March 1, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2024-0006
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically at www.regulations.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

Centene Corporation (hereafter "Centene") appreciates the opportunity to provide feedback on CMS' CY 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, published January 31, 2024. We thank CMS for its continued efforts to ensure the delivery of quality services to Medicare beneficiaries enrolled in MA and Medicare Part D.

Centene is a managed care organization that provides access to quality health care for nearly 1 in 15 individuals nationwide through government-sponsored programs, including Medicaid, Medicare (including Medicare Prescription Drug Plans) and the Health Insurance Marketplace. Our membership is composed of populations that tend to be lower income, with more complex medical needs, and which have been historically underserved by the healthcare system. Centene has a uniquely local approach to providing affordable and high-quality health care coverage, with local brands and local teams who live in and care deeply about the communities they serve. This approach to treating the whole person is backed by the scale of Centene's expertise, data, and collective resources. Our local approach and commitment to sustainable partnerships help us realize our vision of transforming the health of the communities we serve, one person at a time.

Continuing to drive improvements in health outcomes, Centene continues striving towards providing high-quality and affordable coverage to our Medicare, Part D, and dually eligible populations. We remain committed to our members and partnering with CMS to ensure policies are reflective of advancing health equity and, overall, beneficiary access to quality care. Our comments are based on our experiences in meeting the continued and evolving needs of our MA, Part D, and dually eligible beneficiaries.

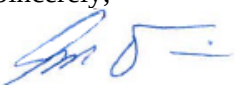
INTRODUCTORY COMMENTS

Before including our detailed comments, Centene would like to highlight our responses to the following specific priority areas within the Advance Notice.

- **Part C Payment Proposals:** Centene appreciates CMS' diligence in its growth percentage considerations and calculations. We ask CMS to consider additional analysis to appropriately account for the rising costs of care due to inflation and sharp industry-wide trend increases in Q4 2023. Also, we thank CMS for considering our previous comments on the impacts of the transition to the CY 2024 HCC-RA model on the dual and partial dual eligible population. While we recognize D-SNP growth, we believe this is primarily a factor of the CMS' lookalike rule requirements and reiterate previous comments on the ways CMS can refine regulations to improve plan offerings for all dual eligible individuals, including partial dual eligible individuals. Further, we request additional information on frailty factors to assist organizations with accurate and stable PACE bidding and propose an approach to mitigate yearly volatility in frailty scores to improve member experience. Finally, we provide analysis of a pattern of historical FFS risk score overstatement in CMS' normalization factor calculations and recommend an alternative method to calculate the normalization factor.
- **Part D Payment Proposals:** Centene thanks CMS for its continued work under the Inflation Reduction Act (IRA). As CMS continues to move forward with these initiatives in CY 2025, we offer a few recommendations. First, it would be helpful for plans if CMS could provide additional clarification around how drugs marketed after August 16, 2022, will not be subject to the Manufacturer Discount Program (MDP) phase-in, and how CMS plans to ensure that plans will not have higher liability. Second, we support CMS' "Proposed Model" for separating normalization factors as we believe that PDPs will be better positioned to meet the needs of the LIS populations most impacted by changes under the IRA by being able to better manage the submission of diagnoses in FFS, and other cost management strategies. Finally, we provide comments on critical matters related to rebate reallocation and the Medicaid Prescription Payment Program for consideration towards stabilizing the market during this transformational period.
- **Stars and Quality Proposals:** Centene values CMS' continued commitment to improving the MA and Part D Quality Rating System. We remain supportive of CMS continuously including steward-endorsed measures and are aligned with those recommendations. Additionally, Centene continues to support a diversified and balanced Star Ratings program and recommends that CMS consider the overall strategy for measures that address the same topic, such as those related to statins and opioids, to ensure they are aligned. Finally, for a number of measures, we request additional information and clarification on how they will be implemented, and express concern related to unintended negative consequences that may arise from the proposed Medicare Plan Finder Drug Pricing Measure.

Thank you for the opportunity to submit comments on the CY 2025 MA and Part D Advance Notice. We remain a committed partner in working with the Administration. If you have questions or need more information, please contact me at JDinesman@centene.com or (314) 505-6739, or Patti Barnett at Patti.A.Barnett@centene.com or (314) 695-0138.

Sincerely,



Jonathan Dinesman
Executive Vice President, External Affairs
Centene Corporation

DETAILED COMMENTS

OVERARCHING RESPONSE TO CMS' CY 2025 ADVANCE NOTICE

Our specific comments are organized in the order that issues appear in the Advance Notice.

ATTACHMENT I. PRELIMINARY ESTIMATES OF THE NATIONAL PER CAPITA GROWTH PERCENTAGE AND THE NATIONAL MEDICARE FEE-FOR-SERVICE GROWTH PERCENTAGE FOR CALENDAR YEAR 2025 (Page 7)

Section B: 2025 Growth Percentage Estimates

CMS updates its historical estimates of per capita Medicare costs based on recent data, providing an estimate for an additional projection year in the Annual Notice. The Agency projects total United States per capita costs (USPCC) non-ESRD will grow by 1.98% and FFS USPCC (Non-ESRD) costs will grow by 2.57% from 2024. CMS' estimates for the USPCCs for 2020 and subsequent years reflect the projected cost impacts related to the COVID-19 pandemic, including estimates for applicable costs related to COVID-19 vaccination, changes in utilization of health care services, elimination of cost-sharing for testing services, and changes in Part B requirements related to provisions of the IRA.

