ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

October 13, 2023

The Honorable Jodey Arrington
House of Representatives
Washington, DC 20515

The Honorable Michael Burgess
House of Representatives
Washington, DC 20515

Dear Chairman Arrington, Representative Burgess and members of the House Budget Committee Health Care Task Force,

The Alliance of Community Health Plans (ACHP) applauds the House Budget Committee for the creation of the Health Care Task Force to find solutions that reduce health care spending and improve patient outcomes. We are submitting the following comments in response to the August 25, 2023, Request for Information.

ACHP is the only national organization promoting the unique payer-provider aligned model in health care, delivering affordable, coordinated and comprehensive coverage options. ACHP member companies collaborate with their provider partners to deliver higher-quality coverage and care to tens of millions of Americans in nearly 40 states and D.C. Deeply rooted in their communities, ACHP member companies understand the value of an integrated system of care, in which providers, payers and community leaders work together to enhance access to services and improve health outcomes. ACHP members provide coverage and care across all lines of business, including the Medicare Advantage program.

Medicare Advantage (MA) is the choice of America's seniors, delivering coverage and care to more than half – and growing - of Medicare-eligible seniors in America. Nationwide, in 22 states a majority of seniors are enrolled in the managed care alternative to fee-for-service Medicare. Most consumers enjoy access to zero-premium plans with prescription drug coverage and many other benefits included at no additional cost. With consistently high-quality ratings, expanded benefits and a record of reaching minority populations, MA is an undeniable success. That said, ACHP believes MA can improve and provide beneficiaries with a program with even higher quality, more meaningful choice and greater value. In June, ACHP launched *MA for Tomorrow*, an ambitious set of policy proposals to modernize and improve the MA program through five pillars: (1) raising the bar on quality; (2) improving consumer navigation; (3) advancing risk adjustment for care, not codes; (4) modernizing network composition; and (5) transforming benchmarks.

MA for Tomorrow equips policymakers with recommendations to take the program from good to great, driving quality even higher, promoting competition and choice and yielding value for every Medicare dollar. *MA for Tomorrow* is in line with the Health Care Task Force's vision to deliver value for every Medicare dollar spent while improving beneficiary satisfaction, choice

and outcomes. We look forward to working with members of the Task Force to implement the five pillars outlined below .

Raising the Bar on Quality

CMS measures MA plans by the Star Ratings system, scoring health plans on a scale of one to five stars. The MA Star Ratings system gives beneficiaries an opportunity to compare plans and choose a high-quality plan that fits their needs. With more than 85 percent of current MA enrollees eligible for a quality bonus payment, the Star Ratings has turned into a quality bonus handout with little distinguishment for the beneficiary. MA's Star Ratings system should allow seniors to differentiate plan options and encourage competition. *MA for Tomorrow* raises the bar on quality by: (1) Removing "topped out" process measures and focusing on patient experience and health outcomes to measure plan performance; (2) Improving quality survey tools used to measure enrollees' experience and rate plan performance; (3) Limiting the number of plans that can achieve a four-star or above to truly distinguish and reward the highest performing plan.

By raising the bar on quality to improve quality measurements and limiting the number of plans achieving a four-star or above rating, policymakers will provide beneficiaries with better visibility into high quality health plans and save taxpayer dollars. If you limit the number of plans achieving a four-star or above Star Rating, you limit the number of plans eligible for a quality bonus, yielding taxpayer savings. Most importantly, health plans competing to obtain a four-star or above rating is good for beneficiaries, distinguishing the highest quality MA plans.

Improving Consumer Navigation

The average senior has 44 MA plans to choose from. In some areas of the country, seniors have well over 100 MA plan options. While faced with shopping for the health plan best suited to their health needs, seniors are inundated with television commercials, mail solicitations and unwelcomed phone calls. This was underscored by a Senate Finance Committee investigation which found substantial evidence of misleading marketing, led by nefarious practices of third-party marketing organizations and "lead generation" firms. While CMS took steps to rein in misleading marketing, more must be done. *MA for Tomorrow* takes additional steps to improve consumer navigation by: (1) Establishing a cap on health plan payments to marketing organizations, providing a fast-track review process for 5-star MA plans and strengthening oversight and penalties for misleading and inaccurate marketing; (2) Putting an end to misaligned broker compensation incentives to foster fair competition and high performance while reducing administrative costs; and (3) Incentivizing brokers to enroll consumers in high-quality and value-based plans versus those offering the highest payments.

ACHP recognizes the important role brokers play in helping seniors understand the coverage options available and finding the right plan for their needs. In exchange for these services, brokers are fairly compensated. That said, current trends for broker compensation has gotten out of control and is costing the Medicare Trust Fund billions. CMS sets an annual maximum commission a health plan can pay brokers (for 2023, it's $611 per new enrollee and $306 for first-year renewal, on average). However, there are no limits on creative add-on fees health plans can pay brokers, such as referral payments, marketing, administrative expenses, bonuses and incentives for completing a health risk assessment. As a result, health plans often pay brokers and affiliated field marketing organizations more than double the broker commission limits, totaling billions of dollars each year that could be used to enhance care or extend the Medicare Trust Fund. The financials are straightforward: the more seniors a broker enrolls in the most lucrative options, the higher their earnings from health plans.

