanageable for beneficiaries to navigate.

Second, more expansive provider directories have the potential for greater inaccuracies without further mechanisms to streamline and address current challenges leading to timely updates. As discussed below, we support attesting to the accuracy of directories by health plans. Nevertheless, additional action could further advance provider directory goals, and Better Medicare Alliance has put forth a number of policy recommendations to improve directory accuracy, including standardizing the process and manner in which health plans request personnel changes from providers and additional accountability measures – we look forward to future partnership with the Administration on this matter.[8] Rather, we suggest CMS consider specifying tiers of entities for inclusion. For example, if an adult day center is contracted with a Medicare Advantage plan to deliver services to beneficiaries, listing the center in the directory should meet the provider directory requirements and provide flexibility for both the providers and facilities as well as health plans and reduce the administrative burden of continuous updates.

[7] CMS. CY 2025 Medicare Advantage and Cost Plan Provider Directory Model and Instructions. Available here.
[8] Better Medicare Alliance. Strengthening Medicare Advantage for Beneficiaries: Recommendations for Policy Makers. October 2023. Available here.

Further, Better Medicare Alliance supports the alternative approach proposed by CMS to establish a subset or separate list for in-home or at-home supplemental benefit providers as beneficiaries would be able to navigate more easily the various types of medical and non-medical care and providers.

- **Defining Community-Based Organization**

Better Medicare Alliance supports the proposed definition of "community-based organization" and encourages CMS to consider any adverse consequences of codifying this definition in Medicare Advantage across other CMS programs and HHS agencies.

The rule proposes to define "community-based organization" and to require health plans include identifiable notations or filters to indicate CBOs in provider directories.

BMA Comments
Better Medicare Alliance appreciates the benefit of notating CBOs in provider directories in the effort to further promote the services and care they expertly deliver within local communities. We believe the proposed definition sufficiently captures the breadth of organizations beneficiaries could expect to engage with and receive services and care from. However, CMS should consider whether there are any consequences of codifying a definition for CBOs in Medicare Advantage across other CMS programs and HHS agencies where there may be significant overlap with stakeholders that engage with multiple agencies and programs, as inconsistencies could arise in how CBOs are understood and engaged.

Behavioral Health Cost-Sharing Limits

Better Medicare Alliance supports improving access to behavioral and mental health by ensuring in-network Medicare Advantage cost sharing does not exceed that of Fee-for-Service Medicare and phasing in as proposed.

The rule proposes improving access to behavioral health services in Medicare Advantage by ensuring in-network cost sharing for Medicare Advantage does not exceed that of Fee-for-Service Medicare, beginning January 1, 2026.

BMA Comments
Better Medicare Alliance supports improving equitable 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 beneficiaries.[9] Better Medicare Alliance is encouraged to see proposals addressing the affordability of behavioral health services for Medicare Advantage beneficiaries.

We appreciate and support CMS' proposal to improve the affordability and accessibility of behavioral health services. Reducing barriers to care, such as lowering costs, makes care more attainable for all beneficiaries within Medicare Advantage, especially those with unaddressed care needs. Better Medicare Alliance has supported efforts to improve access to behavioral health services, such as in our 2023 policy solutions where we support aligning primary care

[9] Better Medicare Alliance. Approaches to Meet Behavioral Health Needs in Medicare Advantage. November 2022. Available here.

and behavioral health cost sharing.[10] Access to behavioral health is vital for beneficiaries, and Better Medicare Alliance supports efforts to improve access to care. We are supportive of CMS phasing in this rule as suggested in the proposed rule, as we want to ensure minimal disruptions to care resulting from this proposal. Additionally, we underscore the importance that any regulatory cost sharing thresholds imposed by CMS do not interfere with a health plan's flexibility in designing cost sharing and tailored benefits for their members. This flexibility is integral for a health plan's innovative approach to delivering high-quality care to beneficiaries.

Health Equity Analysis of Utilization Management Policies and Procedures

Better Medicare Alliance recognizes the importance of reducing disparities in care among Medicare beneficiaries and generally supports the inclusion of additional prior authorization metrics in the annual health equity analysis.

The rule proposes to revise the metrics required for the annual health equity analysis of the use of prior authorization to be more granular and captured at the item and service level. The rule proposes to require that health plans include an executive summary of the results of the health equity analysis that includes additional context to understand the results, clarifying information, and an overview of the information produced such as key statistics and results.