Provide More Information on Growth Percentage Estimates and Consider 2023 Q4 Utilization Trend

Centene appreciates CMS' diligence in its growth percentage considerations and calculations. We ask CMS to consider additional analysis to appropriately account for the rising costs of care due to inflation. Prices for outpatient care and hospital and related services rose 5.7% and 4.2% respectively between June 2022 and June 2023, challenging Medicare Advantage Organizations (MAOs) to account for these continually rising costs.[1] Additionally, Centene requests that CMS examine 2023 Q4 results to inform their trend projections in the April USPCC update. Beginning in Q4 2023, the industry saw higher than average trends, as documented across several large insurance companies' public earnings calls. As these trends were reported across the industry, we believe that the Q4 2023 data feeding the USPCCs will be informative and material.

Furthermore, as shown in recent analysis on the Advance Notice conducted by Wakely Consulting Group, CMS' growth rate projection for 2025 (2.57%) is more than a percentage point lower than CMS' estimated cost trend for 2025 (3.78%). Wakely additionally finds that the impact will vary widely across regions and states, with "about 57% of the states…below the average expected benchmark change."[2]

In its final rate announcement calculations, we urge CMS to consider all available and appropriate data to ensure final growth rates accurately reflect recent and expected trends.

ATTACHMENT II. CHANGES IN THE PAYMENT METHODOLOGY FOR MEDICARE ADVANTAGE AND PACE FOR CY 2025 (Page 22)

[1] Rakshit, Shameek et al., "How Does Medical Inflation Compare to Inflation in the Rest of the Economy?" KFF, July 2023, https://www.kff.org/health-costs/issue-brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/

[2] Wakely Consulting Group. "2025 Medicare Advantage Advance Notice." March 2023. Available at: https://ahiporg-production.s3.amazonaws.com/documents/CY2025-Advance-Notice-Summary-and-Analysis-2.26.2024.pdf

Section D. MA ESRD Rates

CMS proposes to continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the MA ESRD rates.

Request CMS Examine the MA Rate Impacts of Changes Made to the Part D Model

In CMS' discussion of the 2025 Part D risk adjustment model, CMS notes that oral-only ESRD drugs (e.g., phosphate binders) were removed from the calibration of the Part D model, as such products will be covered under Part B instead of Part D beginning in 2025. However, CMS does not address this change in the discussion of the MA ESRD rates or the MA ESRD risk adjustment model. We request CMS clarify if this cost is accounted for in the development of the CY2025 MA ESRD rates, and if so, clarify the amount of the adjustment. If the adjustment has not been accounted for in the rates, we ask CMS to inform stakeholders if it has performed an analysis under the significant cost threshold policy, 42 CFR 422.109, until it is accounted for in the rates.

Request CMS Provide Insight Into Preliminary MOOP Growth Rate Increases as Compared to Preliminary Cost Share Limits

In the Preliminary CY 2025 Part C Bid Review Memorandum, released February 21, 2024, the MOOP limits were shown to be increasing at a higher rate than the components of the overall MA growth rate. The lower and mandatory MOOP limits increased by 7.8% and 5.6%, respectively, over the 2024 limits. These MOOP limits are calculated using the CY 2025 estimated FFS beneficiary spend at the 85th and 95th percentile, respectively, plus 100% ESRD cost differential.

Table I-1 in the CY 2025 Advance Notice shows, excluding this year's MA medical education phase-in, the 2025 non-ESRD USPCC increasing by 3.5% over the 2024 amount. In table I-2, the FFS ESRD USPCC is increasing by 3.1% over the 2024 amount.

If the 85th percentile of FFS beneficiary spend is increasing by 7.8% and the 95th percentile of FFS beneficiary spend is increasing by 5.6%, we ask CMS to clarify the cause of the average FFS USPCC to only increase by 3.5%. This dynamic seems to indicate that the high cost FFS beneficiaries are going to cost more at a much faster rate, while the low cost FFS beneficiaries are going to cost significantly less, such that it lowers the overall trend by more than half of the 85th percentile's trend rate. We request CMS provide additional data and/or information with insight into the dynamic described.

Section G. CMS HCC Risk Adjustment Model for CY 2025

CMS significantly revised the MA risk adjustment model in the 2024 Rate Announcement and included a 3-year phase in period. The new model incorporated the following technical updates: (1) updated data years used for model calibration, (2) updated denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, and (3) a clinical reclassification of the hierarchical condition categories (HCCs) using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CMS proposes to continue to phase in the updated model by calculating CY 2025 risk scores as a blend of 33% of the risk scores calculated with the 2020 (old) model and 67% of the risk scores calculated with the 2024 (new) model.

Request CMS Examine Lookalike Rules Impacting Dual Eligible Individual Plan Options

When CMS proposed HCC-RA model policy changes in last year's (CY2024) Advance Notice, Centene supported CMS' decision to update the model to incorporate ICD-10 codes, as they are influenced by clinical evidence, professional guidelines, and best practices; and, moreover, widely used by almost all providers in most healthcare settings. While we supported the incorporation of ICD-10 codes, we stated our strong concerns with the potential impact of the model's changes on higher risk, medically complex beneficiaries, especially partial dual eligibles and those with chronic conditions. We understand and appreciate CMS' consideration of our comments and its analysis of the impact of the model changes on the dual eligible population, shared in this 2025 Advance Notice. CMS concludes that upon careful analysis, it is proposing to continue implementation of the 2024 CMS-HCC model. The Agency believes it is "necessary and appropriate" to continue implementing, and notes that plan bidding for 2024 signaled growth in the D-SNP market, with increases to both the number of plans and projected enrollment.

