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**Matthew Eyles**  
President & Chief Executive Officer

August 31, 2022

Dr. Meena Seshamani, Director, Center for Medicare  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**RE: Request for Information on Medicare (CMS-4203-NC)**

Dear Dr. Seshamani:

Every American deserves access to comprehensive, affordable coverage and high-quality care, particularly our seniors and people with disabilities. For years, health insurance providers have been committed to delivering that access, including through the Medicare Advantage (MA) program. As the leading association representing health insurance providers that offer MA coverage, AHIP<sup>1</sup> welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information on Medicare (RFI).

The MA program is an enormously successful example of a public-private partnership that delivers tremendous value for America's seniors and people with disabilities. Almost 30 million people choose MA—45% of those eligible for Medicare and more than double the number in MA a decade ago—because MA delivers better services, better access to care, and better value. Enrollees in MA are more racially and ethnically diverse and are more satisfied with their coverage than those in the original Medicare program. The continued growth of the program is a testament to the tremendous value MA offers to all enrollees, but especially those with chronic illnesses who require care management and those with low incomes who rely on MA's access to additional benefits at little or no cost.

The questions in the RFI, primarily focused on the MA program, are organized around the five key goals for Medicare described in a Health Affairs article<sup>2</sup> that you co-authored with Administrator Brooks-LaSure and Dr. Fowler at the Centers for Medicare and Medicaid Innovation (CMMI). The goals build on the agency's overall 2022 CMS Strategic Pillars<sup>3</sup> and address advancing health equity, expanding access to coverage and care, driving innovation to promote person-centered care, supporting affordability and sustainability, and engaging partners.

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<sup>1</sup> AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit [www.ahip.org](http://www.ahip.org) to learn how working together, we are Guiding Greater Health.

<sup>2</sup> See: <https://www.healthaffairs.org/doi/10.1377/forefront.20220110.198444/full/>

<sup>3</sup> See: <https://www.cms.gov/files/document/2022-cms-strategic-framework.pdf>

MA plans strongly support and are uniquely positioned to work with the agency in achieving these critical goals.

### **Solutions to Improve Equity, Access, Innovation, and Value**

Attached to this letter are our detailed responses to the wide range of questions CMS raised under each of the five strategic goals.<sup>4</sup> Our responses include key data, research, and plan practices that demonstrate the long and successful history of MA plans advancing innovative, patient-centered programs that improve care, reduce consumer costs, and address the needs of seniors and people with disabilities. We also offer numerous recommendations on steps CMS can take to improve the MA program for its enrollees while advancing the strategic goals.

Key observations and recommendations include:

- **MA plans go well beyond the original Medicare program in taking action to improve health equity and address social risk factors. CMS should support these efforts through additional benefit flexibility and improved data collection.** Everyone deserves affordable, high-quality health coverage and care regardless of the individual qualities that make us who we are. In our detailed response, we discuss the steps that MA plans are taking to reduce disparities by addressing social determinants of health (SDOH). Evidence shows that these solutions are working. For example, studies have found reduced health disparities for racial and ethnic minorities and rural populations across several key health measures, such as annual flu vaccines, diabetic eye and kidney exams, and access to preventive services.<sup>5</sup> At the same time, many of the supplemental benefits have only recently become available based on legislative and regulatory changes and MA plans need additional time to gain a better understanding of when and how enrollees use these benefits. CMS can promote further successes by expanding benefit flexibility through regulation and demonstrations and promoting better data collection (as discussed below).
- **CMS should expand access to MA coverage (including in rural and medically-underserved areas) to ensure everyone has access to comprehensive benefits that far exceed what is available in original Medicare. The agency should also implement policies that limit low-value care and consider our detailed recommendations to improve care quality for enrollees with kidney disease and those who need mental and behavioral health care.** Our detailed response highlights core elements of the MA program that differentiate it from original Medicare and have contributed to its growth

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<sup>4</sup> We did not respond to questions in the RFI where CMS requests specific data or other information that AHIP does not collect.

<sup>5</sup> RAND Health Care. "Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018." December 2021.

and increased popularity, the ways MA plans are working to advance greater innovation and individualization, and data on the importance of promoting high-value care while reducing the low-value care that contributes to potential patient harm and unnecessary costs. CMS can build on this successful framework by improving how Medicare enrollees review their coverage options. It can update network requirements to leverage new and innovative delivery and payment models. It can build on steps MA plans are already taking to improve the efficiency and reduce the burdens of medical management tools, e.g., through greater adoption of electronic prior authorization. CMS should also promote innovation and lower costs for people with end-stage renal disease (ESRD) and consider a comprehensive set of suggestions for improving access to mental health care and substance use disorder (SUD) treatment.<sup>6</sup>

- **MA is much more cost-effective and provides higher quality care than original Medicare. CMS should consider targeted improvements to the payment and quality components of the MA program to build on these successes.** MA's overall payment, risk adjustment, and quality framework has incentivized plans and their contracted providers to deliver high-quality, cost-effective care. The structure has resulted in access to the same benefits as original Medicare at a far lower cost. Further, an apples-to-apples comparison confirms that total average costs in MA for delivering care to the same population are lower than original Medicare, even including all the extra benefits MA plan enrollees receive. A forthcoming study by Wakely Consulting Group finds that average FFS costs would be more than 9% higher if the costs of 1) providing maximum out-of-pocket protection, as required in MA, and 2) only beneficiaries enrolled in both Parts A and B of Medicare—those eligible to enroll in MA—were included in the calculation of FFS costs. MA plans also outpace original Medicare in using value-based payment contracts with providers that reward value rather than volume.

Given these successes, CMS should focus on ways to support this system and promote further improvements in cost and quality to ensure the longer-term sustainability and affordability of the Medicare program. Our recommendations include Star Ratings improvements that further enhance quality and avoid negative impacts on enrollees; more actuarially appropriate MA benchmarks that reflect the population actually eligible to enroll in MA; and an improved risk adjustment system that includes withdrawal of the unfair and improper risk adjustment data validation (RADV) proposed rule and could include appropriate adjustments for social risk factors. We also make suggestions to improve payments for specific populations such as enrollees with ESRD, enrollees in Puerto Rico, and enrollees in retiree plans.

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<sup>6</sup> See: <https://www.ahip.org/resources/ahip-board-of-directors-statement-of-commitment-improving-access-to-and-quality-of-mental-health-and-addiction-support>.

- **Improvements to the collection and exchange of data is critically important for numerous health policy goals.** Many of the issues CMS has highlighted and the steps that CMS and MA plans can take to achieve the agency’s strategic goals are dependent on better data collection and exchange. For example, improved socioeconomic data and data standards would allow health insurance providers, clinicians, and others to better respond to the diversity and needs of their populations. Broader alignment of demographic data standards at an ecosystem level through federal policy changes is also crucial. With standardized and interoperable data across federal programs, great strides can be made in reducing inequities and the impact of social factors on health while improving outcomes and minimizing data burdens. In various sections of our detailed response, we make concrete recommendations for how CMS can promote policies that standardize data, reduce burdens for providers, and preserve plan flexibilities to respond to different enrollee needs.
- **Because of the tremendous growth of the program, improvements in CMS’ regulatory process are urgently needed.** It is critically important that CMS take steps to enhance engagement, increase predictability, and ensure adequate time for implementation. For example, CMS should ensure there is more timely engagement on major proposals so that MA plans and other stakeholders can provide meaningful feedback. This includes the large-scale changes to Part D in the Inflation Reduction Act of 2022. Those changes, combined with a series of regulatory changes in recent years including the mandate for including pharmacy discounts in point-of-sale prices, will place significant pressure on Part D premiums and could pose difficult and costly implementation challenges. Since more than 90% of MA enrollees are in MA-Prescription Drug (MA-PD) plans,<sup>7</sup> the higher costs for offering the Part D benefit could lead to reduced MA benefits or higher premiums.

In addition, it is critical that program change timelines better align with MA and Part D bid cycles and operational needs. MA plans must be able to appropriately estimate impacts, understand operational implications and dependencies, and implement changes in ways that minimize costs to the program and potential disruptions to enrollees.

We also support CMS efforts to enhance engagement with Medicare-eligible Americans. This includes protecting them from misleading advertising, ensuring they can use well-trained professional agents and brokers to help them navigate their decision-making processes, and improving the process for obtaining information about their experiences.

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<sup>7</sup> CMS. Monthly Contract and Enrollment Summary Report. August 2022. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolldata/monthly/contract-summary-2022-08>.

## The Value of Medicare Advantage

Medicare Advantage delivers better services, better access to care, and better value through innovative, patient-centered programs that improve quality and reduce costs for seniors and the most vulnerable Americans with disabilities.

- **Care for diverse and vulnerable populations.** MA plans care for a growing share of Americans who are dually eligible for Medicare and Medicaid benefits. In 2019, 44% of dual-eligible enrollees were enrolled in MA, up from 25% in 2013,<sup>8</sup> and research shows that dual-eligibles enrolled in MA have greater health needs than those in original Medicare.<sup>9</sup> MA also serves a more racially and ethnically-diverse population. In fact, 32% of MA enrollees are minorities, compared with 21% of those in original Medicare, and that share has grown in recent years.<sup>10</sup> In 2019, almost half of all racial and ethnic minorities eligible for Medicare were enrolled in MA, up from 31% in 2013.<sup>11</sup> Underserved populations especially rely upon MA plans that combine both medical and prescription drug coverage with no monthly premium beyond the standard Part B premium.<sup>12</sup>
- **Greater care coordination and more comprehensive benefits.** MA plans work with their members to prevent, detect, and manage chronic conditions through programs that better integrate and coordinate care compared to original Medicare. MA plans also provide more comprehensive benefits than original Medicare. Some of these essential benefits include integrated dental, hearing, and vision coverage along with innovative telehealth options. In recent years, MA plans began offering new types of benefits that address various social barriers to better health, such as wellness programs and nutrition, transportation, and in-home caregiver services, and the availability of these benefits has grown tremendously. In 2022, 1,851 plans offer non-medical benefits designed to help support MA enrollees, up from 626 in 2020.<sup>13</sup> The availability of special supplemental benefits for chronically ill patients—like nutrition support, transportation for non-medical

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<sup>8</sup> Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. “Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare.” Milliman. October 2020.

