March 7, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

RE: CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P)

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to offer comments in response to the proposed 2023 Medicare Advantage (MA) and Part D Rule to lower out of pocket Medicare Part D prescription drug costs, improve consumer protections, reduce disparities and improve health equity in the Medicare Advantage and Part D programs.

ACHP represents the nation's top-performing non-profit health plans improving affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that provide high-quality coverage and care to 24 million Americans across 36 states and D.C. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data driven systems improvement.

We appreciate CMS' commitment to providing regulatory flexibility and streamlining the MA program. ACHP offers the following support and recommendations to ensure seniors receive the highest value from the MA program.

Improving the Dual Eligible Experience

ACHP recommends CMS continue to rely on states to drive the transition from MMPs to D-SNPs to avoid rushing the transition. ACHP supports the Administration's ultimate goal for plan integration and recognizes the importance of having administrative alignment. We also appreciate the flexibility being given to states. It is important to consider that some health plans have new or existing MMPs that are still being evaluated on how to best address the needs of the beneficiary population. We appreciate CMS not imposing a specific timeframe for this conversion as it enables these plans to make an accurate assessment on programs that are already underway before transitioning them to D-SNPs.

ACHP encourages CMS to make HIDE-SNPs eligible for the frailty adjustment in alignment with the FIDE-SNP existing policy. We appreciate that CMS is working to better define the different types of SNPs, including HIDE-SNPs and FIDE-SNPs. The similarity between populations of HIDE-SNPs and FIDE-SNPs are strong, meaning it would be beneficial to make both plan types eligible to receive the frailty adjustment. Since both plan types serve populations that are generally

frailer than the typical Medicare population, both should be eligible to receive higher adjustment payments if they have a similar average frailty as the PACE program.

Maximum Out-of-Pocket (MOOP) Limit Requirements

ACHP strongly urges CMS to give health plans more time to gather data in order to assess the operational and financial impacts of this requirement. ACHP is concerned that data points needed to implement the requirement – which specifies the MOOP limit should be calculated based on the accrual of all cost-sharing, whether paid or unpaid – will not be available in time to meet the regulation. Plans do not always have awareness of their members' additional insurance or of state activities regarding dual-eligible enrollees. It will be difficult to gather this data and properly price it into bid submissions for 2023. Health plans need more time to assess the impact of this regulation. One ACHP member noted their internal actuarial analysis of this proposal for its D-SNP beneficiaries would be 20-25% higher than the national average. Given the potential significant financial impacts of this policy and the vulnerable and higher risk population, ACHP encourages CMS to approach changes to the MOOP for D-SNP beneficiaries cautiously. Should health plans, particularly regional health plans with narrow margins, incur significant costs as a result of this policy, this ultimately affects the benefits plans are able to offer.

Network Adequacy Requirements

ACHP does not support the proposed requirement to meet network adequacy at the time of application. While ACHP supports the idea of minimizing network adequacy failures, we feel these changes will have a disproportionate impact on regional health plans. It takes time for plans to work with their providers to take on risk and it is difficult for plans to complete contracts for the whole provider network far in advance. Rulemaking, such as the Rate Notice, drives many product design features for plans, which makes the timing for finalizing contracts under the new provision incongruent with plans' typical timelines. While this requirement does not significantly impact expanding within current service areas, the proposal introduces serious challenges when MA plans want to enter a new market. Provider systems may be reluctant to contract with expanding regional plans without any prior business in their market. Additionally, this would require large provider groups to fill in any network adequacy gaps which can take a long time to execute.

There is also a substantial administrative burden for plans. Health plans do not have all necessary information until the final Rate Notice, which means plans might decide to change their decisions on which counties they enter after having to already build the network to meet network adequacy requirements. We believe the proposed changes will negatively impact regional plans attempting to build networks in new markets thereby limiting options for beneficiaries.