Based on our observations, Centene continues to believe MA beneficiaries with complex conditions, including partial dual eligibles and dual eligibles, remain negatively impacted by the model change and continued phase-in. We respectfully disagree with CMS' analysis that the dual eligible plan offering and enrollment growth is a correlation of a favorable model impact. Rather, we believe that these are likely independent of one another. Centene believes that the more likely reason there were more D-SNP plans offered in 2024 than 2023, and likewise the reason enrollment is projected to grow, is because CMS intends to terminate non-D-SNPs with 80% or higher dually eligible enrollment. An implication of this rule, aka the lookalike rule, is that organizations have terminated non-SNP MA plans and attempted to open non-cost share protected D-SNPs. We recognize the 8% increase in total D-SNPs plans, as CMS states; however, there was a higher growth rate in the non-zero-dollar cost share D-SNPs, which have been created for the partial members, whose current plans will be terminated by the lookalike rule. Therefore, we believe that the growth in these plan offerings should not be attributed to the 2024 CMS HCC model but, rather, the market dynamics created by the lookalike rule. Centene recommends that CMS take these considerations into account when analyzing the impact of continuing the 2024 model phase-in in 2025 and beyond.

SNP Type	**2023**	**2024**	**% Change**
Non-Zero Dollar Cost Share	277	304	10%
Zero Dollar Cost Share	513	548	7%
Total	**790**	**852**	**8%**

Given our observation, while our comments do not specifically take issue with the risk adjustment model phase-in, we would like to reiterate our concerns regarding CMS' policies around lookalike plans, including provisions in the recent CY 2025 MA and Part D Proposed Rule that would lower the lookalike threshold to 60% beginning in 2026. We support CMS' goal to integrate care for full duals and agree that these beneficiaries are not well served in a non-SNP, lookalike plan. However, Centene is concerned that CMS is not accounting for the needs of the partial dual population, especially given the differences in state rules restricting D-SNP enrollment for partial duals.

CMS imposed the prohibition on lookalike plans to promote D-SNP enrollment for dually eligible beneficiaries, where there is a specific model of care for them. However, CMS continues to include both full and partial dual members, as the proportion of duals is the only determination for lookalike plans. Centene believes that true lookalike plans, in addition to enrolling a high percentage of dually eligible members, include a Part D Basic Premium at or below the regional Low-Income Premium Subsidy Amount (LIPSA). There are zero-dollar premium non-SNPs at risk of termination under the CY2025 MA and Part D proposed rule that do not target dual eligible beneficiaries; however, in some states there are no alternative plans for these partial dually eligible beneficiaries.

Centene believes that there should always be the option for MA organizations to offer D-SNPs that serve individuals at all levels of dual eligibility, and avenues should be created for such options, including:

1. D-SNPs that enroll full dually eligible members consistent with state and Federal rules for FIDE SNPs.
2. D-SNPs that enroll Qualified Medicare Beneficiaries (QMBs) and full dually eligible beneficiaries that do not meet state rules for FIDE SNPs, that give the members their maximum benefits possible, which provides for a higher level of care. For example: Plans that don't buy down standard Medicare cost sharing, since these groups are cost share protected, and instead are able to provide benefits for disadvantaged members such as transportation, dental, vision, hearing, VBID grocery cards/$0 Part D copays, among others.
3. D-SNPs that enroll non-cost share protected partial duals, as a replacement for non-SNP lookalike plans, since these members often have no suitable plan to enroll in; and
4. A variety of plan options that allow and encourage competition and member choice.

We strive to make available plan offerings consistent with the tenets above to provide the best benefits for specific dual levels; however, state specific rules and regulations hinder our ability to do this nationally. Centene respectfully urges CMS to support these efforts and work with states to ensure that partial, partial cost share protected (QMB), and full dually eligible members all have options available that are best for their unique needs.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

CMS proposes to continue using the frailty factors finalized in CY 2024 and blend the frailty score calculated for FIDE SNPs consistent with the phase-in of the 2024 CMS-HCC model (33% 2020 model frailty factors and 67% 2024 model frailty factors). For CY 2025 only, regardless of 2024 dual status, only the full Medicaid frailty factors will be used to calculate FIDE SNP frailty scores for FIDE SNP enrollees. Specifically, for CY 2025 only, CMS will calculate FIDE SNP frailty scores using all applicable respondents, but CMS will use the full Medicaid frailty factors in the calculation of the frailty scores for FIDE SNP enrollees regardless of a respondent's 2024 Medicaid status.

Request Additional Information and Recommend Implementation of a Two-Year Phase-In/Out Approach to Mitigate Year over Year (YoY) Volatility

Centene understands and agrees with CMS' intent to use only the full scope of Medicaid factors (Full Medicaid bucket) for 2024 survey responses impacting 2025 frailty.

We observed that the 2024 risk model frailty factors will create a narrowing range of possible outcomes for frailty. In the table below, we show the PACE minimum (estimated for the 2024 model) and maximum for both the 2020 and 2024 CMS HCC Frailty factors. As demonstrated below, the range produced by the 2024 model is very narrow, especially compared to its predecessor.

	2020 CMS HCC Model	2024 CMS HCC Model
PACE Minimum	0.129 (2023 Actual)	0.207 (Estimate)
PACE Maximum	0.282	0.248
Range	0.153	0.041

Centene requests further information from CMS to assist organizations with accurate and stable bidding and forecasting. Specifically, we request CMS release the distribution of survey responses corresponding to the PACE minimum for 2020 through 2024. Moreover, we request that in future years, CMS includes the distribution used to calculate the PACE minimum as a standard part of the Advance Notice and/or Rate Announcement. The historic PACE distribution would help plans understand the variation of the minimum from year-to-year and use that information to better project the likelihood of payment.