<sup>9</sup> NORC at the University of Chicago. “Analysis of COVID-19 Impact on Medicare Advantage and Fee-for-Service Beneficiaries.” May 2021.

<sup>10</sup> Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. “Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare.” Milliman. October 2020.

<sup>11</sup> Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. “Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare.” Milliman. October 2020.

<sup>12</sup> NORC analysis of June 2021 CMS Medicare enrollment and demographic data, conducted for AHIP. December 2021.

<sup>13</sup> Rizer, A, and Benzing, L. “Filling The Gaps: The Role And Value Of Supplemental Benefits In Medicare Advantage”. Health Affairs Forefront. August 5, 2022: <https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage>

needs, or structural home modifications to support independent living—have grown even faster, increasing by almost 400% to more than 1,200 plans in 2022.<sup>14</sup>

- **More financial security.** All MA plans deliver more affordable coverage with greater financial security to members by capping annual out-of-pocket costs; individuals with original Medicare coverage alone (i.e., without supplemental coverage) are exposed to extraordinarily high cost-sharing. MA premiums continue to decline, falling 10% from 2021 to an average of \$19 a month in 2022.<sup>15</sup> Further, the Medicare Payment Advisory Commission (MedPAC) reports that in 2022, 98% of those eligible for Medicare have an option to enroll in an MA plan that offers drug coverage for no additional cost.<sup>16</sup>
- **Better health outcomes.** MA has been shown to provide better quality of care on various clinical quality measures,<sup>17,18</sup> employ value-based payment arrangements to improve survival rates while lowering costs,<sup>19</sup> reduce hospital admissions and readmissions as well as patient days spent in rehabilitation facilities and nursing homes,<sup>20,21,22,23</sup> and lower hospital use in the last days of life.<sup>24</sup> Peer-reviewed research has found that MA plans outperform original Medicare across a range of metrics, including better access to

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<sup>14</sup> ATI Advisory. “New, Non-Medical Supplemental Benefits in Medicare Advantage in 2022.” January 2022. Accessed at <https://atiadvisory.com/wp-content/uploads/2022/01/Plan-Year-2022-Medicare-Advantage-New-Non-Medical-Supplemental-Benefits.pdf>.

<sup>15</sup> CMS. CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans. September 2021. <https://www.cms.gov/newsroom/press-releases/cms-releases-2022-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug>.

<sup>16</sup> Medicare Payment Advisory Commission. “The Medicare Advantage Program: Status report and mandated report on dual-eligible special needs plans.” January 2022 Public Meeting.

<sup>17</sup> Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.

<sup>18</sup> Agarwal, Rajender, Connolly, John, Gupta, Shweta, et al. Comparing Medicare Advantage And Traditional Medicare: A Systematic Review. *Health Affairs* 40(6): 937-944. June 2021.

<sup>19</sup> Mandal, Alope K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

<sup>20</sup> Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoS Med* 15(6): e1002592.

<sup>21</sup> Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

<sup>22</sup> Jung DH, DuGoff E, Smith M, Palta M, Gilmore-Bykovskyi A, Mullahy J. Likelihood of hospital readmission in Medicare Advantage and Fee-For-Service within same hospital. *Health Serv Res.* 2020;55:587–595. <https://doi.org/10.1111/1475-6773.13315>

<sup>23</sup> Schwartz, Aaron L., Slaoui, K., Foreman, R., et al. Health Care Utilization and Spending in Medicare Advantage vs. Traditional Medicare: A difference-in-difference analysis. *Jama Health Forum.* 2021: 2(12): e214001.

<sup>24</sup> Teno, Joan M., Gozalo, Pedro, Trivedi, Amal N. et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. *JAMA* Published online June 25, 2018.

preventive care and better clinical outcomes.<sup>25</sup> For example, MA enrollees are more likely to receive important preventive services like annual wellness exams and cognitive screenings than their counterparts in original Medicare.<sup>26</sup>

Studies have also found better outcomes for patients with specific chronic diseases when they are covered by MA plans. When compared to patients with original Medicare, MA members with ESRD have lower mortality rates and reduced utilization rates.<sup>27</sup> Further, MA members with diabetes and cardiac disease experienced fewer emergency room visits and hospitalizations and better quality scores compared with those covered under original Medicare.<sup>28</sup> Lastly, MA members who experience a hip fracture have shorter lengths of stay and fewer hospital readmits.<sup>29</sup>

- **Cost efficiency for Medicare enrollees and taxpayers.** For many years, average MA plan bids for delivering the basic Medicare benefit have been well below original Medicare costs—85% of original Medicare based on the latest MedPAC estimates. Research provides examples of how MA plans achieve these savings: for example, through more efficient prescribing of Part B drugs and MA enrollees receiving care from more efficient providers.<sup>30</sup> Further, according to MedPAC, average payments to MA plans in 2022 are projected to be on par with original Medicare costs while MA offers additional benefits and enhanced financial security for seniors and people with disabilities.<sup>31</sup> In fact, in areas where MA enrollment is higher relative to original Medicare, additional MA enrollment leads to slower growth in original Medicare costs as

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<sup>25</sup> DuGoff, Eva, Rabak, Ruth, Diduch, Tyler, et al. Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. *The American Journal of Managed Care* 27(9). September 2021.

<sup>26</sup> Jacobson, Mireille, Thunell, Johanna, and Zissimopoulos, J. Cognitive Assessment at Medicare's Annual Wellness Visit in Fee-For-Service and Medicare Advantage Plans. *Health Affairs* 39 (11): 1935–1942. November 2020.

<sup>27</sup> Powers, Brian W., Yan, Jiali, Zhu, Jingsan, et al. The Beneficial Effects of Medicare Advantage Special Needs Plans for Patients with End-Stage Renal Disease. *Health Affairs* 39(9): 1486–1494. September 2020.

<sup>28</sup> Landon, Bruce E., Zaslavsky, Alan M., Saunders, Robert, et al. A comparison of relative resource use and quality in Medicare Advantage health plans versus traditional Medicare. *American Journal of Managed Care* 21(8): 559-566. August 2015.

<sup>29</sup> Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoS Med* 15(6): e1002592.

<sup>30</sup> Anderson, Kelly, Polsky, Daniel, Dy, Sydney, et. al. Prescribing of low-versus high-cost Part B drugs in Medicare Advantage and traditional Medicare. *Health Serv Res.* 2021; 1-11. doi:10.1111.1475-6773.13912.

<sup>31</sup> Medicare Payment Advisory Commission. January 2022 Public Meeting Presentation. January 2022.

providers employ MA practice patterns and care guidelines for their remaining original Medicare patients.<sup>32,33,34,35</sup>

- **High satisfaction.** A recent survey finds that seniors continue to be highly satisfied with the MA program, with 93% of senior voters with MA reporting satisfaction with their health care coverage, compared to 83% satisfaction among those with original Medicare. Nearly 60% of senior voters with MA are “very satisfied” with their coverage. Moreover, 9 in 10 senior voters on MA are satisfied with their preventive services and nearly 90% are satisfied with their prescription drug coverage. Nearly all (96%) of senior voters in MA would recommend it to their friends and family.<sup>36</sup>

### **Working Together in a Public-Private Partnership That Works**

Americans deserve a strong and stable MA program based on person-centered, high-quality coverage and care. Our recommendations and attached detailed comments are designed to deliver just that.

By working together, we can ensure MA continues to be a leader in delivering affordability, access, choice, and innovation. We look forward to providing any additional information you may need, and to continuing our work together to improve the health, well-being, equity, and financial stability of Americans.

Sincerely,



Matthew Eyles  
President and Chief Executive Officer  
AHIP

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<sup>32</sup> Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.

<sup>33</sup> Callison, Kevin. Medicare managed care spillovers and treatment intensity. *Health Economics* 25(7):873-887. July 2016.

<sup>34</sup> Baicker, Katherine, Robbins, Jacob A. Medicare payments and system-level health-care use: The spillover effects of Medicare managed care. *American Journal of Health Economics* 1(4):399-431. October 2015.

<sup>35</sup> Baicker, Katherine, Chernew, Michael E., Robbins, Jacob A. The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization. *Journal of Health Economics* 32(6):1289-1300. December 2013.

<sup>36</sup> Morning Consult National Poll. December 3-6, 2021. Available online at: <https://medicarechoices.org/americans-like-ma-2022/>

## **AHIP Detailed Comments**<sup>37</sup>

### **A. ADVANCE HEALTH EQUITY**

Overview of AHIP response: In this section, we highlight Medicare Advantage (MA) plans' strong support for efforts promoting health equity and addressing social determinants of health (SDOH). We also explain how MA plans go far beyond original Medicare in addressing these concerns. They increasingly use their financial efficiency and regulatory flexibility to reduce enrollee costs for Medicare-covered benefits, making health care more accessible and affordable. MA plans also offer benefits unavailable in original Medicare which can improve quality of life, improve health outcomes, and reduce unnecessary health care utilization. We also discuss how MA special needs plans are becoming an option in many states for providing person-centered care plans and services to complex populations. AHIP puts forward numerous recommendations on ways to support these efforts, including expanded benefit flexibility and improved socioeconomic data that would allow health insurance providers, clinicians, and others to better understand and respond to the diversity and needs of the populations they serve.

*1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:*

- *Enrollees from racial and ethnic minority groups.*
- *Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.*
- *Enrollees who identify as transgender, nonbinary, or another gender identity.*
- *Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.*
- *Enrollees with diverse cultural or religious beliefs and practices.*
- *Enrollees of disadvantaged socioeconomic status.*
- *Enrollees with limited English proficiency or other communication needs.*
- *Enrollees who live in rural or other underserved communities.*

Importance of advancing health equity. For far too long, discrimination and systemic racism have served as barriers to health equity for minority and underserved communities. Health insurance providers know that ending these barriers to care is key to an equitable health care system. They are proud to serve Americans of every age, sex, gender identity, race, creed, color, sexual orientation, and health status, working with partners and community leaders across the entire health care system to ensure the needs of all consumers are addressed. Everyone deserves affordable high-quality health coverage and care regardless of the individual qualities that make

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<sup>37</sup> We did not respond to questions in the RFI where CMS requests specific data or other information that AHIP does not collect.

us who we are. AHIP and our members agree with the importance of promoting health equity and are actively taking concrete steps to reduce disparities.

