



August 31, 2022

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

Submitted via [www.regulations.gov](http://www.regulations.gov)

**Re: Medicare Program; Request for Information on Medicare (CMS-4203-NC)**

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) member companies have been leaders in delivering high quality, innovative and consumer-driven Medicare Advantage (MA) for decades. Based in our communities and closely tied to our consumers, ACHP member companies are committed to putting consumers first, utilizing integrated and aligned relationships with providers to provide a seamless and comprehensive member experience. We appreciate the opportunity to work with the Administration to enhance the MA program and serve the needs of today's seniors and thousands of new consumers that join the program every day.

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 36 states and D.C.

Maintaining a robust and sustainable MA program has been a longstanding priority for ACHP member companies and we appreciate the opportunity to provide feedback to the Medicare Program Request for Information. We commend CMS for pursuing a next generation MA program that fosters innovative competition, equity, fiscal stewardship and prioritizes the vital futures of all seniors. Our response reflects our member companies' many years' experiences within the MA program but is by no means exhaustive feedback of all the areas for potential improvement, an undertaking that would require significantly more time. We look forward to subsequent opportunities to share ideas, data insights, on-the-ground experience and practical solutions in the weeks and months ahead.

**Executive Summary**

Medicare Advantage has proven to be one of the most popular and successful government programs, garnering bipartisan support and steady enrollment growth since inception. MA is the choice of America's seniors, reaching nearly 29 million enrollees and accounting for half of all Medicare consumers. Despite projections that the Affordable Care Act would impede MA program growth, enrollment has more than doubled in the past decade with the fastest growth in rural areas. ACHP and our member companies celebrate this success, seeing firsthand the benefit of coordinated, high-quality coverage and care for seniors. Focused on consumers and communities, ACHP members continue to lead the industry in critical health measures and exceptional customer experience. 22 of

ACHP's 23 member plans with a MA plan received 4-stars or above in CMS' 2022 Star Quality Ratings and one-third of all health plan contracts awarded 5-stars are offered by ACHP members. In addition, ACHP MA plans have net promoter scores that are 2.5x higher than the national benchmark for health insurance.

While MA overall remains strong, there is a pivotal opportunity to modernize the program to respond to the challenges associated with rapid growth and the increasing strain on the finance and operations of the US health care system. ACHP and its members are dedicated to ensuring the sustainability and constant improvement of the MA program to serve seniors and address the pressing social needs and health disparities in communities across the country. It is incumbent upon the Administration to ensure a competitive MA marketplace that retains a prominent role for nonprofit and regionally based health plans which can efficiently target and address gaps in care and coverage. Nonprofit, regionally based health plans are essential anchors within their communities and their ability to thrive in the MA market will improve coverage and care for all consumers. We have provided on-the-ground plan and provider experience, feedback and recommendations on a range of topics briefly summarized below:

**Health equity.** Gaps in social determinants and health equity related data prevent health plans from making sustained progress to address disparities. While multiple stakeholders, private entities, health plans and others are working to fill the gaps, a collective, cross-cutting Administration initiative is needed to ensure that we do not end up with a patchwork, but instead a cohesive and interoperable solution across programs.

**Access.** Flexibility with and access to virtual care, behavioral health and supplemental benefits have been essential, especially throughout the COVID-19 pandemic, to person-centered and community-centered care. The growing consensus from consumers is a desire to have their needs met at the right time and right location. Health plans that can offer flexible coverage and care find improved satisfaction, higher-quality and more consistent patient/beneficiary engagement.

**Innovation.** ACHP and our member companies are excited about the pathway the Administration laid out for health care's digital transformation. However, the move to a digital and fully interoperable health care system will take time and resources which can be challenging for regional health plans with competing and equally important business priorities. The Administration must recognize that health plans and the IT departments have multiple ongoing projects and priorities as they develop, troubleshoot and roll out interoperable solutions.

**Transparency.** Price transparency has the potential to transform how consumers navigate the health sector, enabling informed decision making. However, price information alone will not achieve this outcome and may lead to consumers making inappropriate assumptions about quality and outcomes based solely on cost. ACHP maintains that all pricing information should be tied to quality metrics, such as whether a certain provider comes recommended, patient experience and health outcomes. Taking steps to incorporate quality and consumer-valued information (i.e., location/distance) improves the likelihood of consumer uptake and advances the goal to produce meaningful and timely health care transparency.

**Sustainability.** Accurately assessing and incorporating consumer risk within the MA program and continuing to shift the industry to value-based care is essential to MA's success and sustainability. ACHP member companies' payer-provider aligned models inherently incentivize efficiency and mitigate risks for fraud, waste and abuse. However, various program integrity and sustainability initiatives are burdensome, particularly for smaller health plans. We support efforts to include social risk factors into a consumer's health risk. A well-functioning risk-adjustment model must adequately and accurately support health plans and providers providing sufficient resources to manage care effectively. ACHP recommends the Administration approach policies and solutions gradually, balancing changes to the risk adjustment model and social need data collection and standardization progress. One-size-fit-all and across-the-board changes do not address sustainability concerns and only exacerbate differences in risk practices.