Lastly, we ask that CMS consider developing a method to mitigate the YoY volatility in order to provide consistency for plans YoY and, more importantly, provide consistency and added value to members. Centene specifically proposes that CMS consider instituting a two-year phase-in/out approach as an option. This would be similar to how the county benchmark applicable percentages move, where each quartile change starts a new two-year phase-in/out. We believe this is a reasonable approach to help stabilize frailty factor "swings" in organizational revenues and allow payers to better align benefits for members. *Please see the example below*:

Year	Pace Minimum	Frailty Score	> PACE Min	Applied Score	Phase-in %
0	0.130	0.120	N	0.000	0%
1	0.130	0.140	Y	0.070	50%
2	0.130	0.150	Y	0.150	100%
3	0.130	0.120	N	0.075	50%
4	0.130	0.140	Y	0.108	75%
5	0.130	0.150	Y	0.150	100%

Section J. Medicare Advantage Coding Pattern Difference Adjustment

For CY 2025, CMS proposes to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90 percent.

Centene supports the Agency's decision to maintain and not exceed the statutory minimum adjustment.

Section K. Normalization Factors

CMS proposes to change the methodology of the normalization factor calculation (included in the overall risk model) to a multiple linear regression model to better assess risk score trends in COVID-19 impacted years.

Research Historical FFS Risk Score Overstatement for Incorporation into Projections

Risk Score Normalization – Historical FFS Risk Score Overstatement Pattern

Centene has observed a pattern in the historical FFS risk scores that we strongly urge CMS to incorporate into its projections. Since at least 2021, the Agency has overstated the final year in the FFS risk score calculation, inflating trend and, therefore, inflating the pricing year's normalization factors. This pattern of overestimation appears to have begun in 2021, with the 2020 HCC model, and has been consistent in all models since 2022.

Summary of Published FFS Risk Scores by Advanced Notice Year (AN Yr.)					
HCC Model	**AN Yr.**	**FFS RS Yr.**	**FFS RS**	**AN (Yr.+1) FFS RS**	**1 Yr. Change**
2017	2022	2020	1.090	1.085	**-0.005**
2017	2023	2021	1.057	1.054	**-0.003**
2017	2024	2022	1.090	1.084	**-0.006**
2020	2021	2019	1.069	1.064	**-0.005**
2020	2022	2020	1.084	1.078	**-0.006**
2020	2023	2021	1.051	1.048	**-0.003**
2020	2024	2022	1.084	1.079	**-0.005**
2024	2024	2022	0.996	0.992	**-0.004**

Incorporating a 0.005 adjustment (roughly the average 1 year change) to the 2023 risk scores in the Advance Notice for the 2024 and 2020 CMS HCC Models and recalculating the regression using the proposed multiple linear regression methodology in the 2025 Advance Notice, results in a 1.146 and a 1.039 normalization factor for the 2020 and 2024 CMS-HCC models, respectively. Centene believes that these normalization factors are still reasonable when accounting for the overstatement pattern. Therefore, we ask CMS to research the underlying cause of the pattern and adjust the 2023 risk score in the normalization calculation to account for it.

Recommend Alternative Normalization Calculation Method to Include Full Scope of COVID and Pre-COVID Impacted Data

Risk Score Normalization – Part C Calculation Methodology Alternatives

We appreciate CMS' consideration of a new Part C risk score normalization methodology, given the challenges and uncertainty caused by the COVID-19 pandemic to the health care industry. Centene also aligns with CMS on its understanding that CY 2021 risk scores may not have been fully reflective of actual FFS beneficiary experience given reduced utilization because of COVID-19.

While we largely agree with and support CMS' proposed methodology, Centene does have concerns with the proposed use of data from 2019 through 2023 for the regression analysis. We believe that only including these select years of data will disproportionately capture the effects of COVID-19 impacted years. The risk score trend from 2021 to 2022, and to a lesser extent from 2022 to 2023, are elevated relative to the longer historical patterns, which is reasonable to believe is the result of a bounce-back from claims' suppression in the COVID-19 era. Given that the increase in FFS risk scores is primarily due to

utilization bounce-back elevating the trend, over weighting the COVID-19 years in the calculation does not make for a reasonable, forward-looking expectation.

We analyzed numerous other approaches of recalculating the normalization factor, including approaches to remove certain COVID-impacted years from the calculation, as well as calculations with variable COVID-impacted year coefficients. Of the methods tested, Centene recommends that CMS utilize a multiple linear regression, consistent with the proposal, that utilizes 7 years of data, or the years 2017 through 2023. This approach allows for a recognition of recent yearly risk scores but reduces the influence of the COVID-19 bounce-back impact on the final forward-looking projection. The results of this approach demonstrate 2025 normalization factors of 1.135 and 1.029 for the 2020 and 2024 HCC models respectively. Additionally, this method produces a 2024 HCC model estimate of the 2024 normalization factor that is consistent with the CMS estimate of 1.015 from the CY 2024 Rate Announcement, further demonstrating its reasonability.

ATTACHMENT III. BENEFIT PARAMETERS FOR THE DEFINED STANDARD BENEFIT AND CHANGES IN THE PAYMENT METHODOLOGY FOR MEDICARE PART D FOR CY 2025 (Page 71)

Section B. Sunset of Coverage Gap Discount Program (CGDP) and Establishment of the Manufacturer Discount Program (MDP)

The IRA provides for a lower applicable discount for certain manufacturers' applicable drugs marketed as of August 16, 2022, during a multi-year phase-in period, which will conclude by 2031. However, there lacks guidance from CMS in the Advance Notice on how the MDP will address drugs that come to market during this period of time from specified and specified small manufacturers.