Addressing SDOH is also a top priority for health insurance providers. There is a growing body of evidence that indicates socioeconomic challenges lead to poorer health outcomes and higher healthcare costs and can exacerbate health disparities for a broad range of populations, particularly for seniors, racial and ethnic minorities, and individuals with disabilities.<sup>38</sup>

MA serves nearly 30 million seniors and individuals with disabilities, many of whom face socioeconomic risk factors. SDOH reflect the socioeconomic conditions in which we live, learn, work, play, and age and can include inadequate access to nutritious food, lack of affordable housing, lack of convenient and efficient transportation options, limited broadband access, and more. Socioeconomic barriers can impact a person's ability to live a healthy life and access quality health care, putting the person at greater risk of developing chronic conditions leading to poorer health outcomes, more hospital admissions, higher costs, and greater health disparities. For example, an individual may have diabetes-related hospital admissions due to food insecurity, develop asthma due to poor housing conditions, frequently visit an emergency department because of homelessness, or develop mental health conditions due to social isolation and loneliness. A recent Journal of the American Medical Association (JAMA) article highlighted a study focused on MA enrollees that found health-related social needs were associated with significantly higher rates of acute care use, including avoidable hospital stays.<sup>39</sup>

Data collection. Data collection is a critical part of efforts to address health equity and SDOH. Accurate and complete data can allow health insurance providers, clinicians, and others to better understand the diversity and needs of their populations. AHIP and our members are committed to working with CMS and other stakeholders on Medicare policies that support data collection and other efforts to ensure that all MA enrollees receive the care they need.

We support recent CMS steps to improve data collection from Medicare enrollees by adding questions and voluntary response options on race and ethnicity for use on MA and Prescription Drug Plan (PDP) model enrollment forms.<sup>40</sup> However, CMS can take additional steps to improve data collection in the Medicare program:

- Enrollment forms. CMS should consider including additional response options for race on enrollment forms to better reflect the diversity of Medicare enrollees, such as for people who identify as Arab, Middle Eastern, and North African or who only identify as Hispanic/Latino/a/X. Additionally, CMS should add questions on beneficiary

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<sup>38</sup> <https://www.ahip.org/documents/SDOH-MA-IssueBrief-2021.pdf>

<sup>39</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9270697/>

<sup>40</sup> <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol>

sociodemographic information, including race and ethnicity, to the enrollment form for original Medicare. This approach would provide information on the more than half of enrollees still enrolled in original Medicare and allow CMS and others to better analyze how the two programs are serving beneficiaries with similar characteristics. CMS also should educate Medicare enrollees on the value of self-reported sociodemographic data and the guardrails for protecting data privacy and security.<sup>41</sup>

- Other data collection. CMS should take incremental steps to facilitate broader data collection and reporting by stakeholders on a wider set of sociodemographic data. Sociodemographic data collected and reported by health plans, hospitals, and other providers are all critical in informing care and in identifying and reducing health disparities. However, we have concerns about the burdens on key stakeholders (including data-collecting entities and enrollees) if too much data were attempted to be collected at one time. Accordingly, we recommend that CMS focus on a small number of social needs and/or demographic data elements with interoperable codes at the start and then add additional data elements in subsequent years in a phased approach. Plans, hospitals, clinicians, and other organizations will need to design, align, implement, test, evaluate, and revise data collection and application workflows. Focusing on just a few data elements at a time will enhance the likelihood that data collection and use will be implemented successfully. Additional data elements on demographics or social needs should be considered only when current data elements have been implemented successfully in normal operations.
- Alignment of standards. Broader alignment of demographic data standards at an ecosystem level through federal policy changes is crucial to advancing health equity. A major challenge to equity efforts is that health plans, hospitals, and clinicians are following various federal and state data collection requirements on demographics and social needs. Similarly, data collection requirements are being proposed for Medicare, Medicaid, Qualified Health Plans, and more. Data collection standards that vary hinder efforts to aggregate, analyze, and enable apples-to-apples comparisons across markets and across health care entities. An aligned and standardized approach to interoperable demographic data across programs will empower the health care ecosystem to collaborate on shared health equity goals, measure progress towards those goals, and better serve individuals and communities. For example, we are encouraged by the ongoing iterations and updates to the United States Core Data for Interoperability (USCDI) to increase standardized data exchange and believe the Medicare model enrollment forms and other

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<sup>41</sup> <https://www.urban.org/research/publication/collection-race-and-ethnicity-data-use-health-plans-advance-health-equity>

applicable data collection efforts should align with these data standards. With standardized and interoperable data standards, great strides can be made in reducing inequities and SDOH while improving outcomes and minimizing the data burden placed on individuals and on the larger health care ecosystem.

- **Standardized coding.** Standardized coding of responses by providers to document sociodemographic data is another important step to help advance health equity in MA. CMS could look to the Gravity Project for standardized value sets, interoperable codes, and HL7 technical standards to document standardized data on social needs. Interoperable codes could include codes from ICD-10 Z codes, LOINC codes, and/or SNOMED code sets, among others. Use of standardized codes, however, continues to lag. Many providers are not aware of the availability of Z codes to document health-related social needs. Many electronic health record (EHR) systems do not have easy pathways to add a Z code to the problem or diagnostic list. Providers also have concerns with adding Z codes to the problem or diagnostic list because they feel individually responsible for addressing health-related social needs that occur outside of the clinician's office. CMS should work with plans and providers to promote the value of standardized coding, increase awareness, consider provider incentives, and address provider concerns. CMS should also work to encourage EHR system changes to facilitate the use of Z codes.

#### **Recommendations:**

- **We welcome the opportunity to engage with CMS and other stakeholders to identify more ways to improve the MA, PDP, and original Medicare enrollment forms' instructions, questions, and response options to collect self-reported sociodemographic data from Medicare beneficiaries and maximize beneficiary response rates.**
- **We recommend uniform sociodemographic data collection in Medicare that would enable comparisons between MA and original Medicare serving beneficiaries with similar characteristics. CMS should take incremental steps with just a few social needs and/or demographic data elements with interoperable codes and then add additional data elements in subsequent years. Applying a phased approach would help to avoid data burden on key stakeholders (including the data-collecting entities as well as Medicare enrollees being asked to provide this information).**
- **We recommend broader alignment of demographic data standards across programs through federal policy changes that support standardized and interoperable data standards.**

- **CMS should collaborate with the industry and providers to support and encourage standardized coding by providers to document SDOH data through EHR systems and address provider coding concerns.**

2. *What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?*

MA innovations. MA plans are increasingly using expanded regulatory flexibility to offer more benefits, including non-medical services and support to enrollees in need to address SDOH and advance health equity. Research is demonstrating that services and interventions that address the health-related social needs of MA beneficiaries can result in improved quality of life, improved health outcomes, and reduce unnecessary health care utilization.<sup>42</sup> Important legislative and CMS policy changes in recent years have provided MA plans with flexibility to offer expanded access to telehealth and supplemental benefits, including special supplemental benefits for the chronically ill (SSBCI). These benefits go beyond coverage available under original Medicare and can address socioeconomic barriers to health.

MA plans provide services directly and also work with community partners to address a variety of needs, including food insecurity, lack of transportation, social isolation, and housing instability and homelessness, among others. AHIP has compiled examples of those services in the AHIP Issue Brief, “Social Determinants of Health and Medicare Advantage.”<sup>43</sup> A small sample of examples include:

- Programs connect members who self-identify as lonely with social workers and volunteer phone pals who regularly call or visit, to build relationships and help address needs such as transportation, house chores, or simple companionship.
- A technology support program helps enrollees build digital literacy and take advantage of telehealth visits and the digital world, including 1:1 technical assistance by phone with setting up email accounts, navigating video conferencing platforms such as Zoom or Facetime, accessing patient portals, etc.
- A program provides weekly delivery of ten ready-to-eat meals to dually-eligible Medicare and Medicaid members, which saw savings of \$753 per member per month (or 16% less in costs) due to fewer inpatient admissions and fewer nursing facility admissions.

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<sup>42</sup> <https://bettermedicarealliance.org/wp-content/uploads/2021/08/Innovative-Approaches-to-Addressing-SDOH-for-MA-Beneficiaries-FINAL.pdf>; <https://www.ahip.org/documents/SDOH-MA-IssueBrief-2021.pdf>

<sup>43</sup> <https://www.ahip.org/documents/SDOH-MA-IssueBrief-2021.pdf>

Other steps addressing health equity. In addition to working to improve health equity by addressing social barriers to health, health insurance providers are taking other steps to address health care disparities and promote diversity, equity, and inclusion. Examples include an initiative for scholarships and hiring/retention for a community's insurance sales workforce; a partnership with a local fire and rescue service to proactively reach underserved communities; the creation of a health equity department to expand a health insurance provider's activities related to health equity; and the development of tailored care delivery models designed to meet patients' social, cultural, and linguistic needs. AHIP provides additional information and examples in a separate document.<sup>44</sup>

CMS support. AHIP has been a strong supporter of the expanded benefits flexibility provided in the MA program. However, additional flexibilities should be made available. We believe CMS should explore opportunities through regulatory interpretation or through Center for Medicare and Medicaid Innovation (CMMI) models to further expand flexibility in MA and Part D to offer benefits that can address SDOH and health equity. Several potential areas are noted in our recommendations below.