We appreciate the opportunity to provide feedback and ideas to ensure a thriving, competitive market that empowers all seniors to be more informed consumer navigation of the Medicare program.

### **Advance Health Equity**

#### ***Improving Health Equity Data and SDOH Screening***

ACHP member companies serve a unique role within their communities, leveraging longstanding relationships to tailor offerings to consumer and community needs. Persistent gaps in health equity data standardization and collection present hurdles to crafting more personalized care delivery designs and benefits to meet specific needs. Recognizing that health inequities result from a complex combination of clinical, economic, environmental and other social drivers, ACHP developed an actionable framework that deploys equity-focused interventions at the individual, community and systemic level. The issue of health equity and social determinants of health spans all government programs and various lines of business. We offer the following initiatives as a step forward in the journey to address social determinants of health and improve health equitably in our communities.

We encourage the Administration to support existing tools and infrastructure health plans use to collect health equity and social determinant of health data. ACHP member companies predominantly rely on health risk assessments and screening tools to capture a consumer's socioeconomic, demographic and social needs status. Often the assessments are an extension of the plan's population health team that is focused on stratifying and addressing the needs of new or high-risk consumers. These tools provide insight into care under-utilizers - allowing health plans to identify beneficiaries with chronic conditions not accessing care and connecting the consumer to available plan resources. This is a particular benefit for consumers with changing care needs and those that are homebound. Other data supplement options, such as clinical screening and community resource member-facing teams, capture data as free text within a chart narrative note. This makes identifying consumer-specific needs a labor-intensive process to scan all the free text and unstandardized data for reformatting and exchange. We strongly support and encourage ongoing efforts to standardize this data and incentivize its industry wide adoption.

ACHP recommends CMS require social determinant screening with template recommended questions. We advise against requiring specific questions be asked to provide the flexibility for health plans to personalize engagement with consumers. ACHP member companies have refined their social determinant screening questions to generate more reliable, insightful responses. We encourage CMS to consider incorporating health plan incentives for the use of care management teams that ensure the personalization of at-home assessments and follow-up based on consumers' individual circumstances and needs. ACHP members welcome additional sub regulatory guidance setting expectations for health plans' use of data from health risk assessments and what is deemed inappropriate.

We are aware that other health plans may take advantage of the information collected with these tools for the sole purpose of increasing risk-adjustment and appreciate that appropriate guardrails to prevent misuse of this valuable information is needed. ACHP member companies maintain audit ready programs and clear guidelines and scripting for the administration of these assessments to prevent untoward or inappropriate use. Audits should be targeted, relieving burden on health plans closely following risk-adjustment requirements and not in the top cohorts of aggregate coding.

Z-codes provide an additional opportunity to collect social determinant data. These existing data collection pathways and formats are valuable and should be leveraged while ensuring that the data is sharable between CMS, health plans and providers. ACHP strongly supports collaborative efforts that incentivize the use of Z-codes and sharing data collection best practices, ultimately increasing widespread use and reliance on these valuable codes.

Recognizing that health equity challenges are not limited to the Medicare program, ACHP recommends allowing social determinant data sharing access points within other federal programs and agencies, such as the Department of Housing and Urban Development. While the health risk assessments and social determinant of health screening tools provide insight, health plans still encounter gaps where consumers decline to answer questions or existing data that may have been captured elsewhere are unavailable. ACHP member companies noted that they have undertaken significant efforts with vendor partners to fill in these data gaps in their Medicaid and duals populations but were unable to share the data with the state Medicaid agency. In addition, these types of partnerships are expensive and health plans must navigate an increasingly crowded vendor space, attempt to differentiate and assess value and, once the partnership is established, assess whether the social risk data at the individual level are valid.

In a recent ACHP and National Partnership for Women & Families joint project, “Raising the Bar, ACHP findings revealed wide variation in the availability and quality of race and ethnicity data for Medicaid and duals enrollees across the country with some states having applicable data for less than half of their Medicaid and duals enrollees. This project and our member company experience filling in health equity and social determinant data gaps highlight the significant impediments for the availability of race and ethnicity data and the ability to identify and address inequities at the local level. ACHP recommends CMS issue guidance on best practices for social determinant of health data governance to help organizations develop internal policies on how to identify the “original” or “most-reliable” source of data when they encounter conflicting information.