Phased-In Manufacturer Discount Lacks Detail on How Discount Program Will Apply to Future Specified and Specified Small Manufacturer Drugs; Request Additional Information

Centene thanks CMS for providing information within the Advance Notice on how, for drugs produced by specified and specified small manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to all beneficiaries increased to 74 percent during the initial coverage phase and 79 percent during the catastrophic phase. We believe that CMS is making a concerted effort to appropriately adjust Part D risk scores for members who take drugs, which are subject to a phased-in MDP discount percentage. However, there still is a lack of important detail regarding the future of the program and new drugs that will come to market. Using only those applicable drugs, under the IRA, marketed as of August 16, 2022, we believe that under future calibrations without consideration for new drugs that come to market from specified and specified small manufacturers there is a likelihood that innovation for biosimilars will be stymied throughout the multi-year phase-in period concluding by 2031. We request that CMS confirm that the new products marketed by specified and specified small manufacturers after August 16, 2022, will not be subject to MDP phase-ins and that plans will not have higher liability for such products.

Specifically, CMS' current approach appears to undervalue the impact of the MDP phase-ins, and if new drugs marketed by specified and specified small manufacturers in the future are subject to the MDP phase-ins, and the risk adjustment model does not appropriately account for the higher plan liability associated with the new drugs, CMS would create perverse incentives for the coverage of such products. Therefore, we strongly recommend that CMS update the current model in the future years as new drugs come onto the market. Moreover, Centene requests that CMS provide further guidance on how it will

appropriately capture new to market drugs under the MDP for small manufacturers, where there has been little to no customer experience.

Section H. Normalization Factors for the RxHCC Models

CMS proposes to calculate separate normalization factors for risk scores used to pay MA-PD plans and PDPs using the existing five-year linear slope methodology. CMS presents two models for non-PACE organizations in CY 2025:

> Proposed Model: CMS' historical five-year linear slope methodology and average risk scores from 2018-2022, excluding 2021, the normalization factor is 1.073 for MA-PD enrollees and 0.955 for PDP enrollees. The proposed RxHCC model for non-PACE organizations has a 2022 denominator and there are three years of trend between the denominator year and the payment year.
>
> Alternative Model: Using CMS' historical five-year linear slope methodology and average risk scores from 2018-2022, excluding 2021, the normalization factor is 1.131 for MA-PD enrollees and 0.932 for PDP enrollees. The alternative RxHCC model for non-PACE organizations has a 2020 denominator and there are five years of trend between the denominator year and the payment year.

Support Proposed Model for Applying Separate Normalization Factors to Stabilize Basic Market in 2025

We appreciate and support CMS taking into consideration applying separate normalization factors for MA-PD plans vs. PDPs. Centene agrees that, given the significant changes under the IRA redesign of the Part D benefit in 2025, a change in approach is important to help support the stabilization of the market. When reviewing the "Proposed Model" and the "Alternative Model" and taking into consideration the needs of the LIS population, we support CMS' "Proposed Model" and ask that the Agency move towards its adoption. Under the IRA, Centene has observed that the LIS population has been the most impacted by the statutory requirements. In adopting the "Proposed Model," as described in the Advance Notice, we agree that PDPs will be better positioned to manage the submission of diagnoses in FFS, and utilize available strategies used to manage Part D costs, as referenced by CMS in the "Background" section of the Normalization Factors proposal. We support CMS' "Proposed Model" for normalization factors and its ability to best address the needs of PDPs to serve the more vulnerable populations impacted by the implementation of the IRA.

Additional Feedback for CMS' Consideration

Concerns Regarding Rebate Reallocation

As the industry undergoes the 2025 bid cycle, the Part D benefit changes being effectuated in 2025 by the IRA drastically increase the likelihood of Part D bids misestimating the National Average Bid and direct subsidy amounts and the magnitude of misestimation relative to prior years. Currently, the variance of estimates based on our modeling are in the range of +/- $30.00. Centene is concerned about the impact of a miss of that magnitude, and we wish to highlight the following downstream implications for CMS' awareness. Should a PDP need to adjust benefits to +/- $30.00, it is not actuarially sound to adjust benefits without considering and making changes in the assumptions underlying the bids. The current CMS bidding rules do not allow actuaries to modify assumptions, creating a predicament for the certifying actuary.

In accordance with the American Academy of Actuaries and Society of Actuaries standards, actuaries are required to highlight material pricing risks and bring them to the attention of appropriate stakeholders. Centene believes that credentialed actuaries would agree that, as it relates to this issue, CMS' current bidding rules present inflexibility which could lead to forthcoming professionalism concerns in light of the amount of market volatility created by the IRA's Part D redesign changes in 2025. As such, Centene requests that CMS allow the certifying actuaries to adjust key assumptions to allow for adequate pricing in accordance with the adjusted benefits, including the following:

- Given the potential for a large misestimation of the 2025 National Average Bid and Direct Subsidy by PDPs, Centene requests that CMS allow Plan Sponsors flexibility, compared to prior years. To ensure actuarial soundness, we believe that a National Average Bid/Direct Subsidy miss of at least $5.00 should constitute allowing the actuary to change key assumptions to maintain the integrity of the pricing. Key items would include, at a minimum: (a) formulary changes; (b) supplemental benefit changes; (c) bid assumption changes consistent with material population changes; and (d) greater margin changes.

Due to the uncertainty of the National Average Bid amounts (NAMB), Centene also requests that CMS provide directional feedback on the level of variance relative to what each plan assumed in their bids of the National Average Bids shortly after submission. We believe that early indication of the actual National Average Monthly Bid Amount (NAMBA)/Base Beneficiary Premium (BBP), even if preliminary and subject to change as bids are finalized, is critical in making more informed decisions to mitigate material misses in the National Average Bids.