#### **Recommendations:**

- **Given the importance of supplemental benefits to address SDOH, CMS should propose extending supplemental benefits flexibility to Part D benefits, which could advance health equity through targeted interventions that reduce cost sharing for covered Part D drugs.**
- **We recommend that CMS expand the eligibility criteria for SSBCI through the CMMI MA-Value-Based Insurance Design (VBID) demonstration so more enrollees can receive these important benefits. For example, the eligibility criteria for SSBCI could be expanded to include partial duals and enrollees who demonstrate functional need.<sup>45</sup> Some partial duals may not have applied for low-income subsidy (LIS) status, even if they are eligible, and therefore may not be captured by the current VBID socioeconomic status criteria. We also recommend that CMS evaluate the feasibility of expanding eligibility for SSBCI through regulation.**
- **We recommend that CMS extend the MA-VBID demonstration, which is set to expire at the end of 2024, to provide continued support for supplemental benefit flexibilities.**

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<sup>44</sup> <https://www.ahip.org/working-to-advance-health-equity>

<sup>45</sup> <https://atiadvisory.com/wp-content/uploads/2021/12/Two-Pager-Policy-Recommendations-for-the-Administration-to-Advance-Non-Medical-Supplemental-Benefits.pdf>

Confidential stratified reports. We support CMS' recent sharing of confidential reports with MA plans that illustrate differences in contract performance on certain Star Ratings quality measures stratified by disability, LIS status, and dual eligibility (DE) status. We agree with CMS that these reports can support plan efforts to improve the quality of care received by enrollees who are socioeconomically disadvantaged, have disabilities, or need more care compared to enrollee populations with fewer social risk factors. We suggest CMS consider a follow-up engagement strategy with plans to provide further help with plan improvement efforts.

SDOH screening and Health Equity Index. We also support CMS interest<sup>46</sup> in proposing a new Star Ratings measure focused on SDOH screening and in developing a health equity index that summarizes contract performance among those with social risk factors across multiple measures into a single score. However, it is important that specifications for an SDOH measure be flexible and not limit the SDOH tools or questions that MA plans have already developed and are using. We also strongly support CMS providing plans with more details on the methodology for a health equity index, including a component recommended by AHIP that would provide plans with simulations of the impact of adding a health equity index to the Star Ratings program.

#### **Recommendations:**

- **CMS should hold a plan user group call with MA plans to discuss the Star Ratings stratified reports and strategies to improve the reports that are intended to help plans with their efforts to identify and address health care disparities. A user group call would enable the agency and plans to explore which additional measures could and should be stratified as well as additional variables for stratification. During the meeting with CMS, plans could also share their best practices for interpreting stratified quality data to improve health equity for their enrollees.**
- **We recommend the specifications for an SDOH screening measure be flexible and not limit the SDOH tools or questions that MA plans have already developed and are using. We look forward to reviewing and commenting on such proposal in future rulemaking.**
- **We urge CMS to provide plans with the details of a potential health equity index methodology, including simulations of plan performance, and look forward to reviewing and commenting on those details through future rulemaking.**

*3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes,*

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<sup>46</sup> <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>

*quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?*

Standardized data. For years, health plans have been investing resources to collect standardized data on their enrollees' social needs, drawing on SDOH screening tools and toolkits such as PRAPARE, WellRx, Accountable Health Communities SDOH Tool, or others. These tools focus on similar SDOH domains (including food insecurity, housing instability, and transportation issues), although the questions in the tools may differ slightly. An organization may use one of these tools in its entirety or select certain questions from one tool and other questions from another tool based on what they think would work best in their setting and populations. Accordingly, a robust data collection environment has already developed.

Because of this, CMS should not require a specific SDOH tool or questions. Requiring an SDOH-specific tool or questions could require multiple organizations to modify data collection and information technology (IT) systems and have significant spillover impacts into provider EHRs. It could disrupt the continuity of existing assessments; jeopardize linkages to historical data and related analytics; and prevent organizations from using validated questions they have determined work best to elicit information that is most effective in developing individualized plans of care for their enrollees.

Even with such flexibility on tools and questions, the important goal of standardization can still be achieved through an alternative approach: one that focuses on standardized interoperable codes for the social needs enrollees identify. That is, through coding, enrollee responses rather than the questions themselves can be standardized. This approach would be more easily scaled by utilizing existing systems and infrastructure. It would allow organizations to focus on needs and person-centered approaches that best meet the needs of their enrollees. And crucially, it would still promote standardization and interoperability for data analyses and comparisons on social needs. As we previously recommended, CMS could look to the Gravity Project for standardized value sets, interoperable codes, and HL7 technical standards to document standardized data on social needs. Interoperable codes could include codes from ICD-10 Z codes, LOINC codes, and/or SNOMED code sets, among others. For additional safeguards, CMS could specify through rulemaking which SDOH screening tools are permissible to ensure health plans, hospitals, and/or clinicians use questions from validated and vetted tools that have been tested by different communities to ensure they are person-centered and sensitive.

#### **Recommendations:**

- **CMS should not impose requirements that would unduly limit the tools and related actions used by MA plans for screening, documenting, and furnishing health care informed by SDOH.**

- **CMS should instead focus on promoting development of standardized value sets, interoperable codes, and technical standards for data on social needs.**

*9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?*

Tailored care. As required by the Social Security Act, MA SNPs tailor care for their enrollees using models of care (MOCs) reviewed and approved by the National Committee for Quality Assurance (NCQA) to develop and implement person-centered plans for care and services. The MOC is an important care management and quality improvement tool. It is the SNP's detailed framework for identifying the needs of each SNP enrollee and for addressing those needs through the SNP's care coordination practices. The model of care must meet a rigorous set of requirements. Examples include a comprehensive description of the medical, social, cognitive, environmental, living conditions, and co-morbidities of the SNP population and the specially-tailored services available for beneficiaries considered especially vulnerable; a detailed description of the SNP's care coordination program including the use of health risk assessment tools, interdisciplinary care teams and individualized care plans, and management of enrollees' transitions of care; the SNP's process for measuring and improving quality; and key characteristics of the SNP's provider network and how the SNP trains its providers on elements of the MOC.

Critical supplemental benefits. In 2022, 42 percent of SNPs offered SSBCI to their enrollees.<sup>47</sup> Data reveal that SNPs are offering non-medical supplemental benefits at higher rates than non-SNP plans.<sup>48</sup> These greater offerings are likely due to beneficiaries in SNPs facing more social risk factors and unmet needs which SNPs seek to address through SSBCI.

Integrated benefits. D-SNPs increasingly offer integrated benefits and processes for individuals dually eligible for Medicare and Medicaid. Further levels of integration will be provided in accordance with the requirements in the MA and Part D rule for 2023.<sup>49</sup> At the same time, pursuant to the final MA and Part D rule, CMS is working with states to begin a process for phasing out a long-standing integrated alternative to D-SNPs: the capitated financial alignment model for Medicare-Medicaid plans (MMPs). States will have the option to simply conclude their demonstrations, or to convert the MMPs to integrated D-SNPs. For states converting MMPs

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<sup>47</sup> Rizer, A, and Benzing, L. "Filling The Gaps: The Role And Value Of Supplemental Benefits In Medicare Advantage". Health Affairs Forefront. August 5, 2022: <https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage>

<sup>48</sup> <https://atiadvisory.com/wp-content/uploads/2021/04/Non-Medical-Supplemental-Benefits-FAQ.pdf>

<sup>49</sup> 87 Federal Register 27704, May 9, 2022.

to integrated D-SNPs, a smooth transition will require significant planning and coordination by and among CMS, states, and D-SNP sponsors.

**Recommendations:**

- **Supplemental benefits, which can provide great value to all MA enrollees, are especially critical for those enrolled in SNPs. We therefore reiterate our prior recommendation that CMS extend the MA-VBID demonstration and expand the eligibility criteria for SSBCI through the demonstration so more enrollees can receive these important benefits. The expanded eligibility criteria for SSBCI could include partial duals (dual eligibles are currently included) and enrollees who demonstrate functional need. As mentioned above, some partial duals may not have applied for LIS status, even if they are eligible, and therefore may not be captured by the current VBID socioeconomic status criteria. Furthermore, we also recommend CMS evaluate the feasibility of expanding eligibility for SSBCI through regulation.**
- **To support planning and coordination efforts to convert MMPs to integrated D-SNPs, we recommend CMS convene regular meetings with plans and states on the transition process for their respective MMP demonstrations.**

*11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?*

Value of MA rebate dollars. In addition to the ways MA plans are addressing health equity and SDOH using both rebate and non-rebate funds described in an earlier response (see response to question 2 under Section A), MA plans use rebate dollars to advance health equity and address SDOH through a variety of means:

- Reduced costs for Medicare benefits. In 2022, program-wide about 78% of total rebate dollars are used by MA plans to reduce enrollee costs for Medicare benefits, making health care more accessible and affordable and acting as an important tool in advancing health equity and overcoming social barriers to accessing care. Specifically, (i) 43% of rebate dollars reduce cost sharing for Medicare Parts A and B services, including maximum out-of-pocket (MOOP) protections for all enrollees;<sup>50</sup> (ii) 18% of rebate dollars provide enhanced Part D prescription drug coverage; and (iii) 17% of rebate dollars reduce Part D and Part B premiums. In 2022, virtually all Medicare beneficiaries

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<sup>50</sup> Medicare Payment Advisory Commission. March 2022 Report to the Congress.  
<https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>

(98%) have access to at least one MA plan that includes integrated medical and prescription drug coverage at no additional premium. These cost sharing protections and premium reductions are especially valuable for low-income enrollees who do not qualify for Medicaid; two-thirds of all beneficiaries eligible for partial Medicaid benefits are enrolled in MA in 2022.<sup>51</sup>

- Comprehensive benefits. MA plans provide comprehensive benefits beyond those available in the original Medicare program. Those benefits ensure enrollees have access to services that improve health and well-being. These supplemental benefits account for 22% of rebate dollars in 2022.<sup>52</sup> For example:
  - Many MA plans offer integrated dental, hearing, and vision coverage, along with innovative telehealth options.
  - MA plans can offer new types of “primarily health related” and non-medical benefits that, as previously discussed, are often particularly focused on addressing various social barriers to better health. Examples include wellness programs and nutrition; transportation for non-medical needs; in-home caregiver services; home-based palliative care; adult day services; and structural home modifications. Those benefits are being offered in increasing numbers as reflected in several reports analyzing MA plan benefit package (PBP) data.<sup>53</sup> In 2022, 1,851 plans offer non-medical benefits designed to help support MA enrollees, up from 626 in 2020.<sup>54</sup> Further, as noted above, 42% of all SNPs offer one or more SSBCI benefits in 2022.<sup>55</sup>

Data. We recognize CMS’ interest in data on rebate dollars related to the advancement of health equity and SDOH. However, as noted above many of the supplemental benefits that plans offer address these key objectives. The vast majority of rebate dollars (almost 80%) reduce cost sharing or premiums for Medicare benefits; CMS already has data relating to the cost and utilization of such benefits through the MA bid and encounter data process. For the roughly 20% of rebate dollars that finance non-Medicare supplemental benefits, a portion typically provides access to dental, hearing, and vision benefits. These benefits, important to improving enrollee

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<sup>51</sup> Medicare Payment Advisory Commission. July 2022 Data Book: Health care spending and the Medicare program. <https://www.medpac.gov/document/july-2022-data-book-health-care-spending-and-the-medicare-program/>

<sup>52</sup> Medicare Payment Advisory Commission. March 2022 Report to the Congress.

