January 31, 2022

The Honorable Richard Hudson
Member, U.S. House of Representatives
2112 Rayburn House Office Building
Washington, DC, 20515

The Honorable Jim Banks
Member, U.S. House of Representatives
1713 Longworth House Office Building
Washington, DC, 20515

The Honorable Tom Cole
Member, U.S. House of Representatives
2207 Rayburn House Office Building
Washington, DC, 20515

Dear Reps. Hudson, Cole and Banks:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to partner with the ***Healthy Future Task Force*** to help inform the important work of the ***Security Subcommittee.***

ACHP represents the nation's top-performing, provider-aligned and community-based health plans. Collectively, our members improve affordability and outcomes in the health care system for more than 24 million Americans across 36 states and D.C. Our members include *FirstCarolinaCare* in North Carolina, *Health Alliance* in Indiana and *CommunityCare* in Oklahoma.

To provide you informed and targeted feedback, ACHP will focus our response to the *pandemic preparedness* and *public health* sections of your Request for Information.

Q. *Operation Warp Speed was an unquestionable success, delivering the fastest vaccines developed and approved on record. Much of its success is due to accelerated pathways for development, testing, and approval of vaccine candidates. As Congress looks toward the reauthorization of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act, how might Congress codify what worked during the COVID-19 pandemic for future pandemics?*

ACHP Response: Since the start of the pandemic, ACHP members and their provider partners worked to improve access to medically-necessary COVID-19 testing and vaccines. But in the nearly two years since the start of the Public Health Emergency, federal health agencies have rushed guidance and rulings that miss the mark, failing to address the health crisis while burdening the private sector.

The pandemic is a public health emergency, and as such the core responsibilities of ensuring adequate supplies, procurement and distribution of personal protective equipment, diagnostic tests and vaccines lays with government. To be sure, ACHP members are supportive of the Tri-Agency guidance of shared responsibility, and health plans have been on the front lines of providing tests and vaccinations as they became available. But recent guidance from the Biden Administration on

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over-the-counter COVID tests strays from the federal government's core mission, putting the onus of procuring, distributing and reimbursing on the private sector, most noticeably health plans and insurers. The burden on health plans to comply with the guidance is tremendous. The operational challenges behind procuring and distributing tests at a time when there is a national shortage is just one of many hurdles the private sector faces.

Thinking ahead to the next public health crises, it is important to learn from the current public health emergency. Specifically, ACHP members saw sharp increases in pricing for routine COVID tests, protective masks and other types of medical equipment. ACHP supports efforts to ensure that suppliers do not engage in "price gouging" in response to government requirements or a lack of supplies. Moreover, we would encourage members of the subcommittee to develop a national, federally-coordinated strategy that anticipates the need for emergency supplies, surge-capacity, back-up medical personnel and real time data and communications.

As the subcommittee considers ways to build on the success of OWS, ACHP suggests that lawmakers better delineate the roles and responsibilities of federal health agencies, including the Department of Health and Human Services, the Centers for Medicare and Medicaid Services and more, when it comes to testing and treatment. In this way, the private sector will be best positioned to partner with appropriate government agencies…

Q. *The COVID-19 pandemic highlighted the efficacy of removing inefficient regulatory barriers that may stall public health and recovery responses. While many federal barriers to the immediate risk were addressed, long-term impediments remain that could discourage state, local and private sector investment in pandemic preparedness. What regulatory barriers could be modified, consolidated, harmonized or repealed to better ensure federal and state public health agencies are better situated to quickly adapt and efficaciously respond to protect public health in a future PHE?*

ACHP Response: As many have observed, the silver lining of the COVID-19 pandemic has been the remarkable success of telehealth, thanks largely to waivers and regulatory flexibility that enabled innovation to flourish rapidly. It would be a true failure if policy went backward after two years of real-world success. HHS's own research arm last year found the use of telehealth increased 63-fold in 2020 among Medicare beneficiaries, going from approximately 840,000 encounters in 2019 to 52.7 million in 2020.

ACHP continues to support legislative efforts to extend telehealth flexibilities. Specially, we align with the Medicare Payment Advisory Commission's (MedPAC) recommendation to extend the current flexibilities for two-years beyond the end of the public health emergency. This would allow the health care industry, academics and government sufficient time to collect the needed data to demonstrate what works best—and what doesn't—when it comes to telehealth.

The Security Subcommittee should also consider ways to ensure that federal data concerning the dissemination and administration of vaccines is readily available *in real time* to health plans. Specifically, health plans must have access to the Centers for Disease Control and Prevention's Vaccine Administration Management System to fully understand who has and hasn't received a vaccine.