### ***Community Partnerships to Meet Social Needs***

ACHP member companies’ long-standing and deeply rooted connection to their communities enable them to foster new partnerships, especially with individual or single community-based organizations, such as faith groups, barber shops and community centers. When a health plan identifies a valuable community partner there are legal and regulatory compliance issues that must be addressed. For instance, sharing of personal health information requires significant infrastructure and resources to ensure compliance with HIPAA. For community organizations and providers which do not have legal teams capable of handling health care legal compliance, these partnerships can be difficult to formalize. For example, based on current privacy and security regulations, a health plan interested in partnering with a small local parish to help serve as a “go-between” for patients who either do not engage with or trust the health care system would need to assist the parish in establishing a multi-million-dollar HIPAA secure email system. This forestalls a trusted religious leader from reaching out to a consumer and asking if they are taking their medications or need help affording it, vital information that the consumer may be more comfortable sharing with a community confidant. For these community services and providers, CMS could create guidance and guardrails that alleviate burdens on small community partners, paving a path towards closing health care gaps and promoting greater care coordination. In addition, CMS could create exceptions to the uniformity rule which makes it challenging to partner with local community groups that have a limited-service area. This makes it impossible to provide the same benefits and services across an MA service area, denying valuable benefits to a portion of the MA consumers.

We strongly support CMS partnering with other federal agencies to better assess geocoded health risk solutions to target social needs. For instance, in the case of health equity and addressing social needs, CMS could align requirements and incentives across the U.S. Department of Agriculture and U.S. Department of Education to enable seamless and timely referrals for necessary resources to achieve better outcomes, regardless of whether the resource is “clinical” or “social.”

An ACHP pilot program with Socially Determined, a social risk intelligence platform that overlay various data sources, found that in many communities, housing risk is higher than food risk. Further, by comparing SNAP utilization and food insecurity, health plans were able to identify the greatest opportunities to connect consumers to existing resources. These local level insights are readily available through public data sources, if the data are

presented in a manner that enables information and insights to be surfaced quickly. However, many ACHP member companies, as well as many providers, lack the data and analytic capacity to conduct analyses that would provide immense value for targeting benefit offerings and their local and organizational efforts.

### ***Food Security and Other Social Needs***

ACHP member companies invest in supplemental benefits to address food insecurity, including grocery and meal delivery services, medically-tailored meals, personalized nutrition counseling and subsidies for fresh produce via prescriptions for food pharmacies. One ACHP member company's Food Farmacy Program, tailored toward patients with uncontrolled A1C levels, has achieved significant success in reducing A1C levels and addressing food insecurity. This program provides patients, who are identified as having A1C levels greater than 8.0 and as being food insecure, with a "prescription" or referral by their primary care physician for the Fresh Food Farmacy. On average, patients observe a reduction of 2.4 points in their A1C. For context, many medications tout success for reducing A1C levels by 1 point. Patients in this program have also observed lower LDL cholesterol, reduced weight and stabilized blood pressure readings. The program's compounded benefits resulted in reduced emergency department admissions. The success of this food program can be attributed to a care team of registered dietitians who provide tailored and culturally relevant health education classes and nutrition counseling. The program also provides 10 meals a week to both the beneficiary and entire household to address food insecurity in a sustainable, comprehensive manner. To target benefits to enrollees most in need, the health plan utilized heat mapping to identify populations with a high prevalence of food insecurity and Type 2 diabetes.

Another ACHP member company offers FarmboxRx services in one of its SNP products, which allows eligible consumers with qualifying chronic conditions to receive fresh produce delivered to their homes for free. Eligible consumers can receive up to two boxes of fresh fruits and vegetables each month. The boxes are designed by a team of Registered Dietitian Nutritionists and can be customized to accommodate specific health conditions. This is the latest food security initiative from this ACHP member company, which previously launched fruit and vegetable prescriptions, food security screening programs and a kid/family healthy eating program that focuses on partnerships, outreach and education, supporting community food and wellness policies and offering multiple resources for plan members. ACHP encourages CMS to expand eligibility criteria, such as all dual-eligible consumers or those that also meet criteria for low-income subsidies, for these types of supplemental benefits, rather than limiting the benefits to consumers with chronic conditions. ACHP also recommends that medical nutrition therapy should be covered under Medicare, as an important component of a treatment plan for managing chronic conditions.

ACHP member companies note that the enrollment process for housing and food assistance is complex, long and duplicative. ACHP recommends CMS develop the tools and infrastructure for a common application for eligibility into public assistance programs by leveraging interagency intelligence. Food and nutrition security must be addressed from a whole-of-government approach to understand the roots, barriers and strategies to address disparities and better enable community-based organizations, health plans and providers to deploy appropriate interventions. ACHP also recommends that CMS include minority groups in the work to craft solutions to advance health equity. This early inclusion and input to address gaps and challenges in meeting social needs is essential. Without these groups participating, the industry and Administration is at risk of developing solutions that do not address root causes of health inequities.