<https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>

<sup>53</sup> <https://avalere.com/insights/ma-enrollees-can-access-covid-19-supplemental-benefits-in-2021>

<sup>54</sup> Rizer, A, and Benzinger, L. “Filling The Gaps: The Role And Value Of Supplemental Benefits In Medicare Advantage”. Health Affairs Forefront. August 5, 2022: <https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage>

<sup>55</sup> Rizer, A, and Benzinger, L. “Filling The Gaps: The Role And Value Of Supplemental Benefits In Medicare Advantage”. Health Affairs Forefront. August 5, 2022: <https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage>

health and quality of life, can be particularly difficult for vulnerable populations to access without their MA coverage. The remaining portion of rebate dollars provides a wide range of innovative benefits across the MA program, including new types of benefits more directly focused on addressing SDOH and health equity. Many have only recently become available based on legislative and regulatory changes in the past several years. MA plans need time to review and evaluate their own data as they continue to consider new offerings and identify which benefits resonate best with enrollees and assess their impacts on spending and outcomes.<sup>56</sup> If CMS were to require expanded data collection or reporting for such benefits, we are concerned the data could paint a misleading picture of the longer-term cost and value of such benefits, particularly with regard to new SSBCI benefits. Given that CMS has just implemented expanded reporting on supplemental benefits via medical loss ratio (MLR) rules,<sup>57</sup> CMS should not consider additional data reporting—at least until it reviews the data provided through expanded MLR reporting. Such data can inform the agency and the industry on the utility of additional data collection and reporting related to supplemental benefits.

**Recommendations:**

- **Given that MA plans will be reporting expenditure data to CMS on supplemental benefits as part of their MLR reporting beginning for 2023, CMS should not take any steps to seek additional data without first assessing these new data that will be made available to the agency.**
- **If CMS explores additional data sources in future rulemaking, the agency should take an incremental approach that minimizes the burdens of data collection given the impacts those costs can have on plan bids and the still-evolving nature of many supplemental benefits under MA.**

**B. EXPAND ACCESS: COVERAGE AND CARE**

Overview of AHIP response: There is widespread access to MA coverage, with almost 30 million seniors and people with disabilities now enrolled. MA plans offer comprehensive benefits and services, including items and services covered under original Medicare, and adhere to robust network adequacy requirements to ensure enrollees have access to providers delivering covered services. In this section we discuss and recommend improvements to the various ways Medicare enrollees review their MA coverage options and compare them to benefits in original Medicare, including through Medicare Plan Finder (MPF) and agents/brokers. We also

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<sup>56</sup> <https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage>

<sup>57</sup> 87 Federal Register 27704, May 9, 2022.

recommend ways CMS can expand access to MA coverage in rural and medically underserved areas. Further, in light of numerous studies showing that Americans continue to receive inappropriate, unsafe, or low-value care that is causing harm and wasting billions, we discuss the importance of targeted evidence-based medical management tools that promote high-value care, along with steps health insurance providers are taking and policies that CMS can advance to make these tools more efficient, more effective, and less burdensome. We also discuss policies to increase innovation and reduce costs for people with end-stage renal disease. Finally, while a recent AHIP survey shows that an overwhelming majority of individuals are satisfied with the behavioral health care they sought and received, we highlight AHIP's Board of Directors commitment and important steps MA plans and other health insurance providers are taking to improve access, reiterate AHIP recommendations on audio-only telehealth and risk adjustment, and share key principles and recommendations for further improving access to mental health and substance use disorder (SUD) care.

*1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools? & 2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?*

The MA program is a model of consumer choice, competition, and innovation that helps deliver high-quality, affordable coverage and care to almost 30 million Americans. Medicare enrollees currently have access to a number of resources for assessing their current coverage and/or comparing their coverage options. They include an MA plan's customer service center; licensed agents or brokers; 1-800-MEDICARE; State Health Insurance Assistance Program (SHIP) counselors; and the online MPF tool.

CMS has recently taken steps to improve the MPF tool. In May 2022, CMS announced several enhancements that the agency made to the MPF tool for the 2023 Annual Enrollment Period, such as requiring fewer steps for individuals when reviewing plan options and saving information for individuals who establish accounts through MPF.<sup>58</sup>

Improvements to MPF tool and other enrollee resources. We believe additional improvements to the MPF tool and other enrollee resources such as the Medicare & You Handbook would improve enrollees' experience and help them select the coverage option that best meets their care and other needs. Areas for improvement on the MPF tool could include full cost comparisons between MA and original Medicare that account for supplemental benefits and the MA MOOP protections; more detail about available supplemental benefits and comparisons based on these

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<sup>58</sup> CMS HPMS Memo, "Medicare Plan Finder Enhancements for Contract Year 2023," (May 18, 2022).

benefits; and more personalized and customized information. We also believe CMS should focus on steps to expand health literacy, which would improve enrollees' ability to understand their coverage choices and care they need.

**Recommendations:**

- **We recommend CMS consider additional improvements to the search and comparison functionalities of and information displayed in the MPF tool, including more detail on cost comparisons between MA and original Medicare, comparisons based on supplemental benefits, more information on supplemental benefits, and enhanced customization for people using the tool. We welcome the opportunity for continued engagement with CMS on potential improvements.**
- **To inform these improvements, CMS should conduct annual surveys to solicit input from Medicare beneficiaries, agents and brokers, health plans, SHIP counselors, and other stakeholders on ways to improve the MPF tool.**
- **CMS should consider new methods and initiatives for expanding health literacy of the Medicare population.**

*3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?*

As indicated in our response to the prior question, CMS can make certain improvements to the MPF tool to improve beneficiary understanding of benefit options.

Critical role of agents and brokers. In addition to the MPF tool and other educational and informational resources, agents and brokers play a critical role in informing beneficiaries about the Medicare coverage options available to them. Agents and brokers are knowledgeable about the Medicare program and invest in educational tools and resources to assist Medicare beneficiaries. In addition to complying with state licensing and other requirements, agents and brokers are required to be trained and tested annually on Medicare program rules and regulations and on the specific plan benefits their agents and brokers sell. Many beneficiaries rely on agents to help them identify the coverage and benefits options that may best meet their needs. As members of their local communities, agents can also help plans connect with diverse Medicare populations, including racial and ethnic minorities, to ensure that they have the information and resources they need to inform their Medicare coverage selection.

CMS should ensure that agents and brokers are able to continue having a role in the program. In this regard, the MA and Part D final rule for CY 2023<sup>59</sup> imposes new marketing-related requirements including plan oversight requirements for Third Party Marketing Organizations (TPMOs). AHIP supports CMS' goal to protect beneficiaries from misleading advertising and to reduce consumer confusion and abrasion. While we appreciate CMS' goals in protecting against confusing and potentially misleading activities,<sup>60</sup> we have heard questions about the scope of the TPMO requirements and concerns that without further clarifications or modifications, those rules could expand costs and inhibit access to certain agents and brokers. We ask CMS to engage with stakeholders to discuss and address concerns related to the TPMO requirements and ensure beneficiaries are protected from inappropriate marketing activities.

**Recommendations:**

- **CMS should address concerns and consider improvements to the TPMO requirements. The goals should be to avoid limiting access to the agents and brokers that can play an important role in educating potential enrollees about benefits that plans offer while protecting enrollees from inappropriate marketing activities.**
- **We are committed to working with CMS and other stakeholders to ensure the Medicare program provides enrollees with access to a variety of resources to help them navigate their Medicare coverage options to find Medicare coverage that best meets their needs.**

*4. How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?*

Access to behavioral health services. MA plans are required to cover a broad range of behavioral health services, with coverage required to be no less than that available under original Medicare. The MA program also includes network adequacy requirements to ensure access to behavioral health services.

In June 2022, AHIP conducted a nationwide survey<sup>61</sup> that covered multiple product lines including Medicare to understand people's experience accessing care, whether their treatment was covered by insurance, and if insured patients were satisfied with the results. The survey results make it clear: an overwhelming majority of individuals report being satisfied with the

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<sup>59</sup> 87 Federal Register 27704, May 9, 2022.

<sup>60</sup> Id.

<sup>61</sup> <https://www.ahip.org/resources/ahip-mental-health-access-survey-june-2022>

mental health care they sought and received through their health insurance providers. Key findings include:

- Nearly all respondents who sought mental health care for themselves or someone within their household over the past two years received treatment.
- 3 in 4 insured Americans (73%) found it easy to get the care they needed.
- More than two-thirds of respondents were able to find an appointment with a provider in less than a month.
- 9 in 10 reported being satisfied with the mental health support they received, including half who say they were very satisfied.

Telehealth for behavioral health services. At the same time, health insurance providers, including MA plans, continue to work hard on a variety of solutions to further improve access to behavioral health services. One area of focus has been expanding access to telehealth and digital tools for behavioral health services. As described further below, telehealth and digital tools can help Medicare enrollees better engage in their health by offering convenience and flexibility. We support expansion of telehealth coverage through original Medicare, including permanent removal of geographic restrictions and coverage of audio only visits for mental health and SUD care.

