January 3, 2024

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 2025 Medicare Advantage and Part D Policy and Technical Changes Proposed Rule (CMS-4205-P)

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the *CY 2025 Medicare Advantage and Part D Policy and Technical Changes proposed rule*. We commend CMS for the proposals to reform broker agent compensation and urge immediate implementation to reduce unnecessary add-on fees. These reforms are a crucial step towards ensuring seniors are enrolled in the right health plans for their needs and are not steered to the top bidder.

Medicare Advantage (MA) is an undeniable success, delivering coverage and care to more than half of beneficiaries and an estimated 33 million seniors in 2024. To serve current and future retirees, MA must improve the shopping experience to match other retail sectors and address loopholes and excessive costs that dampen robust competition and choice. Seniors deserve unbiased, actionable and easy-to-navigate information to make informed decisions about their coverage and care. That can be a challenge when the average MA beneficiary has 44 health options to choose from.

For many seniors, brokers offer important assistance in understanding health plan options and finding the best plan for their individual needs. Whether independent, employed by a field marketing organization or directly employed by an insurer, brokers are well compensated for their services. We appreciate and recognize the local agents who have been dedicated to their customers and communities for years, offering seniors the full menu of health plan options available with pertinent information on benefits.

The broker reimbursement model is straightforward: the more seniors a broker enrolls, the higher their earnings. However, what began as a modest reimbursement program for enrollment support has exploded into big business, creating an unlevel playing field and shifting Medicare Trust Fund dollars from delivering care to paying for administrative broker costs. Without limitations on "add-ons," ranging from marketing, administrative, technology, training and compliance to bonuses, incentives for hitting enrollment targets or more, some brokers are collecting upwards of $1,300, or more than double the commission cap set by CMS. One lawmaker even compared the add-ons to "junk fees."

The broker compensation arms race translates into billions of Medicare dollars being spent annually on sale agents instead of improving patient care or preserving the Medicare Trust Fund. Most worrisome, untethered and misaligned broker payment policies have led to brokers enrolling consumers in plans with higher broker compensation, not those that provide the highest quality care. Brokers should be

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incentivized to assist consumers in enrolling in the plan that best meets their needs, including offerings that promote value-based care and deliver high-quality services.

On October 18, the Senate Finance Committee convened a bipartisan hearing on questionable MA marketing and middlemen broker practices.[1] Chairman Wyden focused on "marketing middlemen" including "big marketing companies" that "get in the middle between seniors and their coverage." Chairman Wyden added: "to sum it up these middlemen have made seniors their product and they are trying to sell as much as they can." Ranking Member Crapo, a self-described "long champion of MA," expressed the need to "promote a vibrant and competitive broker landscape." He continued, "seniors need clear, credible and accurate information to navigate the coverage and service landscape." Both the Chairman and Ranking Member called on CMS to reform broker compensation to protect seniors, preserve robust choice and competition and safeguard the Medicare Trust Fund.

Security Health Plan CEO and ACHP Board Member Krista Hogland testified at the hearing and urged "Congress and the Centers for Medicare and Medicaid Services (CMS) to protect enrollees and taxpayers with reasonable limits on total agent/broker compensation and stop misleading and aggressive enrollment practices."

"The single most influential perspective in choosing a MA plan remains advice from a broker," Hoglund testified. Therefore, the lure of add-on payments available to agents and brokers can negatively impact enrollment resulting in seniors enrolling in the highest compensation plan for the broker but not the best health plan for the senior. Hoglund's testimony underscored the challenges faced by seniors in receiving unbiased advice and the unfortunate reality regionally-based health plans are faced in competing for enrollment based on broker compensation and not quality, value-based delivery or customer service. Addressing unnecessary broker add-on fees is a core element in ACHP's *MA for Tomorrow* to reduce the exponential growth of these add-on fees that result in seniors enrolling in plans that do not meet their needs. *MA for Tomorrow* offers policies that ensure health plans are stewards of the taxpayer dollar and enhance the quality of coverage and care seniors receive.