ACHP also encourages CMS to expand the network adequacy telehealth credit by county designation. ACHP was very supportive of the recent telehealth credit to meet network adequacy for certain providers in past rulemaking. ACHP encourages CMS to expand on this policy with a focus on rural and frontier counties in future rulemaking. By increasing the telehealth credit, this would enable health plans to increase consumer choice of MA plans in areas where there are limited provider resources, this is particularly true for specialty providers who may not see the value of servicing a market in-person with a low patient population. Allowing health plans to contract with these providers through telehealth means beneficiaries will have improved access to a variety of services.

ACHP urges CMS to build exceptions into the 10% network adequacy credit to better accommodate different health plan service areas. While the 10% credit at time of application is appreciated, we do not believe that it is enough to allow regional plans to meet attestation requirements at the time of application. Historically, contract negotiations for commercial business are more effective after an MA book of business is built. The impact and value of the 10% credit will vary from market to market. For small provider groups, they often make up less than 10% of a network, so the 10% credit would be beneficial if their business was lost. However, for large provider groups that take up more than 10% of market share, a loss would not be covered by the 10% credit. Should CMS move forward with this credit, ACHP recommends building in exceptions to the 10% credit to help rural areas where there may only be a single provider as well as in metro areas where a single provider group dominates.

Part C and D Quality Rating System

ACHP supports the decision to remove the 60% rule and award contracts with the higher of the 2022 or 2023 Star Rating (and corresponding measure score) for each of the HEDIS measures collected through the HOS survey. We recognize the importance of calculating Star Ratings as accurately as possible, including being able to calculate the Star Ratings cut points for the 3 HEDIS measures in the HOS survey. Using the higher of policy will ensure plans are not punished with lower Star Ratings for the 3 HEDIS measures because of the effects of the COVID-19 pandemic.

Marketing and Communications Requirements

ACHP supports the policies for Third Party Marketing Organizations (TPMO) but asks that CMS not place the burden of oversight on health plans. ACHP supports CMS' other proposals to improve oversight of TPMO's to protect consumers from misleading marketing and bad actors. During this most recent annual enrollment period, several ACHP member plans recognized through disenrollment survey data and qualitative analysis of customer service records that a high number of members were directly impacted by high pressure and misleading marketing/sales tactics. This high number of members all had a similar theme of beneficiaries being enrolled into an alternate national carrier Medicare Advantage plan without their knowledge or consent. However, ACHP member companies do not have the internal capabilities or resources to add oversight responsibilities. This is especially problematic given current workforce shortages. ACHP strongly supports strengthening the review of third-party websites, aggregators and exchanges to help protect enrollees from bad actors. However, ACHP does not agree with placing the burden of oversight to enforce accuracy and compliance on health plans and requests CMS consider less workforce dependent oversight options, such as leveraging AI technology or partnering with the Office of the Inspector General.

Reinstated MLR Provisions

ACHP supports reinstating MLR reporting requirements that were in effect for contract years 2014-2017. We believe that improving transparency and oversight concerning the use of Trust Fund dollars is laudable. Many plans already run the detailed data associated with the 2014-2017 MLR reporting method, which required reporting of the underlying data used to calculate and verify the MLR and any remittance amount, such as incurred claims, total revenue, expenditures on quality improving activities, non-claims costs, taxes and regulatory fees. Therefore, ACHP applauds CMS' efforts to improve transparency and oversight within the MA program.

Part D Price Concessions

ACHP urges CMS to reconsider the compliance timeline for the price concession provisions. ACHP member plans are able to implement these changes, however, they will take considerable time. Considering the changes that would be required, it would be challenging for plans to implement these by 2023. Further, several plans predict difficulty for operational readiness by 2024. The limited time given to comply would limit the ability to accurately price, re-negotiation of pharmacy contracts and implement within timelines. Additionally, the change in definition removes the health plan's ability to leverage pay-for-performance and incentive programs on behalf of CMS, which have shown to significantly improve quality performance for key measures.

Thank you for considering ACHP's comments and recommendations. We appreciate the Administration's efforts to support and improve the Medicare Advantage and Part D programs. Please contact Ginny Whitman, Public Policy Manager at vwhitman@achp.org or 202-255-7775 with any questions or to discuss our recommendations further.

Regards,

Ceci Connolly
President and CEO
ACHP