Behavioral health integration. Another area of focus has been integrating mental health support into primary care settings. For example, health insurance providers have promoted collaborative care and enhanced care coordination models by providing primary care clinicians with tools and training to identify and care for patients' mental health needs. This allows primary care clinicians to be better equipped to integrate physical and mental health care, treat mild/moderate conditions, and consult with or refer to specialists when appropriate. We encourage CMS to consider the inclusion of the Collaborative Care Model (CoCM) and other enhanced care coordination approaches in future CMMI models.

AHIP Board of Directors Statement of Commitment. On August 23, 2022, AHIP's Board of Directors released a new Statement of Commitment<sup>62</sup> and a detailed advocacy vision<sup>63</sup> to further improve access to mental health care and SUD treatment for every American. These commitments build on health insurance providers' extensive history of improving access to effective, high-quality care and treatment choices, while offering new solutions for the public sector and private market partners to work together to overcome barriers that persist. The AHIP Board of Directors Statement of Commitment includes the following priorities:

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<sup>62</sup> <https://www.ahip.org/resources/ahip-board-of-directors-statement-of-commitment-improving-access-to-and-quality-of-mental-health-and-addiction-support>

<sup>63</sup> <https://www.ahip.org/resources/a-vision-for-improved-mental-health-care-access-for-every-american>

- Help patients navigate in a timely manner to the right setting and practitioner based on their needs for mental health or SUD support.
- Integrate mental health/SUD support with physical health and primary care visits.
- Create innovative programs to expand system capacity and increase the number of mental health care practitioners available.
- Expand access to mental health care through telehealth, virtual visits, and other innovative uses of technologies that connect people to the mental health support they need.
- Continue to ensure that mental health/SUD treatment is covered—on par with physical health treatment in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Advocate for the importance of addressing issues of equity and the impact of the social drivers of health.
- Improve quality and move toward value.
- Promote access to evidence-based SUD/opioid use disorder (OUD) treatment.<sup>64</sup>

Potential steps CMS can take. Our members are committed to ensuring that Medicare enrollees have access to the covered behavioral health services they need. While our survey data suggest MA enrollees are satisfied and able to access necessary care, we believe there are steps CMS can take to improve the supply and diversity of the behavioral health workforce. Several specific suggestions are included below.

We also caution that any policy changes designed to materially affect benefit availability should require legislation. However, if CMS were to consider new policies aimed at expanding access, any changes applied to MA plans must also apply to original Medicare. Many key issues that can affect enrollee access for specific services in individual geographic areas, including capacity and workforce issues, are outside the control of payers. CMS should not impose new obligations on MA plans that original Medicare itself would have difficulty meeting. Further, the structure of the Medicare program ties MA to original Medicare in multiple ways, including with respect to payments and a common set of mandatory Part A and Part B benefits that includes coverage for inpatient and outpatient mental and behavioral health care services. Consistent with this structure of the Medicare program, no regulatory (or legislative) changes should be made that fail to ensure the same basic benefits are available to all Medicare enrollees.

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<sup>64</sup> <https://www.ahip.org/resources/ahip-board-of-directors-statement-of-commitment-improving-access-to-and-quality-of-mental-health-and-addiction-support>

**Recommendations:**

- **We look forward to engaging with CMS, providers, and other stakeholders to ensure that Medicare policies align with AHIP’s recommendations detailed above to improve mental health access and care.**
- **We oppose more restrictive network standards or other requirements for behavioral health services, especially if proposed to apply only to MA, given the overall structure of the Medicare program and factors such as capacity and workforce issues that are outside the control of plans.**
- **To increase beneficiary access to behavioral health services, AHIP further recommends CMS support the following additional policies that provide incentives for individuals to enter the behavioral health field and improve both the supply and diversity of the behavioral health workforce:**
  - **Increase the number of graduate medical education slots allotted to behavioral health providers and expand loan repayment and scholarship programs.**
  - **Emphasize training programs on behavioral health treatment specific to the Medicare population due to the chronic nature of behavioral health illnesses and the changing physiology of people as they grow older.**
  - **Consider the inclusion of the CoCM and other enhanced care coordination approaches in future CMMI models.**
  - **Support team-based care to improve access and optimize the existing workforce by exploring alternative payment models through the CMMI that support behavioral health integration.**

*5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS’ statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity’s telehealth services?*

Value of telehealth. Telehealth can help Medicare enrollees better engage in their health by offering convenient options for preventive care, routine check-ins for chronic conditions, and care to address more complex needs, including behavioral health care. Health insurance providers continually evaluate the quality of care provided to enrollees, including services provided through telehealth. Health insurance providers use a variety of tools to evaluate the quality of care delivered via telehealth, including data on hospital admissions and readmissions, need for follow up care, and patient and provider satisfaction. Those evaluations have shown

that, for many specialties, delivering high quality care, comparable with in-person care, is entirely possible. However, health insurance providers continue to evaluate the circumstances and terms from which patients can be sure to receive ideal care.

Health insurance providers including MA plans use telehealth in various ways, such as:

- Creating care delivery models with robust networks of providers that allow patients to connect with providers who are farther away, thereby alleviating workforce shortages or misalignment while connecting beneficiaries to care that may not be available in the patient’s immediate geographic area;
- Eliminating the need for in-person visits in some cases to further facilitate convenient care; and
- Employing models that pair telehealth with other digital tools, such as remote monitoring and tools to locate brick-and-mortar services such as lab work or clinics at convenient locations. For example, initiatives like Project ECHO, facilitated through health insurance providers, use technology to connect primary care and rural providers with specialists at larger tertiary hospitals to extend available expertise.<sup>65</sup>

Telehealth advances health equity. In general, telehealth helps increase safe access to care (particularly critical during the global pandemic) and can provide opportunities for individuals in underserved communities to access care in convenient, affordable ways. However, it can also create or exacerbate disparities in access by leaving some populations behind. Research conducted prior to the pandemic revealed that older Americans, rural communities, vulnerable populations, racial and ethnic minorities, and those with lower socioeconomic status are disadvantaged by this “digital divide” and may be unable to take full advantage of telehealth opportunities.<sup>66</sup> They face challenges to using telehealth, including a lack of access to the internet; an inability to afford the technologies needed to access telehealth, such as phones, computers, and data plans; and a limited understanding of how to access virtual care. These disparities could worsen because of the economic impact of COVID-19 as well as other hardships, as vulnerable populations may have reduced or lost income and dropped their internet or data plans to save money, turned off smartphones they can no longer afford, and lost access to publicly available WiFi.

Many health insurance providers are working with provider partners to bridge the digital divide, as described in AHIP’s Issue Brief: Bridging the Digital Divide for Consumers: How Health Plans Address the Social Determinants of Health and Promote Access to Telehealth.<sup>67</sup> Strategies

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<sup>65</sup> <https://pubmed.ncbi.nlm.nih.gov/35192446/>

<sup>66</sup> [https://www.ahip.org/documents/202011-AHIP\\_IB-DigitalDivide.pdf](https://www.ahip.org/documents/202011-AHIP_IB-DigitalDivide.pdf)

<sup>67</sup> Id.

include allowing grants to develop telehealth infrastructure; distributing smartphones to those in need; and creating “hubs” through which members can access virtual programs, services, and telehealth. AHIP’s members have also reached out to their enrollees to inform them about the Bipartisan Infrastructure Law’s Affordable Connectivity Program (ACP) that provides eligible households \$30 per month (or \$75 per month on Tribal lands) toward their internet service plan.<sup>68</sup> Greater connectivity may facilitate telehealth opportunities and help address SDOH.

Audio-only telehealth and risk adjustment. Audio-only telehealth can be a valuable way to increase access to care for some communities—particularly in rural geographies and other underserved areas where access to digital technologies may be limited. Understanding the complexities of the digital divide, CMS has supported inclusion of audio-only interaction as part of original Medicare telehealth benefits. As part of the support for audio-only telehealth, we appreciate CMS’ instruction to MA plans to use Current Procedural Terminology® (CPT) Modifier 93<sup>69</sup> for audio-only telehealth claims beginning in January 2022; this supports better analyses of telehealth and audio-only encounters, including which services are being delivered via which medium, and to whom. We also note the importance of providers and patients having the ability to transition from audio-only care to audio-video if visualization is needed for accurate evaluation, diagnosis, and treatment. Health insurance providers seek to provide care in the most appropriate setting for the patient and providers, while protecting a patient’s safety and privacy during an encounter.

#### **Recommendations:**

- **CMS should continue telehealth policies that support plan and provider efforts to improve access to care and advance equitable access in MA, including the continued ability of MA plans to use diagnoses obtained from telehealth visits using video for risk adjustment purposes.**
- **We renew our prior strong recommendations that CMS allow information obtained from audio-only visits to be included in risk adjustment calculations in MA. Research has shown that there are socioeconomic disparities between people who use audio-only telehealth and those who use audio-video services. Eliminating access to care via telephone would exacerbate those disparities. As telehealth has proven to be a medium through which high-value, high-quality care can be delivered,**

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<sup>68</sup> About 48 million households, or nearly 40% of households in the country, qualify for the ACP. Households are eligible if their income is at or below 200% of the Federal Poverty Level, or if they participate in certain other federal assistance programs, including Medicaid.

<sup>69</sup> <https://www.ama-assn.org/practice-management/cpt/cpt-appendix-t-and-modifier-93-audio-only-medical-services>

**information from telehealth visits should be considered for risk adjustment, quality rating, and network adequacy evaluations.**

- **CMS should promote greater connectivity to help address SDOH such as supporting programs that provide discounts for computer/internet access and provide technology education and awareness to the public.**

*6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?*

The MA program already includes robust network adequacy requirements. The continued growth of the program, the high-quality care that enrollees are receiving, and high satisfaction rates all clearly indicate that plans are providing networks meeting the needs of enrollees.