We are thrilled the Administration recognized in this proposed regulation the urgency to address perverse financial incentives, protect consumers from nefarious marketing practices and safeguard the Medicare Trust Fund. These reforms are strongly supported by consumer advocacy organizations, members of Congress on both sides of the aisle and in both the House and Senate who sent letters to CMS to enact broker compensation reform, as well as health plans committed to being fiscal stewards of every Medicare dollar. We appreciate the Administration's swift action and encourage finalizing these broker compensation proposals promptly.

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 deliver high-quality coverage and care to tens of millions of Americans across 37 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.

ACHP supports the general direction of the policies within this proposed rule and offer our support and recommendations to enhance the implementation of these policies.

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[1] *Medicare Advantage annual enrollment: Cracking down on deceptive practices and improving senior experiences: The United States Senate Committee on Finance*. United States Senate Committee on Finance. https://www.finance.senate.gov/hearings/medicare-advantage-annual-enrollment-cracking-down-on-deceptive-practices-and-improving-senior-experiences

Agent Broker Compensation

ACHP strongly supports restricting contract terms and compensation agreements that would interfere with a broker's ability to objectively recommend plan options to seniors. This topped our priorities in ACHP's carefully curated list of the most impactful reforms to the MA program in our *MA for Tomorrow* policy proposals. The shift to set a single, total compensation cap that clearly includes associated administrative and enrollment related costs will eliminate miscellaneous add-on fees for items such as marketing fees and volume-based bonuses. Our member companies know that these add-on payments drive beneficiaries into plans that may not be the right choice based on their health needs, causing consumer dissatisfaction and churn. Independent brokers provide essential services for seniors enrolling in MA. When perverse incentives are eliminated, brokers are free to offer unbiased coverage options and beneficiaries are more likely to select a plan that suits their needs. True competition will flourish.

ACHP supports CMS increasing the compensation cap from the proposed $31 to $50. ACHP readily acknowledges the essential role brokers play in ensuring seniors can easily navigate the enrollment process and find the best health plan to meet their needs. To ensure brokers are able to do so within the context of these new proposals, ACHP supports increasing the Fair Market Value compensation from $31 to around $50. ACHP member companies note that testing, licensing, appointing and training an agent on average can cost close to $50. We further encourage CMS to work closely in partnership with industry stakeholders to develop a methodology for establishing the total administrative payment amount in future years and updating it for cost inflation on an annual basis.

ACHP appreciates the Administration's previous reforms for MA marketing practices and ACHP encourages further action in future rulemaking. We recommend CMS consider stiffer sanctions, such as monetary and/or temporary suspension of marketing and enrollment activities, against plans whose marketing tactics do not meet the new requirements. We support further rulemaking that mitigates marketing activities that leave beneficiaries confused, are high pressure in nature or generally misleading as per the call recordings referenced in the proposed rule language.

Expanding Network Adequacy Requirements for Behavioral Health

ACHP recommends the Outpatient Behavioral Health specialty type be delineated based on provider and facility. We support initiatives to improve access to behavioral health services, providers and facilities. However, we are concerned that conflating providers and facilities into one category for network adequacy will create operational challenges and will not improve consumer access to behavioral health. We recommend CMS either create separate Outpatient Behavioral Health categories for providers and facilities, or only combine providers and facilities under one category for a limited set of contract years until there is sufficient data for Mental Health Counselor and Marriage and Family Therapists to establish their own network adequacy metrics. Additionally, the telehealth credit should be applicable to this/these category/categories.

Given the worsening provider workforce shortages, particularly in the behavioral health space, ACHP encourages CMS to consider additional flexibilities for meeting network adequacy requirements in future rulemaking. Virtual care is key to improving access to behavioral health care and reducing strain on services that necessitate in-person delivery. As part of *MA for Tomorrow,* ACHP recommends increasing the network adequacy telehealth credit from 10% to 30%. We further recommend CMS allow for virtual appointment wait times to count towards the Appointment Wait Time network adequacy metric.