BMA Comments
Better Medicare Alliance is dedicated to reducing disparities in care for all beneficiaries. In recent years, we have endorsed efforts to reform prior authorization and utilization management that improve access to care and transparency in the processes, including supporting the bi-partisan, bi-cameral Improving Seniors' Timely Access to Care Act of 2024, recent regulatory actions such as reduced request times, and additional recommendations in Better Medicare Alliance's policy solutions released in 2023.

We recognize the value of the analysis as it relates to prior authorization and that it could be helpful in further improving care, 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.

Expanding Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap

Better Medicare Alliance is committed to ensuring beneficiaries are well informed of their Medicare options, however, we encourage CMS to explore other options and pathways to deliver the additional proposed topics agents and brokers must raise in enrollment conversations.

The rule proposes adding low-income subsidy (LIS) eligibility, Medicare Savings Programs (MSPs), and Medicare Supplemental Insurance (Medigap) to the list of required topics that

[10] Better Medicare Alliance. Strengthening Medicare Advantage for Beneficiaries: Recommendations for Policy Makers. October 2023. Available here.

Medicare Advantage and Part D agents and brokers must discuss with a potential beneficiary prior to enrollment. Additionally, this proposed rule would require agents and brokers to ask beneficiaries if they have any additional questions prior to enrolling in a plan.

BMA Comments
Nearly all Medicare beneficiaries nationwide have multiple Medicare Advantage plan options to choose from in addition to the many considerations and trade-offs of Fee-for-Service Medicare. 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 option and health plan that best meets their needs. Critical to the enrollment process are agents and brokers, which Better Medicare Alliance along with CMS recognize as having an important role as beneficiaries navigate the complex programs, decisions, and options available to them.

That said, we believe the information that must be disclosed and discussed with beneficiaries by agents and brokers is already quite extensive and additional topics could negatively impact the enrollment process and leave beneficiaries more confused. As such, we suggest CMS first consider other options and pathways to deliver the proposed LIS, MSP, and Medigap information to beneficiaries, as there are opportunities to streamline the number and topics that must be discussed as well as other formats and platforms, including written materials, to share the necessary and critical information raised in the proposed rule with beneficiaries. Better Medicare Alliance has worked with CMS in the past to update helpful Medicare enrollment resources such as the Medicare & You Handbook and welcomes the opportunity to further collaborate on creating an informative resource for beneficiaries.

Formatting Provider Directories for Medicare Plan Finder

Better Medicare Alliance supports making provider directories viewable within Medicare Plan Finder, however, we request a one-year delay in implementation to ensure smooth adoption. We further support the attestation requirement and updating personnel changes within 30 days and request clarification for updating directory information to ensure accurate and consistent directories.

The rule proposes expanding the existing requirements applicable to Medicare Advantage organizations regarding their provider directories to include submitting provider directory data to CMS to be viewable on Medicare Plan Finder, attest to the accuracy of the data submitted, and submit updated data to CMS within 30 days of receiving notice of provider changes.

BMA Comments
Better Medicare Alliance is committed to streamlining the beneficiary experience and ensuring beneficiaries have the information they need to make a choice that best meets their needs. As such, we broadly support CMS' proposal to make provider directories viewable within Medicare Plan Finder (MPF) to improve the beneficiary experience. However, we suggest delaying implementation of this proposal to the CY 2027 Annual Enrollment Period (AEP) to ensure there is sufficient time between the final rule, understanding the forthcoming provider directory data submissions guide, and the testing and subsequent launch of the data within MPF. Further, if CMS finalizes the proposal that provider directories include all direct furnishing entities, and specifically those that provide in-home and hybrid supplemental benefit services, additional time will lead to a smoother adoption and beneficiary experience.

We further support the requirements that health plans attest to the accuracy of the provider directory data and update data submitted to CMS within 30 days of receiving notice of provider changes. Necessary to maintain accuracy, we request clarification on the process of updating the data submitted to CMS by health plans when notified of provider changes and whether the updates will be immediately reflected on MPF. Without quick action by CMS, MPF will not reflect the updated personnel information and hinder the promotion of accurate and consistent provider directories. We look forward to further partnership with CMS and stakeholders on ensuring provider directories meet beneficiary needs and promote timely updates and accuracy.

