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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8012
Baltimore, MD 21244-1850
By electronic submission at http://www.regulations.gov

RE: CMS-4203-NC: Medicare Program: Request for Information on Medicare

The Rural Policy Research Institute Health Panel was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to the Request for Information regarding various aspects of the Medicare Advantage program. We will address specific questions below, but wish to open our comments with appreciation to CMS for recognizing the importance of addressing the pillars of its strategic plan through the lens of the Medicare Advantage (MA) program.

Rural Perspective on Medicare Advantage

Our comments and feedback are offered from the rural perspective, where Medicare Advantage is an increasingly important source of health care coverage. As of March 2022 MA accounted for 45.7 percent of all Medicare beneficiaries. In rural America 4.3 million beneficiaries were enrolled in MA plans, 38.8% of all rural beneficiaries. While that percentage is lower than urban and overall percentages (47.2 percent and 45.7 percent), the rate of enrollment growth is higher in rural America, 13.4 percent compared to 7.9 percent in metropolitan counties between 2021 and 2022. [Data are taken from a *draft* of a RUPRI Center for Rural Health Policy Analysis policy brief currently under review; the previous brief presenting data through 2021 is available here; (https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Medicare%20Advantage%20Enrollment%20Update%202021.pdf) the current brief will be available from the same site soon.] MA plan enrollment is uneven across states and regions, reflected in the RUPRI Center for Rural Health Policy Analysis state choropleth map (https://rupri.public-health.uiowa.edu/maupdates/nationalmaps/march2021/NationalMaps.pdf)of enrollment in non-metropolitan counties. Rural enrollment is below 18 percent in nine states and between 18 percent and 25 percent 11 states; it exceeds 44 percent of beneficiaries in nine states. This variation reinforces our earlier point that actions taken in the MA program will have geographically varying impacts.

Lower enrollment in MA plans in some areas is related to both supply and demand issues related to plan availability and affordability. In particular, in areas with lower populations, plans face diseconomies of scale, which raises the costs of MA plans. This can lead to higher premiums for the plans or fewer plan benefits, reducing demand for the plans.

Our reason for citing these data is to make two points supportive of the proposed actions by CMS: 1) the immediate impact of actions in the MA program will be greater in urban than rural (metropolitan vs. nonmetropolitan) areas, making it more important in rural areas to continue leveraging the Traditional Medicare program to achieve similar objectives; and 2) the more rapid MA enrollment growth in rural counties points to the importance of taking advantage of actions intended to achieve strategic plan objectives through the MA program by focusing on particular needs in rural places.

A: Advance Health Equity

Equity in availability of MA plans across geography (and therefore underserved populations).

Before answering the specific questions from the RFI, the Panel presents data indicating that an opening concern in equity is whether or not there is equity of opportunity to participate in MA plans offering high value benefits such as zero premiums. The following tables from a RUPRI Center for Rural Health Policy Analysis *Policy Brief* (https://ruprihealth.org/publications/policybriefs/2021/MA%20plans%20supplemental%20benefits.pdf) show the differences in MA Plan benefits available to rural and urban enrollees:

Table 2. Proportion of MA plans offering supplemental benefits, by county type, 2020; ordered by benefits most often included in plans

Supplemental Benefits	Noncore Counties	Micropolitan Counties	Metropolitan Counties
Eye exams	85.4%	90.2%	94.1%
Fitness programs	69.7%	80.0%	87.7%
Hearing exams	73.2%	80.6%	86.0%
Preventive dental care	73.4%	80.9%	86.9%
Remote access technologies*	42.6%	49.4%	56.3%
Over-the-counter items	54.5%	60.6%	66.9%
Health education	29.5%	35.5%	40.1%
Transportation services	10.3%	15.2%	23.0%
Smoking and tobacco cessation services	15.3%	20.3%	21.4%
Personal emergency response systems	8.3%	10.3%	11.3%
In-home safety assessment	2.8%	3.7%	3.0%
Post discharge, in-home med. Reconciliation	1.0%	1.9%	1.8%

Source: CMS Plan Benefit Files for 2020.

