March 3, 2023

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

Re: CMS-2023-0010

Dear Administrator Brooks-LaSure:

The Healthcare Leadership Council (HLC) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to submit comments in response to the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC appreciates CMS efforts through the payment and policy proposals to lower out-of-pocket Medicare Part D prescription drug costs and improve consumer protections, reduce disparities, and improve health equity in MA and Part D. MA continues to grow in popularity and today serves more than 30 million Medicare beneficiaries (48% of the total Medicare population); the program appeals to new beneficiaries whose previous employer-sponsored health coverage resembles MA.[1] Our members come from all healthcare sectors and touch the lives of Medicare beneficiaries in multiple ways. They have seen firsthand the positive impact of MA and Part D and encourage CMS to support the programs' continued growth and success in the final rate notice.

We have been pleased to see stable funding to MA over the past years, which is important to providing access to high quality care, supports, and services to beneficiaries. Per CMS' fact sheet, three proposed changes included in the rate notice, if finalized, would result in an average reduction in MA rates 2024 by 2.27%. However, these changes will impact health plans differently due to a number of factors. These changes include a 3.12% reduction due to

[1] CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program, Keeping America Healthy (February, 2023) CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) (govdelivery.com)

revisions in the MA risk model, 1.24% lower quality bonus payments under the Medicare Star Ratings program, and a 2.09% effective growth rate which is less than half the growth rate issued in 2023 (4.88%) and well below both the Medicare Trustees 5.4% projected growth per enrollee Medicare costs for 2024, and the Congressional Budget Office's (CBO) projections of more than a 9% increase in Medicare costs from 2023 to 2024.[2] [3]

The Medicare payment cut could result in less funding that health plans use to offer supplemental benefits and lower premiums for their beneficiaries. As you know, supplemental benefits play a pivotal role in addressing social determinants of health (SDOH) related to food insecurity, social isolation, wellness, and transportation needs. Benefits such as vision, hearing, dental, physical activity, and in-home supports are critical to the overall health and well-being of beneficiaries. These benefits have reduced avoidable hospitalizations, lowered hospital readmission rates, and increased utilization of preventive services. In addition, MA's overall outcomes for high-need high-cost beneficiaries have resulted in lower hospital readmission rates and higher utilization of preventive services, as well as 43% fewer avoidable hospitalizations compared to traditional Medicare.[4]

It is important to recognize that these changes to the risk adjustment model will have a varying impact depending on several factors unique to individual health plans. On average, according to a recent Avalere report the payment impact could result in a $540 decrease in benefits per member per year, which is larger than what CMS has projected.[5] These cuts will disproportionately hurt seniors from rural and other underserved communities, as well as those with serious long-term health conditions such as diabetes or heart disease. Seniors depend on the affordability, increased benefits, and better health outcomes MA provides which include spending nearly $2,000 less on out-of-pocket costs and premiums each year when compared to traditional Medicare beneficiaries. If these cuts are implemented in 2024, it will have a detrimental impact on their ability to access affordable and high-quality healthcare which counteracts CMS' goal to advance health equity and improve quality care.

While CMS has noted that the risk adjustment model update is necessary to account for the transition from ICD-9 to ICD-10, these changes also include the removal of nearly 2,300 ICD-10 diagnosis codes from the model. These codes are specifically used to identify Medicare beneficiaries with chronic diabetes complications, major depressive disorders, vascular disease, and rheumatoid arthritis and inflammatory connective tissue disease, which are all prevalent among the most vulnerable beneficiaries.[3] Further, CMS' proposal reduces specificity in coding which will prevent providers from recognizing asymptomatic diseases, resulting in an unwanted increase in avoidable emergency room visits, hospital admissions, and higher costs. In addition to these risk adjustment changes, physicians are likely to face revenue cuts, impacting their ability to provide care for their Medicare patients enrolled in MA programs. Multiple consequences could also ensue, including the closure of urban and rural clinics resulting in vulnerable MA enrollees losing access to needed care.

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[2] 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (February 2023) https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf

[3] The Budget and Economic Outlook: 2023 to 2023, Congressional Budget Office (February 2023) The Budget and Economic Outlook: 2023 to 2033 | Congressional Budget Office (cbo.gov)

[4] Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-For-Service Medicare, Better Medicare Alliance (December 2020) BMA-High-Need-Report.pdf (bettermedicarealliance.org)

[5] Proposed MA Plan Payment Changes May Impact Premiums and Benefits, Avalere (February 2023) https://bettermedicarealliance.org/wp-content/uploads/2023/02/20230214_Advance-Notice-Impact_Final.pdf

Based on these concerns, HLC urges CMS to update the effective growth rate to appropriately reflect the documented increase in Medicare costs, including inflation, and to not move forward with the Part C risk model policy changes until these changes are made. We encourage CMS to work with all stakeholders to assess the impacts these proposals will have on beneficiaries, especially vulnerable populations whose needs are best served by the coordinated care model under MA. It is important that CMS ensures the over 30 million seniors and people with disabilities maintain access to the affordable and comprehensive coverage they deserve.

Inflation Reduction Act Updates for 2024

Lowering the out-of-pocket costs consumers pay for prescription drugs and ensuring that consumers can manage those costs over the plan year is a priority for HLC members. Now that the IRA has become law, implementation of the IRA by the Department of Health and Human Services (HHS) must happen in a way that includes sufficient safeguards and provides clarity in the implementation process for all stakeholders, especially the patient. These include:

Engaging in meaningful stakeholder input

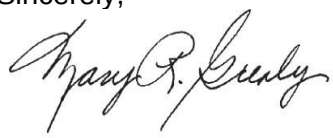
The development of guidance and rules should be open, transparent, and provide meaningful opportunities for stakeholder input; include safeguards for patients; and create accountability for HHS to ensure the program is achieving the goals of helping patients gain access to the medicines they need. It is particularly important that, at least for the initial years, HHS provide ample time and opportunity for stakeholders, including manufacturers, distributors, providers, pharmacists, health plans, and patients, to comply with provisions in the law, and also seek feedback on the implementation of the requirements over time. We also encourage HHS to work in collaboration with Congress in the event technical changes are needed to avoid unintended consequences. Additionally, public education campaigns will be vital for patients to understand how the IRA will benefit them as changes take effect.

Utilizing the federal rulemaking process

The IRA includes monumental changes to drug pricing policy that will require significant overhaul of existing systems, processes, and practices throughout the healthcare system. Before HHS formally begins calculating rebates, negotiating for drugs offered under Parts B and D, and reforming the Part D benefit design, formal notice and comment periods should be undertaken to ensure that a broad range of stakeholders can provide input on how best to proceed. This will allow HHS to properly structure these changes and minimize any potential access problems for consumers.

Thank you for considering our request to not cut care for MA beneficiaries. HLC looks forward to working with you on our shared priorities. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,



Mary R. Grealy
President