Enhancing Review of Marketing & Communications

Better Medicare Alliance appreciates the changing marketing and communications landscape that necessitates action to ensure beneficiaries are not misled and well-informed, but we encourage CMS to consider the breadth of materials that will require review and ensure there is adequate and reasonable review periods for stakeholders.

The rule proposes to eliminate the content standard in existing regulation for the definition of "marketing," effectively expanding the scope of materials and activities subject to CMS oversight. Additionally, CMS proposes changes to the definition of "advertisement (ad)" to align with the updates to the content standard.

BMA Comments
Better Medicare Alliance recognizes the notable change in the marketing and communications landscape over the past decade and the need for regulations and guidance to evolve to effectively work within the current environment. Moreover, we appreciate the overall sentiment towards creating an environment that ensures beneficiaries are not misled, are well-informed, and able to make the right health care choices to meet their needs. We support CMS' efforts to improve oversight and remove misleading materials from the environment, yet it is reasonable to expect the number or amount of material subject to CMS review will significantly increase under the revised marketing definition. As a result, there could be a buildup of materials requiring review and should be considered in finalizing this proposal to ensure adequate and reasonable review periods for both CMS and stakeholders.

Star Ratings System Measure Changes

Better Medicare Alliance supports the inclusion of individuals 40-49 years old in the breast cancer screening measure.

The rule proposes several measure changes to improve the Part C and Part D Star Ratings System by focusing on clinical outcomes, including updating the age range for the Breast Cancer Screening Part C measure from 50-74 years to 40-74 years of age in accordance with updated clinical guidance.

BMA Comments
Better Medicare Alliance appreciates CMS' commitment to ensuring high-quality care is delivered in Medicare Advantage. Breast cancer is the second most common cancer death among women in the U.S. Over 42,000 women are estimated to have died from breast cancer in

2024.[11] While only a small share of Medicare Advantage beneficiaries are under 50 years old – 3.1 percent[12] – including individuals 40-49 years old in the screening measure may have a significant impact on health. Detecting breast cancer early is one of the most important factors affecting prognosis, as treatment is more effective when the cancer is less extensive.[13]

Better Medicare Alliance supports expanding screening to individuals 40-49 years old because it could lead to earlier detection and intervention, resulting in fewer deaths from breast cancer. As the Medicare Advantage population continues to serve an increasing share of beneficiaries, expanding the screening age could have a measurable impact on early detection efforts. To promote the health and wellbeing of beneficiaries regardless of age and support earlier detection, the age range for breast cancer screening should include individuals 40-49 years of age.

Health Equity Index Reward

Better Medicare Alliance urges CMS to contemplate whether the Health Equity Index (HEI) reward will meaningfully address disparities as intended and looks forward to engaging the administration further.

The rule proposes three updates to how the HEI reward is calculated 1) for contract consolidations for the second year following consolidation, 2) for plans that have or will move a D-SNP in an existing contract to a D-SNP only contract to satisfy state Medicaid requirements, and 3) for permissible I-SNPs.

BMA Comments
Better Medicare Alliance appreciates the clarifications in the proposed rule as stakeholders prepare for the application of the HEI. It is critical that populations with the specified social risk factors are contemplated and actively addressed by health plans in an effort to reduce disparities and improve health outcomes of these populations. Nevertheless, we urge CMS to contemplate whether the HEI reward will meaningfully reduce disparities as intended. Better Medicare Alliance looks forward to engaging the administration to discuss the unique opportunities within Medicare Advantage to address the underlying drivers of health within the population.

Improving Experiences for Dually Eligible Enrollees

Medicare Advantage is unique in that health plans are able to offer tailored plan options to meet particular needs of beneficiaries through Special Needs Plans (SNP), including dual eligible SNPs (D-SNP). Enrollment in D-SNPs has tripled since 2014, with over 5.8 million enrolled in 2024, about 19 percent of all Medicare Advantage enrollees.[14] A majority of dual eligible beneficiaries in Medicare Advantage are full duals compared to partial duals.[15] 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.[16]

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[11] American Cancer Society, Breast Cancer Facts & Figures 2024-2025. Available here.
[12] Milliman, Comparing the Demographics of Enrollees in Medicare Advantage and Fee-for-Service Medicare, October 2020. Available here.
[13] American Cancer Society, Breast Cancer Facts & Figures 2022-2024. Available here.
[14] MedPAC, Health Care Spending and the Medicare Program, July 2024. Available here.
[15] *Id.*
[16] Analysis of CMS Monthly Enrollment File. June 2024.