*Including web/phone-based technologies and nursing hotline.

Table 3. MA plan premiums, by county type

	Noncore Counties	Micropolitan Counties	Metropolitan Counties
Plans with $0 premium	38.7%	39.9%	47.2%
Average number of $0 premium plans available	4.5	6.1	10.4
Counties with no $0 premium plans	63 (4.9%)	25 (4.0%)	18 (1.6%)
Counties with one $0 premium plan	165 (13.0%)	50 (7.9%)	33 (2.8%)
Average maximum out-of-pocket	$4,819	$5,026	$5,100

Source: CMS Landscape Files for 2020.

These data raise two important considerations for CMS. First, there is an existing disparity in availability of benefits associated with MA plan offerings that places a substantial number of rural Medicare beneficiaries at a disadvantage, with the most obvious impact being in noncore counties (e.g., 4.9 percent of noncore counties and 4.0 percent of micropolitan counties with no plan offering zero premium, compared with 1.6 percent of metropolitan counties). Second, if efforts to realize CMS strategic pillars focus on changes to the MA program, the current disparities in available offerings for rural beneficiaries both higher cost and fewer covered benefits) could portend uneven impact of achieving strategic objectives.

The Panel suggests three approaches to addressing these concerns. First, CMS could work with MA plans to understand and mitigate rural-relevant factors influencing decisions to offer the full array of allowed (counting toward medical loss ratio) benefits such that they will be available to all beneficiaries. Second, to the extent the first approach cannot extend to all areas, CMS could, to the extent possible under statutory authority (and if not possible, work with policy makers to enact appropriate changes), be sure that all steps to enhance equity through MA plans are replicated in Traditional fee-for-service Medicare. Third, CMS could develop a certification process assuring MA plans to operate in geographic service areas that combine counties such that the same premiums and benefits would be offered to all potential enrollees in regions that encompass both rural and urban counties. Implementing the approach could require statutory change.

Question 1: What steps should CMS take to better ensure that all MA enrollees receive the care they need?

One means of insuring the unique needs of particular populations are addressed would be to allow expenses related to meeting health needs of particular populations (including rural beneficiaries) to be included in calculating the clinical services and quality improvement component of the medical loss ratio of the MA plan. Certain services that meet rural beneficiary needs could be targeted, including some already offered by plans such as transportation and remote technology services. Additional services could include respite care, housing assistance and food assistance. This suggestion is consistent with H.R. 3969, introduced by Representatives Curtis and Cardenas in June, 2021, which proposes to include activities addressing social determinants of health in calculating medical loss ratios applied to plans competing in health insurance marketplaces (Section 2718 of the Public Health Services Act).

Another approach is to include rural areas combined urban/rural county service areas, combined with network adequacy rules specific to access to services for all beneficiaries. This may require statutory change

to how CMS calculates MA plan payment and the application process for MA plans to move to statewide or substate regions to encompass multiple counties (urban and rural) in a single area rather approval-by-county. Network adequacy rules could specify providers specialized in meeting needs of the population groups identified in the bullets in this CMS question.

2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

CMS should use analyses of how the availability of plans, and the costs of these plans, varies in relationship to the sociodemographics of the residents of the area (e.g., degree of rurality, race/ethnicity, income and poverty) as the basis for data-informed policy and programs. Policies and programs should be developed based on this analysis; to the extent that these analyses indicate that there are disparities in the availability and affordability of plans.

It is worth noting that MA plans are the main source used by some lower income beneficiaries to close the gap of out of pocket costs (Commonwealth Fund, 2020; Commonwealth Fund, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/medicare-advantage-enrolling-low-income-medically-complex), while beneficiaries with higher incomes are more likely to buy a Medigap plan or have employer health insurance coverage.