Biosimilar Biological Product Maintenance Changes and Timing of Substitutions

ACHP supports treating biosimilar biological product substitutions, other than interchangeable biological products, as "maintenance changes." We agree that this is important to ensure patients are notified of the substitutions prior to the point of sale. Allowing these formulary changes and substitutions are a valuable part of improving prescription affordability.

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

ACHP supports shifting the burden of proof to health plans given the proliferation of supplemental benefit offerings since its inception. We recommend CMS issue guidance for a broad definition of "relevant acceptable evidence" to include internal case studies as an example of acceptable evidence. CMS should publish, and update on an annual basis, a list of approved SSBCIs for which evidence of potential benefit has been sufficiently established by relevant acceptable evidence. This approach would streamline the process and limit unnecessary duplication of effort across the program by not requiring multiple plans to compile and submit identical bibliographies to support the same benefit. We further request CMS set implementation of this provision for Contract Year 2026 to allow plans sufficient time to develop and finalize the necessary evidence.

Mid-Year Notice of Unused Supplemental Benefits

ACHP requests CMS not finalize the proposal for mid-year notification of unused supplemental benefits and coordinate with stakeholders on the most valuable and operationally feasible options for benefits communications to seniors. Mid-year notification of unused supplemental benefits will create significant operational challenges and only be relevant to a small portion of the consumers receiving the notification. A mailed notification provides snapshot information that may be outdated by the time the consumer receives it, creating unnecessary beneficiary confusion.

Health plans factor likely supplemental benefit utilization into each MA plan bid with the expectation that some consumers will need and use them more than others. Not all supplemental benefits, such as hearing aids, are applicable to every beneficiary within a plan. As another example, health plans may offer supplemental benefits such as "waiver of a 3-day hospital stay for SNF" which would not be relevant information for many of the consumers receiving the notification. ACHP welcomes the opportunity to collaborate with CMS to identify alternatives that would meet the intent of a mid-year notification. Such alternatives may include targeted outreach to consumers with certain risk factors about specific applicable supplemental benefits. Any notification requirements of unused supplemental benefits should focus on the appropriate use of those benefits for the appropriate beneficiaries.

Other alternatives include (1) more general communication that educates and reminds seniors of the most valuable supplemental benefits available to them, without including specific information as to their individual use; (2) health plan attestation confirming a certain percentage of beneficiaries utilized specific supplemental benefits which would address concerns about benefits not being used while reducing the administrative complexities of the proposal; or (3) strengthened marketing restrictions to reduce the likelihood of supplemental benefits being used as a marketing ploy.

Annual Health Equity Analysis of Utilization Management Policies and Procedures

ACHP supports CMS defining "expertise in health equity" and recommends CMS delay the effective date for publicizing the health equity analysis. ACHP supports the specific criteria for expertise in

health equity and agrees that utilization management may disproportionately impact underserved and marginalized individuals. We support the proposed initiatives to reduce health inequities but note that an analysis of utilization management may not be sufficient to identify equity gaps. We request CMS delay the health equity analysis requirement and recommend health plans conduct the health equity analysis, to be shared with CMS upon request, to determine whether the results adequately reflect gaps in health equity.

Health Equity Index Reward

ACHP supports the overall direction of a Health Equity Index Reward but remains concerned that the methodology disproportionately impacts smaller health plan products. Per our comments on the *CY 2024 MA and Part D proposed rule*, the Health Equity Index Reward should be carefully evaluated and vetted before going live. ACHP recommends this occur by implementing the HEI as a display measure for its first year to enable plans to better understand the impact and methodology and prepare for its full implementation.

To better align incentives for MA plans to enroll dual eligible beneficiaries in aligned and integrated coverage options, we recommend that CMS, for contracts operating in states mandating stand-alone D-SNPs, (1) determine eligibility for the HEI reward at the parent organization level, or (2) waive the HEI enrollment threshold permanently for MA contracts that would have otherwise qualified for the HEI reward. These policy modifications would promote further integration of Medicare and Medicaid coverage and benefits for dual eligibles in states mandating stand-alone D-SNP contracts.

Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization

ACHP supports the creation of a new integrated care SEP to allow dually eligible individuals to elect an integrated D-SNP on a monthly basis. There is value for dually eligible enrollees to receive Medicare and Medicaid services from the same organization. However, we recommend that CMS allow dual eligibles to retain their current flexibility to choose between any MA plan or traditional Medicare with a stand-alone PDP under the following circumstances: (1) During state Medicaid MCO open enrollment, in order to align MA enrollment with state Medicaid enrollment; (2) Upon a Medicare beneficiary becoming newly eligible for Medicaid, to accommodate any Medicare-related enrollment changes stemming from the initiation of Medicaid coverage; and
(3) In states that do not have any Medicaid managed care, or carve dual eligibles out of Medicaid managed care, and therefore have no integrated D-SNP options available in which these beneficiaries can enroll. Given the complexity of implementing this new SEP, ACHP requests implementation not begin until CY 2027 when the new enrollment limitations take effect.

ACHP supports the creation of a monthly SEP for dually eligible individuals and others enrolled in the Part D LIS program to elect a standalone PDP; however, ACHP recommends CMS not eliminate the current quarterly SEP for states that do not have Managed Medicaid Organizations. ACHP is concerned that eliminating the quarterly SEP will hinder growth of DSNPs in advance of any state integration, and could promote shifting of individuals to Medicare FFS, which would remove the care coordination and financial protections offered by MA-PD plans.

The combination of these two SEPs will support both ends of the spectrum in state integration models, thereby not hindering growth of DSNPs in geographies without integrated plans and supporting the growth of integrated plans where they are available.

While the integrated care SEP proposed concurrently with these limitations would reduce the ability of dual eligible beneficiaries to elect an unaligned D-SNP, we anticipate the imposition of enrollment

restrictions on D-SNPs with affiliated Medicaid MCOs could create circumstances that lead to growth in unaligned D-SNPs and/or growth in churn between unaligned and aligned D-SNPs. ACHP encourages CMS to consider additional ways to strengthen the requirements for unaligned D-SNPs to coordinate Medicaid-covered benefits and care under these circumstances, such as aligning their MA provider network with the provider network of their consumers Medicaid coverage.

Proposed Measure Update: Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)

ACHP does not support the proposed update to the Medication Therapy Management measure originally proposed in the CY 2024 Policy and Technical Changed to MA and Part D proposed rule (the "December 2022 proposed rule"). For smaller, regional health plans, the volume of CMR-eligible MA consumers necessitates outsourcing to approved MTM vendors. Due to the nature of a vendor relationship, there is limited access to beneficiary information compared to the information health plan pharmacists can view and complete for CMRs. Our member companies see limited uptake of recommendation made by the vendor pharmacists CMRs and performance improvement does not track with the increase with the growing volume of CMR completions. ACHP is concerned that expanding the eligibility requirement will create downstream effects stemming from the reliance on vendors to manage the volume of individuals within MTM Programs. Even the largest vendors will likely need to further automate processes to account for increased volume, decreasing consumer satisfaction.

The original proposed change to the MTM measure would result in significant and unmanageable increases in MTM eligible consumers. It would also detract from the efforts made to reach the beneficiaries who are the most complex and in need of MTM services by decreasing the maximum number of Part D drugs from 8 to 5. Given the extent of our concerns, we appreciate CMS moving this measure to the display page if the previous December 2022 proposals are finalized.

Thank you for your consideration of ACHP's comments and recommendations. We appreciate the Administration's efforts to support and improve the Medicare Advantage and Part D programs and are thrilled to see a major component of *MA for Tomorrow* on broker compensation be included. Please contact Michael Bagel, Associate Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions or to discuss our recommendations further.

Regards,

Ceci Connolly
President and CEO
Alliance of Community Health Plans