### **Expand Access: Coverage and Care**

#### ***Telehealth***

The pandemic catapulted MA plans into widespread adoption and utilization of virtual health. ACHP member companies with existing telehealth platforms quickly ramped up capabilities and member companies that had not

yet established telehealth platforms and services created a telehealth benefit within weeks of the public health emergency (PHE) declaration. The speed and flexibility of the pivot to virtual care, especially for health plans integrated or aligned with providers, reflected the value MA offers consumers of benefit design flexibilities and innovation.

As consumers transition to living with a COVID endemic, the industry continues to see strong reliance on virtual care. This is particularly evident for virtual behavioral and mental health. ACHP member companies have experienced significant utilization of virtual options for behavioral health care reducing stigma when consumers are able to meet with their provider in the privacy of their home, especially in rural communities where individuals feel their car will be easily recognizable in provider parking lots. This convenience led ACHP member companies to report significantly lower no-show rates – often zero – since the beginning of the COVID-19 pandemic.

The success of virtual care requires continued CMS support. Virtual care access will be dictated by the type of insurance card consumers hold once the pandemic ends. For those with traditional Medicare, their options will be significantly limited, depressing provider interest in virtual care investment across other care delivery lines of business. ACHP supports actions the Administration has taken within existing authority to make virtual care accessible. We will continue to push for Congress to make virtual care delivery permanent past the end of the public health emergency to mitigate further disparities within the health care system.

Health plans are facing value-based payment design challenges for virtual care. ACHP released a white paper early in the pandemic laying out glidepaths to value-based payment arrangements for virtual care. Without Administration leadership, value-based payment design for virtual care will stall. Despite the capitated nature of MA plan design, health plans frequently utilize reimbursement rates from the Medicare fee schedule when they are unable to engage providers within a value-based payment contract. ACHP encourages the Administration to incorporate guidelines within the VBID CMMI Model to promote virtual value-based care. This would accelerate the transition to these models and establish a federal model to track and evaluate the impacts of virtual value-based care.

ACHP member companies have found enormous relief with CMS granting a telehealth credit for certain providers to meet network adequacy requirements. After being in effect for a few years, ACHP urges CMS to expand this network adequacy telehealth credit by county designation, with a focus on rural and frontier areas. ACHP members in rural and frontier counties still have difficulty meeting network adequacy requirements, particularly in instances where the “distance” to a provider may appear to be contractable, however, the actual travel logistics make it an unreasonable option for consumers. By increasing the telehealth credit, health plans could increase consumer choice of MA plans in areas where there are limited provider resources. This is particularly important for specialty providers who may not see the value of servicing a market with a low patient population. Allowing health plans to contract with these providers through virtual care means consumers will have improved access and more coordinated care.

### ***Behavioral Health***

ACHP member companies are leaders in behavioral health integration, through co-location (i.e., incorporating behavioral health specialists into primary care or specialty care), reverse co-location (i.e., incorporating primary care physicians into behavioral health spaces) and behavioral health consultation for primary care physicians. Behavioral health integration is an effective way to mitigate access issues and provide a continuum of mental health care to accommodate consumers with all levels of need. This continuum includes, but is not limited to, primary care consultation and integration, apps and digital therapeutics, outpatient therapy, case management and inpatient treatment.

ACHP member companies have identified several opportunities to improve beneficiary care experience. We strongly recommend that CMS make it as easy as possible for consumers with substance use disorders (SUD) to get the treatment they need. The SUD treatment barriers that were removed during the pandemic for medications, such as suboxone and buprenorphine, should not be reinstated. These barriers include limiting the number of patients to whom doctors can prescribe these medications at one time and prescribing these medications over telehealth. This single change could produce immediate, life-saving results.

Additionally, ACHP recommends CMS develop incentives for behavioral health providers to contract with health plans. Along with the rest of the health care industry, ACHP member companies are facing substantial behavioral health workforce shortages. This is worsened by private practice behavioral health practitioners often not accepting any insurance. The result is consumers must pay out of pocket, which is infeasible for many, and individual health plans have a limited ability to convince these providers to join a network. ACHP members have been innovative in establishing value-based contracts to attract these providers. For instance, one ACHP member established a value-based payment arrangement for in-network psychiatrists and psychiatric nurse practitioners in a similar payment structure as other specialties, such as cardiology. The health plan pays a set amount per member per month, and the practitioners are eligible for bonuses based on performance. Practitioners who have achieved 3-stars or higher on a group of eight HEDIS measures and a few others (all compared to national performance) are eligible to receive incentives related to medical loss ratio reductions. CMS should collect and share these examples and establish value-based payment templates to encourage further contracting innovation.