Specifically, MA plans are subject to a general requirement that they maintain and monitor a sufficient network of providers and provide adequate access to covered services for their MA enrollees. Further, for many categories of providers and facilities, MA plans are subject to specific numeric access and availability (time and distance) standards determined by county and specialty in CMS' Health Service Delivery (HSD) tables.<sup>70</sup> MA plans must demonstrate compliance with those requirements at various points, including with new applications and when they seek a service area expansion. MA plans must also meet additional access requirements set by CMS, including ensuring that medically necessary services are available 24 hours a day, seven days a week.<sup>71</sup> In addition, MA plans are expected to create and maintain a proactive, structured process to assess on a timely basis the actual availability of their network providers and to verify adequate access to covered services for their enrollees.<sup>72</sup>

Network adequacy improvements. We support changes CMS made in certain network adequacy standards that recognize the value of telehealth, provide flexibility in rural areas, and address states with Certificate of Need laws in the MA and Part D 2021 rule.<sup>73</sup> We believe network adequacy requirements should further leverage new and innovative delivery and payment models to provide alternatives to traditional time and distance standards and face-to-face visits. Physical access to providers can be supplemented with virtual access through advancements in technology and practice design that enable electronic means of communication (e.g., e-visits, Skype) and

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<sup>70</sup> <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps>

<sup>71</sup> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>

<sup>72</sup> Id.

<sup>73</sup> 85 Federal Register 33796, June 2, 2020.

telemedicine technologies such as virtual consultations that can eliminate geographic barriers, dramatically expand service areas, improve access, and foster team-based care coordination. Additionally, CMS should consider allowances for in-home delivery of services and the use of mobile health clinics, as permitted for MMPs.<sup>74</sup>

In addition, CMS should engage with plans on further improvements to the MA network exceptions criteria and process. We ask CMS to consider additional exceptions criteria including geographic features and other factors that CMS considers for MMPs.<sup>75</sup> We also remain concerned that there may be circumstances, particularly in rural and medically underserved areas, where it will be challenging for an applicant to have a full network in place in a new service area almost one year prior to the beginning of the contract year.<sup>76</sup>

Advancements in dialysis technology. We also encourage CMS to continue exploring policies that promote innovation, increase access, and reduce costs for people with end-stage renal disease (ESRD). AHIP continues to have serious concerns about the negative effects of consolidation among dialysis providers, including continued overuse of in-center dialysis treatments in the United States. MA plans use different approaches to attempt to overcome these barriers to improved health and outcomes for people with ESRD. CMS has also taken important steps to encourage more treatments through home dialysis and other alternatives to dialysis centers, including through CMMI models designed to overhaul the delivery of kidney care and through new flexibility in MA network adequacy standards for dialysis facilities included in the 2021 MA and Part D rule. These initiatives are critically important. For many patients with ESRD, home dialysis can be a convenient, effective, affordable way for them to receive their life-sustaining treatments. We remain hopeful that advancements in dialysis technology, combined with stakeholder efforts and CMS policies, can support home dialysis as an important choice for patients for whom it is appropriate.

#### **Recommendations:**

- **We recommend CMS and plans work together to consider additional network adequacy flexibilities to support innovative delivery and payment models that do not rely on traditional time and distance standards. We caution against more restrictive network standards due to continued growth of the program, access to high quality services, and consistently high satisfaction rates.**
- **We recommend CMS engage with plans on improving the MA network exceptions criteria and process. Exceptions should be considered, especially in cases when**

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<sup>74</sup> <https://www.cms.gov/files/document/mmpapplicationcy2022.pdf>

<sup>75</sup> <https://www.cms.gov/files/document/mmpapplicationcy2022.pdf>

<sup>76</sup> This is a new requirement for MA plans that is effective starting with the 2024 application cycle.

**meeting the network adequacy requirements at the time of or during the application process is challenging due to factors outside of plan control. These challenges include provider/facility shortages, ongoing attempts to obtain the participation of a provider that has large market share, as well as other factors including those considered under current MA and MMP exceptions.**

- **CMS should retain network flexibility with respect to dialysis facilities and consider further steps, such as modernizing the Medicare ESRD Conditions for Coverage and related guidance, to support home dialysis as an option for patients for whom it is appropriate.**

*9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)?*

As explained above in our response to question 11 under Section A, the vast majority of funds applied toward supplemental benefits reduce cost sharing or premiums for Medicare benefits. These benefits can make services more affordable, and the data relating to such benefits is already available through the MA bid and encounter data process. For other supplemental benefits which are directly focused on addressing certain SDOH/health equity, we reiterate our caution that many such benefits are still new and in a period of transition and innovation. It is likely far too early to get a credible picture of their long-term utilization, let alone draw any reasonable conclusions about their impacts on health outcomes or other elements. If CMS were to expand reporting of supplemental benefits, there is a significant risk that whatever data might become available from expanded reporting will paint a misleading picture of the longer-term cost and value of such benefits, particularly with regard to new SSBCI benefits. And while the value of data at this time may be questionable at best, the cost of imposing additional reporting burdens could increase bids and thereby reduce the availability of supplemental benefits and/or increase premiums. Lastly, CMS has just significantly expanded MLR reporting for supplemental benefits starting in CY 2023. At a minimum, additional reporting should not be considered until data provided through MLR reporting is analyzed.

**Recommendations:**

- **We recommend CMS not consider proposing any new reporting requirements for supplemental benefits data at this time.**

- **If CMS were to pursue expanded reporting, at a minimum it should not be considered until CMS analyzes the data provided under new MLR reporting requirements.**

*10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care? & 11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?*

Value of prior authorization (PA). PA is one of the many tools health insurance providers use to promote safe, timely, evidence-based, affordable, and efficient care. MA plans and other health insurance providers have adopted a range of evidence-based medical management tools, including PA, to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient. Under the supervision of medical professionals, PA can reduce inappropriate care by catching unsafe or low-value care, or care not consistent with the latest clinical evidence. Low-value or otherwise inappropriate care can contribute to potential harm to patients and unnecessary costs.

The evidence showing the value of PA is clear. For nearly two decades, numerous studies have documented Americans frequently receive inappropriate care in a variety of settings for many different medical procedures, tests, and treatments.<sup>77</sup> The Institute of Medicine has confirmed that geographic variations in spending are substantial, pervasive, and persistent over time and there is little to no correlation between spending and health care quality.<sup>78</sup> Needless medical tests are unsupported by evidence, causing harm and wasting billions. In a national survey of over 2,000 physicians, most (64.7%) reported at least 15-30% of medical care is unnecessary.<sup>79</sup>

PA can ensure care is delivered in the most appropriate setting, at the most appropriate frequency, and by the most appropriate provider (such as ensuring chemotherapy medications are prescribed by specialists with expertise in monitoring the patient's treatment). At the same time, as more providers transition to value-based payment models where they take on partial or full

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<sup>77</sup> <https://www.ahip.org/issues/medical-management>

<sup>78</sup> Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care; Board on Health Care Services; Institute of Medicine; Newhouse JP, Garber AM, Graham RP, et al., editors. Variation in Health Care Spending: Target Decision Making, Not Geography. Washington (DC): National Academies Press (US); 2013 Oct 1. Summary. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK201637/>

<sup>79</sup> Lyu H, Xu T, Brotman D, Mayer-Blackwell B, Cooper M, Daniel M, et al. (2017) Overtreatment in the United States. PLoS ONE 12(9): e0181970. <https://doi.org/10.1371/journal.pone.0181970>.

financial risk for the care of their patient population, providers will be accountable for the efficacy and safety of care they deliver, decreasing the need for PA by health plans.

The MA program rules support the use of PA as a critical tool to ensure Medicare enrollees receive safe, effective, and appropriate care. Moreover, CMS has repeatedly recognized PA as an important tool to protect patients and has taken a number of actions to thoughtfully expand its use under original Medicare. In response to recommendations from the Government Accountability Office (GAO)<sup>80</sup> and Medicare Payment Advisory Commission (MedPAC),<sup>81</sup> original Medicare has implemented evidence-based guidelines and PA for outlier professionals to address the overuse and misuse of imaging services, which can expose patients to unnecessary and potentially harmful radiation, unnecessary surgery and office visits, undue stress, and add wasteful costs to the health care system.

Improvements to PA. In July 2022, AHIP posted a comprehensive report<sup>82</sup> on how health insurance providers have delivered on their commitments to improve PA for patients and providers. This report follows up on the 2018 Consensus Statement<sup>83</sup> among providers, health insurers, and other stakeholders recommending opportunities to improve the PA process. Since then, health insurance providers have taken and continue to take concrete actions to help achieve the shared goal of making PA more efficient, more effective, and less burdensome. Those actions include:

- Using PA selectively, targeting specific drugs or services prone to wide variation or inappropriate use.
- Streamlining PA requests by leveraging electronic standards and systems.
- Regularly reviewing which services and drugs need PA based on the latest evidence as well as input from providers.
- Actively advocating for new standards to support transparency and communication related to PA information.
- Waiving or reducing PA requirements for certain providers based on their performance or participation in risk contracts and certain patients to promote continuity of care.

It is important for CMS, plans and providers to work together to ensure these processes work as effectively as possible, which is why health insurance providers are continually improving PA

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<sup>80</sup> <https://www.gao.gov/products/gao-18-341#:~:text=GAO%2D18%2D341%20Published%3A,or%20items%20like%20powered%20wheelchairs>

<sup>81</sup> [https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18\\_ch10\\_medpacreport\\_sec-pdf/](https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18_ch10_medpacreport_sec-pdf/)

<sup>82</sup> <https://www.ahip.org/documents/AHIP-1P-Consensus-Statement-Actions-072722-FINAL.pdf>

<sup>83</sup> [2018 Prior Authorization Consensus Statement](#)

programs to reduce physician and enrollee burdens and improve outcomes for patients. We look forward to reviewing and commenting on the Interoperability and PA proposed rule that CMS expects to release sometime this Fall. We also have recommendations below on ways to increase provider adoption of electronic PA (ePA) technology; uniform ePA standards and systems; and effective date and response times.

Gold carding. Health insurers remain committed to improving the PA process. As part of health insurance providers' long-standing commitment to the 2018 Consensus Statement and continued process improvements, AHIP recently surveyed health insurance providers on the use and impact of gold carding programs with a focus on how these programs impact patient care. AHIP's research<sup>84</sup> found that the use of gold carding has increased since 2020—and gold carding programs are most effective when they are used selectively and are continually reevaluated to ensure patients are receiving the high-quality care they deserve. Additional findings include:

- Health insurance providers are using gold carding programs more frequently to improve efficiency and speed.
- Gold carding programs work better for some services than others.
- Gold carding programs include providers with sufficient PA volume and low denial rates.
- Frequent reviews of provider performance are vital.
- Gold carding programs have mixed reviews.
- Concerns about care quality for patients and challenges with implementation are top reasons for discontinuing gold carding programs.