Concerns Regarding the Medicare Prescription Payment Plan (MPPP)

Additionally, Centene would like to emphasize how the MPPP introduces new pricing risk in 2025. Given that guidance notifies plans that they will be at-risk, Centene wishes to use this opportunity to highlight concern. Due to the historical precedent and limited data, plans are reliant on data gathering exercises in an attempt to measure the default risk. From data gathered from various vendors that offer programs similar to MPPP, Centene understands the potential default risk to be more than 30%.

With final Part 2 guidance not expected until late summer or early fall, which is post-bids, plans' ability to adjust accordingly for this default risk is limited. Additionally, without final guidance sooner, plans will face significant pressure to operationalize overall changes within a short amount of time. This may impact plans' ability to implement the changes most successfully. Given the potential risk to the industry, it would be helpful if CMS could provide both additional information on how assumptions around such risk might be evaluated during bid review, as well as issue final guidance as soon as possible.

ATTACHMENT IV. UPDATES FOR PART C AND D STAR RATINGS (Page 111)

Centene appreciates CMS' insights regarding potential measure changes. We would like to reiterate our support for CMS continuously including steward-endorsed measures, as we largely remain consistently aligned with those recommendations. Moreover, Centene would like to also generally express our support for measures that address beneficiaries' health outcomes, as we believe those are the ultimate indicators of quality.

Centene would also like to support a diversified and balanced Star Ratings program that has a wide array of measures, with no one topic area disproportionately influencing quality. Additionally, we support an overall strategy that ensures measures addressing the same topics are aligned and assessed consistently.

Overall, Centene envisions a Star Ratings program that paints a robust picture of universal quality, minimizes members' and providers' burdens, and includes a balance of topics across quality areas.

Below please find Centene's responses to CMS' proposed measure-specific changes.

Changes to Existing Star Ratings Measures for the 2025 Year and Beyond

Future Universal Foundation Star Ratings Measures

As finalized in the CY 2024 Rate Announcement, CMS will add Depression Screening and Follow-Up for Adolescents and Adults (Part C) and Adult Immunization Status (Part C) measures to the 2026 display page. Additionally, CMS seeks to add the Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C) to the Star Ratings pending future rulemaking.

Support with Considerations

Overall, Centene supports the proposed changes. Regarding the Depression Screening and Follow-Up for Adolescents and Adults measure, we remain supportive of efforts to improve mental health care among beneficiaries but would like additional guidance and information from CMS on this measure. CMS should approve a uniform screening tool for this measure, to help reduce provider burden, and ensure that plans can collect and share this data in a consistent manner. We believe that alignment and interoperable data can help improve access to care and ensure members receive treatment in a timely manner.

Centene remains committed to improving access to SUD treatment for members. However, if the Initiation and Engagement of SUD Treatment measure were to be added to the Star Ratings, it would present issues surrounding privacy and data exchange. In certain states, there are privacy laws in place that prohibit information sharing about SUDs. Federal and state agencies should collaborate and develop guidelines that permit data exchange in certain circumstances, such as communication from the behavioral health provider to the primary care provider via the health plan. The barriers currently in place would make it a challenge if this were to be added to the Star Ratings.

Statin Therapy for Patients with Cardiovascular Disease (Part C)

NCQA plans to add the exclusion "myalgia or rhabdomyolysis caused by a statin at any time during the member's history through December 31 of the measurement year" and create a specific value set for this exclusion for measurement year 2025.

Support with Considerations

Centene supports this proposed change and is aligned with NCQA's recommendations. We would like to take this opportunity to request that CMS review the overall strategy for measuring statin use in patients with cardiovascular disease and diabetes to ensure that there is a consistent strategy adopted across all relevant measures. For example, the Statin Use in Persons with Diabetes (Part D) measure uses PQA (Pharmacy Quality Alliance) technical specifications, and the Statin Therapy for Patients with Cardiovascular Disease (Part C) measure uses NCQA HEDIS technical specifications. Further, of the 42 measures that will be used to calculate the 2025 Star Ratings listed in the Advance Notice, three are aligned to this single medication class. Given the similarity and overlap between the measures, Centene recommends CMS work with the measure stewards to identify ways to better align these measures and make them consistent, including ensuring that the measures fully account for all beneficiaries with contraindications or intolerance to statins. Additionally, we continue to support a diversified set of Star Ratings measures that do not overweigh specific topic areas.

Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions (Part C)

CMS is considering eliminating the additional five days the Independent Review Entity (IRE) allows for appeal files that are submitted electronically as well as using the electronic system receipt date and time as the date the appeal was received by the IRE, regardless of whether it is during the IRE's business hours, for electronic submissions.

Support

Centene supports these changes, given that over 99% of cases are submitted to the IRE electronically. We particularly appreciate the proposed change to use the electronic submission receipt date and time as the date the appeal is received, as this will remove any dependency on the IRE's business hours when submitting cases. Centene agrees that this should be considered a substantive change and is supportive of the legacy appeals measures remaining in the Star Ratings until the updated measures are on the display page for at least two years.

Cross-cutting: Gender-Affirming Quality Measurement in HEDIS (Part C)

NCQA continues to evaluate approaches to update measure specifications where eligible populations are currently defined with gendered language to ensure inclusive and gender-affirming approaches that are aligned with measure intent and clinical evidence.

Support with Recommendations

Centene supports CMS' efforts to ensure inclusive and gender-affirming care within the Stars program, however, we request that these changes not go into effect until standardized data capture is established between state and CMS regulators. Additionally, plans and providers will need time to build updated data infrastructure so that all Sexual Orientation and Gender Identity (SOGI) data can be accurately captured. This will also allow plans and providers time to establish how SOGI data can be exchanged efficiently between plans.