MA data parallel to current FFS data for consumer use in selecting providers (within network, out-of-network) should be easily accessible. Further, such data needs to be at the provider level, so consumers understand differences in cost and quality across providers who are in the provider network. Access by bona fide researchers to the Virtual data center should be provided.

As CMS is actively moving toward using measures of health equity in public reporting and payment for fee-for-service Medicare providers, MA plans should be accountable for a parallel set of measures as well. The MA health equity measures should be coordinated with fee-for-service measure for public reporting in such a way to be helpful and not confusing for those with Medicare coverage making choices about their care and services. For the new social factors risk screening measures, MA plans could, for example, report the screening rates used by their network providers as performance metrics. In addition, MA plans should be required to report a similar health equity structural measure about their health plan organization as hospitals and others health care organizations will be reporting.

3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

See below

4. Successful MA plan methods to ensure access to language services

See below

5. What socioeconomic data do MA plans leverage to better understand their enrollees and to inform care delivery? What are the sources of this data? What challenges exist in obtaining, leveraging, or sharing such data?

See below

6. How have compensation arrangements with local community-based organizations partnering with MA plans and providers been structured?

See below

7. What food- or nutrition-related benefits MA plans provide today?

See below

8. What physical activity-related supplemental benefits do MA plans provide today?

The Panel has no direct answers to questions 3-8, given that we have not analyzed data required to provide the answers. However, we encourage CMS to cluster replies received into plans serving primarily metropolitan areas and those serving rural areas. The RUPRI Center for Rural Health Policy Analysis has done so for supplemental benefits offered by MA plans in 2020; finding the proportion of MA plans offering those benefits to be lowest in noncore counties (https:\ruprihealth.org\publications\policybriefs\2021\MA plans supplemental benefits.pdf), and lower in micropolitan than metropolitan counties. This was particularly notable for transportation services (10.3 percent of plans in noncore, 23.0 percent of plans in metropolitan counties), health education (29.5 percent vs. 40.1 percent), and fitness programs (69.7 percent vs. 87.7 percent).

9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPS), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

The Panel does not have the information necessary to provide a direct answer. However, we do wish to point out that enrollment in SNPs has grown dramatically, more than doubling from 2.31 million in 2017 to 4.8 million as of June 2022 (Special Needs Plan Comprehensive Report. Center for Medicare and Medicaid Services. Published June 2022 (https:\ruprihealth.org\publications\policybriefs\2021\MA plans supplemental benefits.pdf). There has also been considerable growth in the number of plans targeting dually eligible beneficiaries and those with chronic conditions. The RUPRI Center is currently assessing the growth of those plans in rural counties. CMS could take the following steps to assure appropriate benefits are offered to enrollees in SNPs: 1) analyze data regarding actual uptake of supplemental benefits by SNP enrollees, by geography and population characteristics; and 2) assess offerings of palliative care benefits in particular with a focus on costs (direct and administrative) involved, enabling discussions of the value of making that a required benefit.

10. How have MA plans and providers used algorithms to identify enrollees that need additional services or supports, such as care management or care coordination?

The Panel has no comment.

11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

The Panel recommends CMS collect and make available data showing the uptake of supplemental benefits (the data in our comment is for the number of plans offering the benefits) by geography and other population characteristics.

B. Expand Access: Coverage and Care

1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

The Panel commented earlier regarding making all plan data available in user-friendly formats, including providers in the plan's network (updated frequently), variation in cost and quality across providers, availability of supplemental benefits, and total costs to consumers. We also suggest supporting navigators to assist consumers. CMS could collaborate with State Health Insurance Assistance Programs who are tasked with providing free local health coverage counseling to Medicare enrollees.

2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

Complete information regarding the following items must be readily accessible, and/or available to navigators assisting enrollees: costs of premiums associated with benefits beyond what is available in Traditional Medicare and structure of deductibles and copayments for those benefits, providers included in MA plan networks, costs associated with using out-of-network providers, direct comparisons of benefits available across MA plans, contrasting MA plans to Traditional Medicare, and supplemental plans. In addition, a beneficiary should be easily able to compare quality measures between the Traditional Medicare providers and MA plans they are considering, which requires parsimony of measures and user-friendly presentations of data to help consumers make informed choices.