Telehealth has saved lives throughout the pandemic, and we strongly support keeping those flexibilities in place for both the future of medical care delivery and in the event of future pandemics. This includes eliminating originating site and geographic restrictions, allowing more

telehealth providers and services, reforming outdated licensure requirements and implementing a value-based payment for telehealth encounters.

While video telehealth visits are becoming more common, subcommittee members should be aware that many individuals, especially older Americans and those living in rural or medically underserved communities, may need to connect with their providers over the telephone. The reasons vary—some individuals are uncomfortable or have a disability that prevents them from using video-enabled equipment; and others may live in rural communities with unreliable or limited access to broadband technology.

Audio-only encounters were every bit the lifeline that video-enabled encounters were, yet CMS does not fully recognize them in Medicare Advantage. In 2021 and 2022, CMS allowed Medicare Advantage plans to use video-enabled telehealth visits to document a patient's health, but the agency has not extended this flexibility to audio-only telehealth encounters. As a result, this has created inequities in communities across the country.

The subcommittee should call on CMS to allow diagnoses from Medicare Advantage audio-only telehealth encounters to be included in risk adjustment calculations, consistent with the agency's treatment in the ACA marketplaces.

Q. *Social determinants of health are another key driver of healthcare spending. Individual behavior and social and environmental factors are estimated to account for 60% of health care costs.*

a. To what extent do federal health programs already account for and address social determinants of health?
b. How can Congress best address the factors that influence overall health outcomes in rural, Tribal, and other underserved areas to improve health outcomes in these communities?
c. What flexibilities or authorities are needed to promote the adoption of policies and strategies in federal health programs to address these social determinants?
d. What innovative programs or practices, whether operated by non-governmental entities or local, State, or Tribal governments, might Congress examine for implementation nationally?

ACHP Response: ACHP members are in the vanguard of addressing unmet social needs. As the subcommittee considers legislative policies to address SDoH, members should consider the following drivers of social disparities—

- **Affordability**—Cost concerns have a significant impact on a person's health, including their ability to afford routine prescription drugs or buy small-dollar nonmedical items and services that could lead to better health, such as fees that are required for housing applications or car repairs.
- **Low health care literacy—**A person's health literacy may be influenced by their education, income levels, ethnicity, age and more. The impact of low-health literacy is far reaching and can adversely impact a person's care and treatment.
- **Access to care—**While overall access to care is a challenge for individuals who are already impacted by adverse external factors, it is particularly acute for specialty care, dental care, long-term care and behavioral health.
- **Transportation—**Getting to and from doctors' appointments and pharmacies is an issue in lower-income and rural communities, especially for older Americans. A lack of reliable transportation also impacts a person's ability to access community resources that may be available to them.

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- **Affordable housing—**Across all communities, this is the most frequently-cited challenge individuals face.
- **Food insecurity—**Tens of millions of Americans struggled to have access to nutritionally-sound food before the pandemic. But the public health emergency around COVID-19 only exacerbated the problem, especially as unemployment grew and wages disappeared. As highlighted by the advocacy organization Feeding America, food insecurity disproportionately impacts persons of color across the U.S.

The subcommittee should consider authorizing demonstration projects and funding for implementation research, and consider ways to improve data standardization and exchange. This is especially important with regards to race, ethnicity, provenance of information and the ability for individual consumers, patients and members to submit and update their information.

More broadly, policymakers must help accelerate the shift to a value-based health system, rein in exorbitant drug prices and tamp out consolidation that drives up pricing.

Q. *Vaccines are perhaps the greatest public health tool, yet the COVID-19 pandemic demonstrated how widespread vaccine hesitancy is nationwide, fueled by misinformation campaigns or Americans' lack of knowledge about the importance and efficacy of vaccines. Prior to the pandemic, vaccination rates for numerous vaccine preventable diseases were in decline, resulting in what were previously rare epidemics of measles in some U.S. cities. During the pandemic, lockdowns and hesitancy to visit health care sittings has resulted in millions of children, and even adults, missing important routine vaccinations. How can the federal government work to reverse both short- and long-term declines in vaccination against vaccine preventable diseases?*

ACHP Response*:* The subcommittee should consider a variety of ways to combat sources of misinformation and clearly articulate public health information. Federal dollars should be directed to trusted community partners, including not-for-profit health companies, to educate and inform consumers. On social media, for instance, lawmakers may consider policies that require the removal of advertisements making false claims.

Q. *How can Congress better utilize existing programs to address the maternal health crisis?*
ACHP has done extensive research on maternal health issues and their root cause, which can be found here.

As always, ACHP welcomes the opportunity to work with the Healthy Future Task Force as it develops policies to improve the health of our nation.

Thank you,

Dan Jones

Dan Jones, Vice President, Federal Affairs
Alliance of Community Health Plans

cc: Molly Brimmer, Rep. Hudson
Andrew Keyes, Rep. Banks
Shane Hand, Rep. Cole