Another option could be adding SOGI data set elements to the Medicare Model Enrollment Forms as categories for voluntary response, as this information can be challenging to obtain otherwise. Capturing SOGI data from beneficiaries will be essential to identifying barriers to adequate and responsive healthcare.

Care Coordination (Part C)

CMS is considering updating two of the questions included in the Care Coordination measure, specifically removing two questions currently included in the composite measure and replacing them with two new questions.

Support with Clarification

Centene supports CMS updating two of the questions in the Care Coordination composite measure and appreciates CMS' efforts to improve the survey. To assist with understanding the implications of this change, we request that CMS provide additional information on how this change will impact measure scoring and weighting within the Star Ratings.

Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D)

CMS has included the IOP-LD measure in the 2023 Measures Under Consideration (MUC) list and intends to propose to add the IOP-LD measure to the Star Ratings in future rulemaking.

Centene Insight

Centene appreciates CMS' efforts, and we agree that this is a critical topic. However, as we've previously noted for the statin-related measures, we suggest that CMS consider reviewing the overall strategy for assessing opioid-related measures to ensure there is a consistent strategy adopted across all relevant measures. Centene believes that there are already a substantial number of opioid-related Star Ratings measures on the display page and would like to continue to support a diversified and balanced Star Ratings program with a wide array of measures, with no one topic area disproportionately influencing quality. Further, due to CMS' Overutilization Monitoring System (OMS) and other various required edits, there are a number of mechanisms already in place to ensure members' appropriate use of opioids. Centene believes that further alignment of these measures and other mechanisms would prevent duplicative work and undue burden on members and providers. Additionally, we ask that CMS consider the potential impacts to health plans of adding new measures, and whether risk adjustment may be needed for this measure to ensure that health plans can continue to provide the best care possible to the most vulnerable members.

Members Choosing to Leave the Plan (Part C & D)

CMS plans to adjust the years of service area data used to better reflect contract service area starting with the 2026 Star Ratings, so that for disenrollments occurring at the end of the measurement year, CMS will use the service area for the year following the measurement year for both the old and new contracts. Additionally, CMS plans to exclude any enrollment into a plan designated as an Applicable Integrated Plan (AIP) from the measure numerator for the contract the enrollee is leaving, unless the plan the enrollee is leaving is also an AIP or if the switch is between D-SNPs in Florida.

Support with Clarification

Centene supports the proposed changes to the measure and appreciates CMS' efforts to more accurately reflect involuntary disenrollments. To better understand how these changes will be implemented, we request that CMS provide additional information on the two changes.

Regarding the change in adjusting the years of service area data, Centene asks that CMS release technical instructions on how to operationalize this new scenario for disenrollments at the end of the measurement year. Specifically, in order to determine whether this scenario is occurring, we would appreciate that CMS share what code will be used to identify this scenario and whether health plans or CMS will be reconciling the data.

With respect to the exclusion of any enrollment into an AIP, Centene requests that CMS clarify the scope of what is considered an AIP for the purposes of this exclusion. We are supportive of ensuring that all beneficiaries, including dually eligible beneficiaries, are enrolled in MA plans that best meet their needs. As such, we request CMS confirm that this policy will exclude from the measure numerator eligible members that leave one D-SNP to enroll in another D-SNP offered by the same MAO or its parent company, inclusive of both HIDE and FIDE SNPs. More broadly, we also recommend excluding scenarios in which any member switches to a new plan within the same parent organization, so that H-contract switches are also not considered voluntary disenrollments.

Moreover, Centene requests CMS provide guidance on which transaction code will be used in the Transaction Reply Report (TRR) files and how CMS will differentiate this scenario from other scenarios, such as a relocation outside of the service area. We recommend that CMS flag these as involuntary

disenrollments to ensure they are captured as such. Additionally, Centene requests clarification on whether this change will be implemented retroactively back to measurement year 2024.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Health Outcomes Survey (HOS) (Part C)

CMS is seeking OMB approval to conduct a field test to evaluate new survey items, the effects of the revised survey, and the addition of a web-based survey mode for HOS measure. CMS is planning to test survey content related to Patient-Reported Outcomes Measurement Information System (PROMIS) Physical Function Items, Generalized Anxiety Disorder 2 (GAD-2) Items, and Health-Related Social Needs (HRSN) Items.

Support with Recommendations

Centene supports CMS' efforts to further enhance and refine the HOS measure. We agree with expanding the mental health conditions assessed in HOS beyond depression and believe that having this information can help reduce disparities in health care. In screening for Generalized Anxiety Disorder, we would like to ensure that the phrasing of this question only applies to members who have recently sought mental health care and recommend that the wording reflect that. Additionally, if CMS moves forward with implementing these changes in the future, Centene requests that the GAD-2 items be considered for risk adjustment.

Centene also agrees with CMS that the collection of health-related social needs is incredibly valuable in terms of addressing health equity and reducing health disparities. However, we recommend that CMS consider how these questions may overlap with other measures that aim to capture members' health-related social needs, including NCQA's Social Need Screening and Intervention (SNS-E) measure. Centene would like to ensure that similar measures are not duplicative and are aligned to ensure consistency, as well as reduce any additional burden on members and other stakeholders. Centene also believes that there may be other, more effective ways to capture members' health-related social needs. For example, CMS may consider collecting initial health-related social needs data on applications for traditional Medicare. This foundational data capture would help health plans as those members enroll in MA and help inform CMS on the prevalence of these issues early on in beneficiaries' membership.

Blood Pressure Control for Patients with Hypertension (Part C)

NCQA is exploring the development of a new blood pressure control measure utilizing the capabilities of digital quality measures and leveraging standardized electronic data for measurement year 2025 and beyond. Specifically, NCQA intends to test a new approach which expands upon the current denominator method by including members with at least one claims-based diagnosis and at least one dispensed anti-hypertensive medication and test a lower evidence-based blood pressure control threshold (<130/80 mmHg) and leverage structured electronic clinical data for assessing the last reading in the measurement year.