Compounding this workforce shortage is the availability and reimbursement of alternative providers. ACHP strongly recommends that CMS expand the list of behavioral health care providers eligible for Medicare reimbursement such as licensed mental health counselor, licensed professional counselors, professional clinical counselors, marriage and family therapists and peer support specialists. Patients will have better access to behavioral health care if MA is able to cover their services. Coverage for peer support specialists is notably important as their role in care delivery is shown to reduce costs by engaging patients in their treatment, increase patients' tenure in the community and reduce stigma.

### ***Supplemental Benefits***

Supplemental benefits and special supplemental benefits for the chronically ill (SSBCI) transformed coverage and care for millions of seniors. ACHP member companies offer an incredible array of supplemental benefits curated to meet individual needs while considering local and community-wide preferences and behaviors. In addition to offering the more standard supplemental benefits, such as over-the-counter benefits, prescription drug benefits or hearing, dental and vision care, ACHP member companies also offer benefits that target social needs. The most common examples of these are food insecurity interventions, transportation assistance, family and social support services and housing.

ACHP member companies constantly assess which supplemental benefits should be offered. This includes whether certain high-value services are being underutilized, likelihood for consumer engagement, pilots in other product lines, primary research and consumer feedback and preferences. Even with all the factors used to consider supplemental benefit offerings, it can be challenging to determine an attributable return-on-investment for these types of benefits. While these benefits are still in their infancy, it is undeniable that seniors expect to have access to supplemental benefits and use those offerings in determining which health plan they select.

ACHP member companies prioritize care coordination with their provider partners and supplemental benefit vendors. For example, one ACHP member company serves a diverse, frail elderly population for whom they hire care coordinators from a variety of cultures and who speak multiple languages. These care coordinators assist members throughout all interactions with the health care system to ensure members are receiving appropriate care and having their needs met. However, as regulatory requirements for care coordination continue to increase,

care coordinators are spending increasing amounts of time on paperwork. While ACHP and our members recognize the importance of these requirements to ensure oversight and high-quality services, ACHP looks forward to working with CMS to reduce regulatory burden for care coordination efforts, particularly for health plans that obtain high Star Ratings.

### ***Marketing***

ACHP member companies are committed to providing consumers with concise, easy-to-understand information about the MA program and their health plan products. However, our member companies often find that many consumers remain fundamentally confused by the difference between traditional Medicare, Medigap and MA, too often assuming they are all the same. We continue to receive feedback from consumers that Evidence of Coverage documents are overwhelming and difficult to understand. ACHP members employ robust enrollment and onboarding processes to help overcome these challenges, including providing enrollment kits which provide detailed documentation of standard benefits, supplemental benefits and programs and services. During onboarding, new consumers are provided additional information and support tools to ensure they can access their benefits and are informed on how to reach the health plan when in need of assistance. ACHP encourages CMS to establish a technical expert panel with consumers and consumer groups to determine how to best convey information about the various Medicare program options. Part of this consumer engagement should focus on understanding and disseminating educational resources on the MA Star Ratings program to ensure that consumers are able to use quality in their value determination when selecting coverage.

We strongly recommend CMS conduct a full review of marketing practices, requirements and financing for third party marketing organizations (TPMOs). Without sufficient oversight into TPMOs, seniors are experiencing aggressive marketing and misleading tactics which too often result in involuntary disenrollment. ACHP member companies have provided numerous examples of nefarious behavior and will continue to do so. Nearly all health plans rely on agents/brokers and the growing use of navigators or connectors. However, there is an urgent need to review the reimbursement practices of agents and brokers to ensure that regional health plans are equally presented as options for seniors during enrollment opportunities. The use of agents/brokers and connectors leads ACHP member companies to make significant resource investments to be able to compete, impacting premiums, and yet too often consumers are steered towards the products of national plans. Regional health plans tend to be more agile and member-centric compared to national plans and deserve the opportunity to compete fairly in MA. We look forward to discussing ideas to improve the consumer experience and ease the health plan selection navigation process.

In addition, ACHP is concerned about the questionable practices of private equity, particularly in attempts to influence Medicare consumers. There continue to be voluminous examples of private equity leveraging health care providers with attractive financial packages and solutions that intercede in payer/provider contracts. These often result in risk-based arrangements between the provider and health plan with a private equity firm governing the relationship. These private equity firms use the consumer to increase risk-based revenue, which is concerning given the actions they are willing to take at the cost of the consumer to influence clinical decision making. ACHP member companies report instances in which the private equity firm fails to provide consumers with full information and ultimately the consumer is steered toward a different health plan with the most advantageous risk arrangement for the provider group. This potentially results in seniors selecting private equity backed health plans that do not accurately address their needs. ACHP encourages CMS to regulate private equity's participation in MA, using the bid process, similar to what is required for related party due diligence or DIR reporting. This would ensure that all players are participating equally in the MA program's financial sustainability and investing shared risk earnings back into health equity initiatives and services to improve outcomes and access.