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.[17]

- Dual eligible beneficiaries in Medicare Advantage report more chronic conditions and higher rates of specific conditions than dual eligible beneficiaries in Fee-for-Service 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 Fee-for-Service 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 Fee-for-Service Medicare. Among duals in Medicare Advantage, 91 percent report a usual source of care compared to 86 percent in Fee-for-Service Medicare. Duals in Medicare Advantage also report less difficulty getting health care, 11 percent, compared to 15 percent in Fee-for-Service Medicare.

With the growing dual eligible population in Medicare broadly, and specifically within Medicare Advantage, 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.

- **Member ID Cards, Health Risk Assessments, and Individualized Care Plans**

Better Medicare Alliance supports requiring integrated ID cards for dual eligible beneficiaries in Medicare and Medicaid with additional guidance and further recommends that integrated health risk assessments (HRA) only be required for beneficiaries in fully integrated D-SNPs.

The rule proposes establishing new requirements for D-SNPs whose enrollment is limited to beneficiaries that are also enrolled in a Medicaid managed care organization owned or controlled by the same parent organization. The proposed requirements include an integrated ID card for both the Medicare and Medicaid plan and an integrated HRA under Medicare and Medicaid for any dual eligible enrollees, rather than separate HRAs for each program. The rule also proposes codifying timeframes for HRAs, developing an individualized care plan (ICP), and prioritizing the involvement of enrollees when developing an ICP.

[17] Better Medicare Alliance. Data Brief: Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections When Enrolled in Medicare Advantage. December 2021. Available here.

BMA Comments
Better Medicare Alliance recognizes the complexities and potential confusion of navigating the health care system, especially as a dual eligible beneficiary and commends CMS for its efforts over the years to improve the experience for beneficiaries. We broadly support efforts focused on improving the beneficiary experience for dual eligible beneficiaries.

We support the proposal to adopt an integrated ID card for both Medicare and Medicaid, as it would reduce the burden for dual beneficiaries in navigating and maintaining the appropriate paperwork for both programs. We further recommend that CMS issue a model integrated ID card as an example, as this would reduce the administrative burden for states while ensuring all requirements from both Medicare Advantage and Medicaid are accounted for within the card. Better Medicare Alliance is committed to streamlining and improving the beneficiary experience, particularly for duals who often must navigate two distinct and complex programs.

Better Medicare Alliance supports an integrated HRA for a subset of beneficiaries enrolled in D-SNPs, specifically fully integrated D-SNPs (FIDE SNPs). HRAs, particularly in-home HRAs are valuable clinical tools for beneficiaries as well as health plans and providers, as care gaps are identified and addressed. Having an integrated HRA would reduce redundant time beneficiaries could experience and be more efficient, as they would receive only one HRA that covers all necessary components for Medicare and Medicaid. Additionally, receiving a single HRA and reviewing any necessary next steps and follow ups at once may create a more complete experience for beneficiaries with regard to the information shared. All questions, comments, and concerns a beneficiary may have would only need to be discussed and addressed once, leading to a more coordinated experience.

We have some concerns about expanding this requirement to certain types of D-SNPs, including highly integrated D-SNPs (HIDE SNPs), and coordination-only D-SNPs (CO D-SNPs). Given the degree of integration required between the Medicare and Medicaid entities for FIDE SNPs, they are better positioned to provide an integrated HRA because the plan design includes a shared, single entity with both the Medicare Advantage contract and the contract with the state Medicaid agency. This degree of integration streamlines the process of providing a single HRA between the two programs that encompasses both Medicare and Medicaid requirements. An integrated HRA can improve the time meaningfully spent when delivering care for dual beneficiaries, but only when the D-SNP plan design allows for it. As HIDE SNPs and CO D-SNPs have less integration in plan design and infrastructure between the two programs, facilitating an HRA becomes less seamless and therefore does not further advance the aim of an integrated HRA.