

STRENGTHENING MEDICARE ADVANTAGE

The Alliance of Community Health Plans (ACHP) is dedicated to ensuring access to affordable, high-quality coverage and care through Medicare Advantage (MA), supporting policies that prioritize the health of seniors and strengthen the program.

Medicare Advantage provides exceptional coverage and care for more than 27 million Americans – and growing. The program provides convenient, coordinated health coverage and drives greater value and accountability in Medicare. MA provides all the benefits of fee-for-service Medicare plus enhanced benefits, high value coverage, better health outcomes, greater transparency and superior customer experience — all at a lower cost. High-need, high-cost populations have up to 18 percent lower costs for medical and pharmacy care!

Pass the Medicare Advantage Quality Payment Relief Act

Current law prevents many seniors in high-quality MA plans from receiving expanded benefits, reduced premiums and/or lower co-pays. Seniors in counties across the country are hurt by the MA benchmark cap.

- Enact the Medicare Advantage Quality Payment Relief Act (QPRA) to ensure seniors enrolled in high quality MA plans receive the full benefits that Congress intended.
- In 2021, more than 5.7 million seniors missed out on approximately \$230 million in additional services and/or reduced premiums due to the payment glitch.

Modernize the MA Quality Measurement Program

In 2020, more than 80% of MA seniors were enrolled in a four-star or higher MA plan. It's time to raise the bar. Quality measurement should focus less on process-measures and more on outcome-based measures.

- Support a Quality and Star Ratings program that is centered on streamlined and meaningful patient experience and measures tied to health outcomes.
- Reduce or eliminate the weight of improvement measures that reward low performers.
- Add a consistency measure to promote and reward health plans for maintaining the highest levels of quality coverage and care.
- Eliminate topped-out process measures and reduce the total number measures.
- Streamline and synchronize quality measures across health care programs to reduce reporting burden on consumers, providers and health plans.

Adjust Benchmark Calculations

MA county benchmarks include the costs associated with fee-for-service seniors enrolled in Part A-only as well as those enrolled in both Parts A and B. This approach mixes apples and oranges, including costs of costs of seniors still working and not eligible for MA. The impact of including Part-A-only spending drives benchmarks lower than they would be if they were calculated using a comparable population.

- Calculate the MA benchmark with only seniors enrolled in both Medicare Part A and Part B.



STRENGTHENING MEDICARE ADVANTAGE

Move to Updated Risk-Adjustment Model

The Affordable Care Act established a coding intensity adjustment to mitigate coding comprehensiveness between fee-for-service and MA. Since 2019, the coding intensity adjustment has been -5.90 percent. CMS is required to establish and transition to a risk adjustment system based on encounter data, at which point the coding intensity adjustment would go away. In 2021, CMS fully transitioned to the CMS-HCC 2020 risk-adjustment model which relies solely on encounter data and is in a position to create a new risk-adjustment model based on encounter data. Unlike fee-for-service, MA beneficiaries were twice as likely to belong to a racial or ethnic minority group and be dually eligible for Medicaid. As a result, MA continues to have more beneficiaries with social risk factors or struggling with health equity as compared to fee-for-service.

- Direct CMS to move to a risk-adjustment model based solely on MA encounter data.

Expand Virtual Care in Network Adequacy

Virtual access to clinicians throughout the COVID-19 pandemic provided a valuable use case for provider network adequacy. Expanding virtual care in network adequacy would increase access for many rural, frontier and underserved communities.

- Permit alternative methods to demonstrate network adequacy. Time and distance standards alone are inadequate and obsolete.
- Allow more telehealth providers to count towards meeting network requirements.

Increase Broker Contract Transparency

Health insurance brokers are not required to disclose details of their commissions or if they are contracted by certain organizations, allowing brokers to push consumers towards specific health plans based on a contract with the plan. As a result, some plan options that may better suit a consumer are frequently overlooked. Disclosing contract information can help even the playing field. Brokers also receive a stay-in fee for seniors that remain enrolled in the plan and contract the broker previously facilitated.

- Require brokers to divulge to consumers their contract source and commission incentives.
- Eliminate the broker stay-in fee. With approximately 98 percent of MA enrollees continuing to enroll in the program, this policy is outdated and an unnecessary cost to MA.