### **Drive Innovation to Promote Person-Centered Care**

## ***Health Plan Price Transparency***

Individuals and their families need better information to make the best health care decisions, including information about out-of-pocket prices prior to treatment. Price transparency regulations bring a level of accountability on a system-wide level with the intent that researchers may determine if one hospital has a much higher cost of care compared to other hospitals in the area. Until recently, health care prices have gone unchecked because consumers are shielded from the true price, which is largely absorbed by payers through negotiated rates. ACHP remains concerned that making these rates known without quality information will lead consumers to inappropriately tie cost to quality – equating higher costs to better quality and undermining the intent for transparency to drive down costs. There are missing components to the current price transparency rules that would help establish how this information will make a difference to consumers, who should take precedence.

Health plan machine-readable files required by the *Transparency in Coverage* final rule will do little to help individual consumers or their family members facing important medical decisions. Beyond the files being incomprehensible and so sizable that third-party companies will have to devote significant time and resources to producing usable information, the only information included in the files is prices for certain treatments. These files do not consider that consumers take into account multiple factors when seeking care many of which are of higher importance than price, such as earliest appointment availability and location. Consumers also want to know whether a certain provider comes recommended or has good outcomes. Price transparency without the context of quality transparency will only lead to continued uninformed, and even misleading, choices.

ACHP encourages CMS to implement equal incentives and investments for both payers and providers in any new transparency measures. For payers to effectively update provider directories and produce advanced explanations of benefits, payers will need significant collaboration with providers. These transparency measures should be designed so that providers are held to the same level of accountability as payers in ensuring this communication occurs. Taking these steps would ensure the Administration's transparency initiatives produce meaningful transparency with the intended results for consumers and positively impact the MA program.

## ***Interoperability and Data Exchange***

ACHP member companies have made considerable progress in data exchange and interoperability since the *Interoperability and Patient Access API* final rule. Each next step in the progression toward health care interoperability brings unique hurdles. Typically, the first question a health plan will consider is whether to build the tool/software/infrastructure in-house or to contract with a vendor. Both options are costly and have their own benefits and downsides: there is limited technical expertise in the health care interoperability field making it competitive and challenging to onboard and many health vendors fall outside the authority of CMS regulations.

It is imperative that future evolutions of health data and interoperability policy have consistency across federal programs. This ensures that health plans can maintain consistent and efficient internal systems, reducing regulatory burden. As noted earlier, the industry needs a universal standard for social determinant of health data capture and exchange. The stark reality of current efforts to address health equity is the absence of high-quality data on race and ethnicity available at the individual member/patient level. ACHP member companies utilize a variety of methods to extrapolate information from population-based sources for purposes such as creating algorithms for stratification, targeting resources and interventions for specific segments of their populations and identifying disparities in care.

ACHP member companies' participation in a pilot with Socially Determined, a social risk intelligence platform, clearly indicated that population-based data alone is not sufficient for achieving the kind of whole-person care to which CMS aspires in its vision. To provide a service or referral to meet a specific need, health plans need individual level data. CMS' leadership in aligning the industry around a set of standards and expectations for

collection of race and ethnicity data is sorely needed. With ONC finalizing USCDI v3, which adds new demographic and SDOH-type data classes, and the Gravity Project & HL7's ongoing work, ACHP is optimistic that the industry will identify solutions to SDOH data standardization and exchange, finally enabling health plans to use data to improve consumer and community services.

ACHP recommends CMS implement additional financial incentives and provider requirements to collect and exchange data. Once social determinant of health data standards are finalized, the health care industry will need proper incentives to collect data. We appreciate that CMS is already considering health plan incentives in the form of quality measures and risk-adjustment model modifications. We recommend similar financial incentives for providers as they have more regular interactions with consumers. Having this type of data as up to date as possible ensures health plans are able to identify consumers' eligibility for benefits that are tailored to their needs.

ACHP further recommends issuing more timely updates on current and future interoperability mandates. Health plans are still awaiting updates and expectations on the payer-to-payer API requirement from the *Interoperability and Patient Access API* final rule. In addition, health plans expect rulemaking on Advanced Explanation of Benefits as required in the No Surprises Act and eventually electronic prior authorization programs. ACHP emphasizes an incremental approach to these various improvements to enable sufficient implementation time. In addition, ACHP recommends CMS implement provider requirements in future rulemaking for Advanced Explanation of Benefits and electronic prior authorization programs. These requirements should include a basic requirement that providers must share data with the health plan for the transaction to be completed within a specified timeframe.