3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan?

The Panel has no comment**.**

4. How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

The Panel recommends that actions taken through the Medicare program, both Traditional Medicare and Medicare Advantage, be consistent with general recommendation(s) to improve access to, and quality of, behavioral services in rural America. We described these in our document (principal authors were John Gale, Jaclyn Janis, Andrew Coburn and Hanna Rochford) released in December 2019 (http://www.rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf) as follows:

- Promote rural community engagement
- Support development of local and regional behavioral services
- Reform behavioral health regulatory and payment policies

- Expand behavioral health workforce and create incentives for rural practice

In a follow-up paper focused on farm families in times of economic distress (https://rupri.org/wp-content/uploads/Economic-Disruption-brief-4-February-2022.pdf) released in 2022 we reinforced our earlier recommendations, including these recommendations that could be actionable through the Medicare program:

- Leverage Medicare payment systems to support coordinated care for families in distress
- Continue to integrate primary and behavioral care as the cornerstone of a high-performing rural health care system
- Increase telehealth services and repurpose available space to expand access to behavioral health services

5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

The Panel recommends considering telehealth as a resource that augments existing delivery systems in rural areas as a vehicle for enabling interaction with providers otherwise not present in the community. As such including telehealth as a recognized expense to MA plans assists in assuring access to services across the care continuum.

6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide arrange of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

The Panel has no comment.

7. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?

The Panel's general comment at the beginning of this section included data regarding the differences in plans offering supplemental benefits across three geographic categories of counties (noncore, micropolitan, metropolitan). While we cannot comment directly on factors MA plans consider, or on their partnering with third parties, the substantial differences in offering benefits across counties as population size and density increase suggests issues of scale that need to be considered.

8. How are enrollees made aware of supplemental benefits for which they qualify?

The Panel has no comment.

9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts…

The Panel has no comment.

10. How do MA plans use utilization management techniques, such as prior authorization?

The Panel has no comment.

11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques?

The Panel has no comment.

C. Drive Innovation to Promote Person-Centered Care

1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program?

The Panel has no specific comment. However, we wish to reinforce the importance of answering this question in the context of plans with low beneficiary enrollment in rural areas. In particular we encourage CMS to collect data and conduct analysis related to value-based contracting with rural providers. Analysis should include understanding when contracts offered by MA plans may be unrealistic for low-volume rural providers.

We also offer general observations about factors motivating rural providers and healthcare organizations to participate in innovations, drawn from focus group discussions with rural and frontier providers in 2013 and 2015: (https://ruralhealthvalue.org/files/Innovators_In_Rural_Health_Care_Delivery.pdf)

- Reflect a climate of necessity
- Identify resources and funds to test and initiate change
- Find and use innovators in the community, people to make it happen
- Encourage creativity, with a focus on meeting individual patient needs

A follow-up convening of rural and frontier innovative organizations in 2020 (https://ruralhealthvalue.public-health.uiowa.edu/files/Rural VBC Summit Report.pdf) identified six implementation and operation themes that facility or hinder participation and success in VBC models:

- Rural-oriented design of the methodology
- Aligning the model with existing programs
- Initial infrastructure investment
- Rural-relevant planning and care delivery
- Flexibility and timing
- Information technology and data

2. What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based programs in Traditional Medicare (for

example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?

The Panel suggests explicitly recognizing value-based payment by MA plans as making providers eligible for classification as practicing in an Advanced Alternative Payment Model. Doing so would encourage provider participation in MA networks. Further, MA plans would be encouraged to use the same quality metrics used by ACOs.

3. What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?

The Panel has no comment.

4. How are providers and MA plans incorporating and measuring outcomes for the provision of behavioral health services in value-based care arrangements?