Support with Recommendations

Generally, Centene supports changes to this measure and is aligned with NCQA's recommendations. However, Centene maintains that there are substantial barriers to leveraging electronic clinical data, and we request that CMS provide additional information on how this would be implemented and consider the timeline for implementation. Specifically, Centene requests clarification on what criteria will be used to allow digital measures. For example, would only digital-generated information be considered, or would

members be able to submit hand-written blood pressure measurements to their providers? Further, Centene recommends that this measure be delayed beyond measurement year 2025 to provide sufficient time for providers to develop the IT infrastructure need to support this measure.

Centene also requests that CMS consider the potential outcomes of lowering the blood pressure control threshold to <130/80 mmHg. Clinical guidelines are not all aligned on this new lower threshold and blood pressure guidelines are frequently adjusted. Additionally, implementing lower blood pressure goals across the eligible population without considering member-specific risk factors (e.g., advanced age, other chronic conditions, fall risk) could result in sub-optimal health outcomes, affect total cost of care, and impact member's overall quality of life. Therefore, we recommend keeping the measure at the existing control threshold and continuing the established definition of controlled blood pressure.

Breast Cancer Screening Follow-Up (Part C)

NCQA is developing a new measure for measurement year 2025 to assess documentation and follow-up of abnormal mammogram results as an Electronic Clinical Data Systems (ECDS) measure, which would include two rates: Documented Breast Imaging Reporting and Data System (BI-RADS) Assessment following a mammogram and Follow-up After Abnormal Screening.

Support with Clarifications

Centene supports this proposed measure and is aligned with NCQA's recommendations. We would appreciate additional information from CMS on how this new measure would be assessed, including details on what is considered a follow-up visit, the timeframe for follow-up after an abnormal screening, and what types of codes this would be based on.

Social Connection Screening and Intervention (Part C)

NCQA is developing a new measure for measurement year 2025 that assesses the percentage of members aged 65 and older who were screened, using prespecified instruments, at least once during the measurement year for social isolation, loneliness, or inadequate social support and received a corresponding intervention if they screened positive.

Support with Clarifications

Centene supports this proposed measure and believes it will help reduce social isolation among Medicare members. We would appreciate additional information on the prespecified instruments for screening for social isolation. Centene recommends a standard instrument be established to allow for better tracking and monitoring of health outcomes.

Chronic Pain Assessment and Follow-Up (Part C)

NCQA is developing a measure for measurement year 2025 to assess chronic pain and follow-up in Medicare members aged 65 and older to replace the Care for Older Adults – Pain Assessment indicator planned for retirement.

Support with Recommendations

Centene supports the development of the chronic pain assessment and follow-up measure and agrees with expanding the measure to include all populations. We recommend that, as part of this measure, NCQA and CMS assemble a list of approved screening tools and identify which providers can administer these

authorized tools. We would also like additional clarity on the indicator that assesses the follow-up received, and the types of methods that would be permitted, such as telehealth.

Tobacco Use Screening and Cessation and Lung Cancer Screening and Follow-Up (Part C)

NCQA is exploring the development of two new measures related to tobacco use screening and lung cancer screening for the ECDS reporting method, for no earlier than measurement year 2026.

Support with Clarifications

Centene supports these proposed measures and is aligned with NCQA's recommendations. We would appreciate additional information on how these new measures would be developed. Specifically, Centene requests that NCQA and CMS define a standard list of what is considered a cessation strategy and what documentation would be sufficient to close these health care gaps. Additionally, we recommend setting a specific age range for adolescents included in this measure and clarification on if these proposed measures would be coded during health care visits.

Functional Status Assessment Follow-Up (Part C)

NCQA is exploring the development of a new measure to assess follow-up after a Functional Status Assessment, specified for ECDS reporting, for measurement year 2026 at the earliest.

Support with Clarifications

Centene supports this new measure and is aligned with the NCQA recommendations. However, to understand the scope and impact of this measure, we request clarification on whether this measure would include all populations or if it would be specific to the special needs population.

Medicare Plan Finder (MPF) Drug Pricing Measure (Part D)

CMS is considering a new measure to evaluate the accuracy of sponsors' pricing data displayed on the MPF tool and is seeking feedback on how to develop this measure. Once developed, CMS would add it to the display page and consider adding it to the Star Ratings through future rulemaking.

Oppose with Considerations

Centene appreciates CMS' efforts to ensure the accuracy of pricing data displayed in the MPF, and we believe it is important that beneficiaries have access to accurate data when comparing their plan options. However, we request that CMS not move forward with developing this measure. There are already a number of complexities and uncertainties involved in this process and if introduced, this new measure may result in unintended negative consequences. For example, plan sponsors are already implementing new plan year market changes while managing both Annual Enrollment Period (AEP) and current plan year adjustments. Adding a new AEP measure would introduce additional complexity and risks, including limiting the ability for plans to make needed changes at the beginning of a new plan year. For example, the inclusion of submitted MPF prices higher than Prescription Drug Events (PDEs) during AEP may penalize plans for pharmacy rate improvements that happen during ongoing negotiations with in-network pharmacies during AEP.

Additionally, plans that experience membership changes after initial price setting may need to make further price adjustments in order to meet contractual pharmacy obligations. Prices are set based on expectations and may need to be adjusted as the result of the actual membership compared to the forecasted membership.

Overall, as this new measure may penalize plan sponsors for implementing new plan year market changes while managing AEP and current plan year price increases and decreases, Centene recommends that CMS not move forward with developing this new measure.