ACHP has actively engaged with CMS to standardize broker compensation. Lawmakers should work with CMS, encouraging them to use their existing statutory authority, to improve competition in MA markets, ensure seniors are directed toward the health plan that best meets their needs, save Medicare dollars and guarantee taxpayer dollars are going to seniors' care.

Advancing Risk Adjustment for Care, Not Codes

MA plan payments are adjusted for the health status of each consumer, a process known as risk adjustment. Risk adjustment is intended to provide health plans with financial resources to provide comprehensive care for consumers with more complex conditions and higher medical costs. Plan payments are adjusted based on risk scores and there is an associated risk score for each consumer's documented health condition. The more documented conditions a consumer has, the higher the risk score and the higher the payment. Unfortunately, this has produced a misaligned incentive to aggressively code. Aggressive risk adjustment practices in MA are delivering bigger payments than bonuses for high-quality coverage and care, costing the Medicare Trust Fund without knowing if the dollars are producing better health outcomes. *MA for Tomorrow* improves risk adjustment by: (1) Calibrate the risk adjustment model on MA encounter data; (2) Tier the coding intensity adjustment; and (3) Target risk adjustment data validation (RADV) audits.

The current risk adjustment model is calibrated using fee-for-service claims data, not accounting for differences in coding patterns between volume-based and value-based care. Recalibrating the risk adjustment model to use MA encounter data, which CMS has collected for more than a decade, will improve payment accuracy and mitigate effects of aggressive coding. The Affordable Care Act requires CMS to apply an intensity adjustment to account for differential coding practices between traditional fee-for-service Medicare and MA. CMS currently applies an

across-the-board adjustment to all MA plans despite the variance in coding intensity by plan. As coding practices differ, so should the coding intensity adjustment. Tiering coding intensity adjustments will deter outliers, reduce aggressive coding behavior, which will save taxpayer dollars, and level the playing field in MA to benefit seniors.

Modernizing Network Composition

Currently, CMS uses time and distance, provider ratios and appointment wait times to determine MA plan network adequacy. However, these qualifiers are dated and there is no single metric that sufficiently assesses a health plan's provider network. Current metrics also fail to appropriately consider the value of virtual care in expanding access, particularly in areas struggling with workforce shortages. In rural communities, one of the most significant hinderances to robust MA competition are network adequacy requirements. Having robust MA competition in rural and underserved communities allows more access to value-based care and the ability to save taxpayer dollars. *MA for Tomorrow* modernizes network composition by: (1) Increasing opportunities to leverage virtual care; (2) Streamlining the network adequacy exceptions process; and (3) Establishing new metrics to achieve network adequacy.

Modernizing network composition, coupled with the other pillars of *MA for Tomorrow*, will allow for robust competition of a high-quality, high-value MA program in rural communities—providing an alternative to volume-based care. Modernizing network composition requires policymakers to understand the rural reality: there are insufficient specialists, and sometimes primary care providers, within the current, stringent geographic thresholds. *MA for Tomorrow* allows health plans to leverage virtual care opportunities and encourages top-of-the-licensure practice by alternative care providers such as Physician Assistants and Nurse Practitioners. Coupled together, MA plans will have better opportunity to enter markets with little or no MA products and better allow for value-based care options.

Transforming Benchmarks

Benchmarks serve as the cornerstone of MA payments, establishing the maximum per beneficiary monthly payment to a health plan to cover basic Medicare benefits. The benchmark methodology is based on average spending in traditional fee-for-service Medicare, adjusted by county. However, with MA surpassing fee-for-service Medicare in terms of enrollment, basing MA payment benchmarks solely on fee-for-service is outdated. A new MA benchmark methodology better reflecting average Medicare costs with incentives for quality and investments in coordinated care will drive fiscal sustainability of the program. *MA for Tomorrow* transforms benchmarks by: (1) Removing the ACA benchmark cap; (2) Including only beneficiaries with Part A and Part B; and (3) Blending national and local fee-for-service costs; (4) Modifying rebate percentages to differentiate high-quality.

The current benchmark methodology was established when MA accounted for a smaller subset of Medicare enrollees. Changes are needed to ensure MA operates in the best interest of the taxpayer now that is the majority of the Medicare program. Reducing the reliance on local fee-for-service costs and better reflecting the changing composition of Medicare enrollment will deliver a more reflective, sustainable benchmark. Use a county with 80 percent MA penetration as an example. In that geographic area, CMS is basing MA benchmarks on the 20 percent of enrollees utilizing fee-for-service. Without a benchmark reflective of the beneficiaries being served, benchmark spending in those counties soar. This trend will continue as MA surges compared to fee-for-service Medicare. *MA for Tomorrow* updates MA benchmarks, providing a more reflective benchmark and financial sustainability in the program.

ACHP looks forward to working with the House Budget Committee's Health Care Task Force to implement the pillars of *MA for Tomorrow* to reduce spending and improve quality and beneficiary satisfaction within MA. Please contact Josh Jorgensen, ACHP Associate Director of Legislative Affairs, at jjorgensen@achp.org with any questions.

Sincerely,

Dan Jones

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