The Panel does not have the specific information needed to answer this question, but we wish to point to the importance of behavioral health services for rural enrollees and therefore encourage CMS to parse out answers to understand any unique arrangements in rural places.

5. What is the experience for providers who wish to simultaneously contract with MA plans or participate in an MA network and participate in an ACO? How could MA plans and ACOs align their quality measures, data exchange requirements, attribution methods and other features to reduce provider burden and promote delivery of high-quality, equitable care?

The Panel focuses on the second question and suggests the following actions:

- Align use of HEDIS measures in MA and advanced payment models (including ACOs)
- Minimize reporting burden, but retain the value of the measures
- Align incentives in MA and APMs, including using the same metrics
- Be comprehensive and transparent in use of quality measures and data exchange requirements

6. Do certain value-based arrangements serve as a "starting point" for MA plans to negotiate new value-based contracts with providers?

The Panel has no comment.

7. What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? …

The Panel has no comment.

8. How do beneficiaries use the MA Star Ratings? Do MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

Clearly MCOs have incentives to improve star ratings, since it affects payment to the plans. There is less known about how beneficiaries might use that same information. In one study there is a statistical association between low star ratings and disenrollment by high-need beneficiaries, but not direct evidence of the rating itself having influenced beneficiary decisions (see for example Meyers et al, 2019, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2725083). With MA now covering nearly half of all Medicare beneficiaries, and nearly 40% in rural areas, reporting and improving the quality of care in a data-informed way across Traditional FFS Medicare and MA is imperative. The Medicare quality improvement programs (QIN-QIO, HQIC, ESRD Networks) are currently assessed for their effectiveness and results based solely on FFS data, which accounts now for only just over half of the Medicare beneficiary population across the country. The contractors implementing these essential national quality programs are operating at a deficit, not able to target interventions to the providers and communities who may most benefit from their assistance and support. Similarly, researchers have more limited access to MA data. A comprehensive data approach for quality, equity, and research could make a significant difference to more accurately reflect care and outcomes.

9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovation to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and no-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

The Panel encourages innovation in care delivery that supports quality, efficiency, equity, and person-centeredness. Payment design should reward those care processes and outcomes. Payment exclusively for units of service does not accomplish these goals.

10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity?

The Panel has no comment.

11. What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID Model? What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?

The Panel recommends CMS encourage MA plans to include a palliative care benefit to complement hospice. Palliative care not only provides person-centered care, it also facilitates the appropriate use of hospice, which improves quality of care and quality of life and reduces costs.

12. What issues specific to Employer Group Waiver Plans (EGWPs) should CMS consider?
The Panel has no comment.

D. Support Affordability and Sustainability
1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

MA payment should flow preferentially to providers who are improving and/or achieving the goals of quality, equity, and efficiency.

2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

The Panel has no comment

3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

The Panel believes there are two important implications of the increased percent of beneficiaries enrolling in MA plans. First, as addressed in this RFI, CMS (and others) need to consider how to achieve public policy objectives through a program that is managed by private insurance carriers. Second, as we stated in the opening comment under equity considerations, CMS (and policy makers) need to consider implications of MA plans with multiple supplemental benefits being easily accessible to a large percentage, *but not all* beneficiaries, disproportionally in rural areas where plans are not offering all supplemental benefits.

4. **Are there additional considerations specific to payments to MA plans in Puerto Rico or other localities that CMS should consider?**

The Panel has no comment.

5. What are notable barriers to entry or other obstacles to competition within the MA market generally, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program?

The Panel has no comment.

6. Are there improvement CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?

As commented earlier, the Panel recommends incorporating actions addressing social determinants of health be included in the MLR, with particular attention to determinants affecting rural beneficiaries.

7. How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks?

The Panel has no comment.

8. What new approaches have MA plans employed to combat fraud, waste, and abuse, and how could CMS further assist and augment those efforts?

The Panel has no comment.

E. Engage Partners

The Panel has comments in this section.

Respectfully submitted,

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