### ***Value Based Payments and Contracting***

ACHP member companies embrace the unique MA program's unique ability to design and implement value-based payment arrangements with aligned provider partners. Particularly in the primary care space, ACHP members are leaders in offering unique, high value, high quality programs for seniors. Advancing the adoption of value base care models is a longstanding ACHP priority. We recognize the industry-wide challenges to achieving a full transition to value-based care and, through our members' experience, have identified key factors necessary for successful models. First, an organization needs to make transitioning to value based payment a priority. Second, health plans need engaged and motivated provider partners. Without the initial motivation to participate in a value-based care arrangement, no incentive can modify provider behaviors. Some health plans find that their providers are most willing to participate in arrangements that are familiar, such as the Medicare Shared Savings Program, CMMI models or other arrangements within the market, since they do not require establishing new processes or guidelines. Lastly, health plans and providers need tangible results shown through data. Large enough patient panels are a key competent to telling a compelling story through data. ACHP member companies' ability to rapidly identify what works and what does not for value-based payment models provides an ability to lead. Of the three key factors for success in a value-based payment arrangements, the Administration can play an especially critical role in the last one – showing tangible results through data. Both the data and how the data are communicated are essential to the successful transition to value-based care.

### ***Star Ratings***

Based on the 2022 CMS MA and Part D Star Ratings, 68 percent of MA plans that offer prescription drug coverage will have an overall rating of four stars or higher in 2022, up from 49 percent in 2021. While this is a significant milestone that should be celebrated, the Stars program must be regularly evaluated to focus on meaningful measures that enhance a consumers' understanding of their health plan and make informed choices when selecting a plan. The current star rating program has too many measures, improper emphasis on process measures instead of a singular focus on patient experience and outcomes and rewards improvement over consistency. ACHP was a leading voice in the establishment of the MA star ratings program and continues to lead the industry in quality delivery. We look forward to partnering to advance a modernized star ratings program that fully rewards high

quality health plans and appropriately stratifies performance for consumers to utilize when making coverage selections.

For years, ACHP has called for more emphasis on member experience within the Stars program. Just as with other quality measures, the specific measures used to evaluate experience are critical to the validity of efforts to incentivize high-quality and comprehensive care. A focus on clinical outcome performance metrics, measures of access, satisfaction, complications and sustained or improved function support more meaningful evaluation of care and a shift towards more equitable care. ACHP recommends CMS target resources and leverage external stakeholders to identify methods of evaluating experience of care in real-time, digital formats that are less burdensome for both the surveyor and the survey-taker. Such options could address the decrease in response rates and provide more meaningful information from a more diverse audience.

ACHP member companies dedicate significant resources for improvements to member experience, yet improvements seen in scores frequently do not align with the investments made. Current member self-report surveys (CAHPS and HOS) may not be the best way to measure the goals that are core to CMS' vision, given the small subset of a population these sampled surveys represent and declining response rates year over year. In a joint ACHP and Johns Hopkins Carey Business School research project, we found that almost all MA plans lack significant data for non-white populations, indicating that current methodologies used to evaluate member experience may be ill-suited for more diverse populations.

We encourage CMS to lay a clear path for the advancement of electronic clinical quality data submission, use of new data sources and advanced measures and establishing clear timelines for specific milestones health plans will be expected to meet. One of the most significant barriers to data exchange is the ever-increasing demand for data and analytic services across different state and federal health care programs. The extensive digital infrastructure required for data exchange among the data sources necessary to improve health equity and quality measurement requires budgeting over several years. Planning for these types of improvements and additions (i.e., stratification of results by race and ethnicity; reporting on more meaningful quality metrics like functional status, etc.) is complicated without specific, realistic timeframes from CMS and reduces the likelihood that resources will be prioritized for this purpose.

### **Support Affordability and Sustainability**

#### ***Program Sustainability***

ACHP member companies offer affordable and comprehensive benefit packages that adopt value-based payment models and care management tools to advance the industry away from episodic, volume-driven fee-for-service care. In addition, ACHP member companies' affiliation with established provider systems and groups enables direct partnership to establish alternative and value-based payment arrangements. These arrangements and payer-provider centric approaches largely focus on preventing hospital readmissions, creating incentives for consumers to seek care from efficient, affiliated providers, promoting virtual care, offering integrated Part D drug benefits and giving consumers predictable cost-sharing and capped out-of-pocket expenses. In addition, ACHP members leverage technology products to improve the quality and affordability of care. For example, one ACHP member company uses an internal analytics platform to identify opportunities for providers to make behavioral practices changes that would help to improve the total cost of care, quality measurement and management of consumers' chronic conditions.

With equitable payment policies and targeted program oversight, MA plans can offer more affordable care, consumers, spend less than the traditional fee-for-service program for comparable services and provide extra benefits to consumers. ACHP views risk adjustment accuracy of preeminent importance to ensure an equitable and sustainable program. The risk-adjustment program is ripe for modernization and **ACHP has repeatedly called for**

**the transition to encounter data and elimination of the across-the-board coding intensity adjustment which unfairly creates winners and losers based on coding practices.**

With the growing focus and importance of addressing social determinants of health and health equity, ACHP appreciates the Administrations interest in a risk-adjustment model that accounts for social determinants of health. While we support this long-term goal, we caution that such a progression of the model should be thoroughly evaluated before complicating an already complicated methodology. ACHP recommends CMS evaluate geographic delineations to determine localized social needs. We look forward to partnering with the Administration to modernize the risk-adjustment program and determine how to incorporate social determinants to advance our shared goal – improving care delivery and providing appropriate resources for each individual consumer.

***MA Program Integrity***

ACHP member companies are committed to efficient spending and the integrity of every Medicare dollar. The fully capitated model of MA plans and our member companies’ non-profits margins of less than two percent, are strong incentives to ensure program efficiency and limit fraud, waste and abuse. Current CMS methods (i.e., quality measurement, audits, network adequacy reviews, etc.) for monitoring and oversight activities help ensure that MA plans adequately meet the care needs of consumers and identify improper payments. We encourage the Administration to consider ways to make these oversight tools less burdensome. For example, an industry-wide initiative would streamline efforts to maintain MA program integrity and oversight and thereby administrative costs. ACHP supports an audit process that can fairly establish the accuracy of medical records, leveraging Artificial Intelligence and Machine Learning. This process should allow record review for approval upon submission, identify gaps in a timely manner to allow for corrected information and allow plans to meet requirements up front, potentially eliminating the need for audit at all.

ACHP also recommends CMS leverage the wealth of program integrity data it collects to conduct analyses that provide timely insight into providers that health plans should avoid contracting with. The provision of this information would save health plans the heavy resource investment in analytics to support mitigating fraud, waste and abuse requirements which disproportionately affects nonprofit, regional plans.

***Utilization Management***

Utilization management tools – especially prior authorization – are a necessary safeguard that ensure consumers receive only clinically appropriate care. These tools are valuable components to health plans’ ability to be stewards of the MA program dollar. ACHP member companies recognize their role and value to ensure consumers are receiving care that is medically necessary and evidence based. Health plans typically pursue multiple utilization management strategies, which can include robust internal network design and payment systems, as well as member level engagement and education systems. Prior authorization is just one facet of health plans approach to managing appropriate care delivery and maintaining high quality care. Health plans analyze utilization trends, regularly evaluate clinical best practices and focus on high volume, high cost, quality of care, member satisfaction and more to set prior authorization parameters. ACHP member companies carefully review and select a targeted list of services that will have the most meaningful influence on health outcomes and minimize provider burdens.

Without prior authorization, unnecessary or low-value care can cause harm to patients and increase program costs. ACHP recognizes the need to improve prior authorization processes and steps to do so are underway. When the previous Administration issued a rule on electronic prior authorization, it was limited to all federal programs except MA. Now there are legislative efforts for an electronic prior authorization program in MA-only gaining traction in Congress. Both in response to the earlier rule and current pending legislation, ACHP looks to the

Administration to ensure that this future program spans all federal programs, not just MA, and is implemented consistently across programs to limit operationalization burdens.

ACHP member companies support regulatory incentives to automate the prior authorization process, allowing payers to better communicate with providers about the evidence necessary to approve coverage of requested services. Creating an electronic pathway for this process in providers' electronic health record systems will alleviate today's manual procedures. ACHP member companies are uniquely familiar with this issue because of their integrated and established relationships with their providers.

ACHP supports processes that automate aspects of prior authorization and reduce provider burden, such as document lookup services and document repositories. Over time, these new features will become familiar and easy so that complete documentation supports a diagnosis and necessary treatment, making prior authorization determinations much faster. CMS should adopt policies that automate prior authorization with a phased-in approach, as recommended both by ACHP and the Health Information Technology Advisory Committee (HITAC). This will ensure that all stakeholders will have time to properly implement the infrastructure required and ensure any policies do not interfere with the practice of medicine or add any undue requirements.

ACHP maintains that automating prior authorization will drastically alleviate administrative tasks from an already stretched provider workforce and ensures information given to plans by providers is accurate and complete. This, most importantly, expedites the authorization process for patients, ensuring that the saying of "right care at the right time" is not just a theoretical principle but an actual truth—and care is not delayed by any unnecessary amount. ACHP strongly encourages CMS to implement these future policies as applicable across all plans' lines of business. ACHP member companies report that this consistency across lines of business will prevent implementation that increases confusion and overall burden.

### **Stakeholder Engagement and Conclusion**

We are excited to continue collaborating with the Administration to ensure seniors continue to have access to a MA program that is efficient, affordable, high quality and addresses social needs that negatively affect health. Thank you for the Administration's initiative to bolster the Medicare Advantage program. Please contact Michael Bagel, Director of Public Policy at [mbagel@achp.org](mailto:mbagel@achp.org) or 202-897-6121 to discuss our recommendations further.

Regards,



Ceci Connolly  
President and CEO, ACHP