#### **Recommendations:**

- **To realize the benefits of PA while reducing provider burden, AHIP has recommended additional pathways be explored by CMS to increase provider adoption of ePA technology. These pathways could include a combination of: (1) increasing the availability of the technology enabling ePA to providers; (2) increasing the use of the technology where it is already available by identifying and addressing challenges, such as provider readiness and training and workflow integration.**
- **CMS should support parallel use of ePA technology by both providers and plans. If plans are required to make PA information available to providers electronically,**

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<sup>84</sup> <https://www.ahip.org/resources/new-survey-effective-gold-carding-programs-are-based-on-evidence-and-value-for-patients>

**which requires significant investment, providers should have an obligation to use the electronic system.**

- **Any proposed changes to the existing response times for PA requests should allow for an exceptions process and be established through rulemaking. We also believe current response times for PAs submitted in writing should be preserved. Imposing shorter timeframes for manual responses could have the unintended consequence of discouraging provider adoption of ePA standards and systems.**
- **The effective date for any changes to the current PA regulations should provide plans and providers with sufficient lead time to ensure that their systems and workflows fully support ePA standards adopted by the Secretary and that electronic systems have been tested and are fully operational.**

### **C. DRIVE INNOVATION TO PROMOTE PERSON-CENTERED CARE**

Overview of AHIP response: In this section we highlight how MA plans have a long history of innovation in payment models, care delivery, and benefit designs that support the needs of individual enrollees and empower them to achieve better health. MA plans have been at the forefront of engaging with providers to create new payment models that reward value rather than volume and incentivize person-centered care that results in improved health outcomes for patients while making care more efficient and affordable for both individuals and the Medicare program generally. Over the past five years, MA plans outpaced original Medicare and other programs in moving toward value-based payment models. MA plans are also working to bring greater personalization and innovation in benefit designs to enrollees through Centers for Medicare and Medicaid Innovation models such as the VBID model. We identify steps CMS could take to support MA plans and providers along this path, including through additional improvements in data exchanges among plans, providers, and patients. We also address the important role Star Ratings play in driving better quality and outcomes for enrollees and share key recommendations for ways to continue improving the program.

*1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program (MSSP), Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?*

AHIP members are committed to expanding the use of value-based arrangements to better manage and improve the care of enrollees, reduce cost growth, and transform the health care system from one that rewards volume to one that rewards high-quality, coordinated, and affordable care. MA plans strive to support providers at all stages of their value-based payment journey—from easing the transition into innovative arrangements for inexperienced providers to ensuring continued success and sustainability for providers already in value-based contracts. For example:

- Tools and data. One large MA organization collaborated with an EHR vendor to offer providers in value-based contracts enhanced insight into patient information through existing workflows. Specifically, the arrangement supports providers at the point-of-care by supplementing clinical data in real time to give providers necessary insights to identify time-sensitive gaps in patient care.<sup>85</sup> Another MA plan implemented a capitated arrangement for primary care providers across MA, Medicaid, and commercial lines of business that provides contracted physicians access to a risk-adjusted predictive modeling tool that shares quality and utilization data.<sup>86</sup> Another example is an MA plan that partnered with Aledade on a multi-year value-based care contract that includes patients in the MA market. Through this collaboration, the health plan and Aledade work together to provide tools, resources, coaching and support, and data sharing to rural and independent primary care providers.<sup>87</sup>
- Continuous engagement. A health insurance provider in Florida implementing a shared savings collaborative care model for MA patients meets with contracted providers on a regular basis to exchange information, enhance the relationship between the health plan and physician groups, and identify opportunities to improve physician performance.<sup>88</sup> Another MA plan deploys a physician engagement team that collaborates closely with the quality department to support continuous improvement in practices that participate in its capitated model.<sup>89</sup> The engagement teams include physician specialists who each work directly with practices, making regular visits and keeping in close contact to help identify areas for improvement in care and efficiency.

2. *What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in*

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<sup>85</sup> <https://www.athenahealth.com/press-releases/athenahealth-and-humana-collaborate-to-improve-healthcare-outcomes-for-its-members>

<sup>86</sup> <https://www.cdphp.com/providers/programs/enhanced-primary-care>

<sup>87</sup> <https://news.regence.com/releases/regence-and-aledade-collaborate-to-enhance-rural-primary-care-for-members>

<sup>88</sup> <https://www.floridablue.com/providers/programs/medicare-advantage-collaborative-program>

<sup>89</sup> <https://www.cdphp.com/providers/programs/enhanced-primary-care>

*Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?*

AHIP’s members have been leaders in working with providers to transform payment from volume-based to value-based. AHIP partners with the Health Care Payment Learning & Action Network (HCP-LAN) on its annual survey evaluating adoption of alternative payment models (APMs), which showcases how MA plans are working with their provider partners to fundamentally change the way care is provided and reimbursed to reward high-quality, low-cost care rather than volume of services. Most recently, almost 60% of health care payments from MA plans were tied to value-based APMs in 2020, compared to 43% in original Medicare.<sup>90</sup> In fact, since the HCP-LAN began measuring APM adoption by line of business five years ago, MA plans have outpaced the original Medicare program in moving toward value-based payment models (see Table 1).

**TABLE 1. HCP-LAN PAYMENTS MADE THROUGH VALUE-BASED PAYMENT MODELS\***

<b>Payment Year</b>	<b>Aggregate</b>	<b>Commercial</b>	<b>Medicaid</b>	<b>MA</b>	<b>Medicare FFS</b>
<a href="#">2017</a>	33.6%	28.3%	25%	49.5%	38.3%
<a href="#">2018</a>	35.8%	30.1%	23.3%	53.6%	40.9%
<a href="#">2019</a>	38.2%	32.1%	35.6%	50%	41.9%
<a href="#">2020</a>	40.9%	35.5%	35.4%	58%	42.8%

\*Represents payments made in Categories 3 (APMs built on fee-for-service payment architecture) and 4 (population-based payment) of HCP-LAN’s 4 categories of payment.

**Recommendation:**

- **Many of the providers with whom AHIP members have value-based arrangements also serve Medicare FFS patients through MSSP participation. As discussed in more detail in our response to question 5, AHIP believes that aligning cost and quality incentives across payers serves to create synergies that advance the respective programs further and faster.**

<sup>90</sup> <https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/>

*3. What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?*

AHIP encourages CMMI to pursue more multi-payer APM models that include MA plans. Until now, CMMI has primarily focused on demonstrations that test arrangements covering original Medicare beneficiaries. Implementing multi-payer APMs will help make a stronger business case for providers to participate in value-based payment arrangements as they will have a greater total share of revenue flowing through an innovative payment model; and enable them to leverage private sector tools and capabilities. Having stronger provider buy-in will encourage the behavioral changes APMs seek to drive and incentivize providers to make the clinical, operational, and financial changes necessary to succeed in APMs.

**Recommendations:**

- **We recognize that CMMI has implemented a few multi-payer models, such as the Primary Care First model, but believe more of such models should be considered. In addition, to ensure strong plan participation and increase the likelihood of success, CMMI should consider several key elements:**
  - **Ensure stakeholders have timely, clear information about model details. CMS must recognize the operational, business planning, and other aspects of model development and implementation that drive plan decisions about participation. MA organizations need sufficient time to consider opportunities to participate in new models within MA bid cycles and broader business planning processes. They need enough time and information to reasonably project costs and risks of such opportunities including understanding how a new model may impact existing plan offerings, enrollee decisions, and business operations. Decisions about model participation also take place as part of broader strategic planning and decisions around asset deployment, infrastructure investments, and business goals. Models should remain reliable and consistent throughout their lifecycle, from the time of announcement throughout the duration of the performance period, to justify decisions about participation and investment.**
  - **Tap into MA plan expertise by engaging them in the beginning stages of APM design, and not simply seek participation from payers at the implementation stage after key design decisions have already been made. Early and ongoing engagement with MA organizations can ensure new models have the best chance of success through strong, well-conceived participation. AHIP and its members stand ready to work with HHS to bring these capabilities to both multi-payer models and payer-focused models.**

- **Facilitate collaboration with rural providers. AHIP recognizes the unique challenges that rural providers face when considering participation in value-based care and payment models. Many providers, especially those in rural communities, face significant resource constraints and financial challenges. Through collaborative efforts, health insurance providers supporting these providers with the tools, guidance, and support to deliver the benefits of value-based care will both improve the lives of patients and strengthen the vitality of these anchors of primary care in their local communities.<sup>91</sup> We encourage CMS to join with health insurance providers in these efforts.**

*4. How are providers and MA plans incorporating and measuring outcomes for the provision of behavioral health services in value-based care arrangements?*

AHIP believes value-based care models can serve to encourage the use of measurement-based care for behavioral health services. “Measurement-based care” is a process for clinicians to (i) obtain patient progress and outcome data through validated, evidence-based instruments administered throughout treatment, and (ii) use the data to inform clinical care decisions.<sup>92</sup> This might include symptom measures to characterize severity over the course of treatment; quality of life and functioning metrics; and/or patient satisfaction.

Studies have shown that measurement-based behavioral health care is associated with improved outcomes.<sup>93</sup> To help increase adoption of measurement-based care, health insurance providers are testing and implementing innovative approaches to improving behavioral health as part of value-based payment models. To encourage the use of measurement-based care, insurance providers are developing value-based payment arrangements that incentivize use of routine screening/identification standardized tools (e.g., PHQ-2, PHQ-9, AUDIT-C, GAD-7) as well as evidence-based digital health technology tools. They are also using value-based payment approaches to ensure appropriate patient triage, use of pharmacotherapy, and adherence to treatment.

In addition to these individual health insurance provider efforts, the industry has partnered with CMS, as well as primary and specialty societies, consumer and employer groups, and quality

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<sup>91</sup> <https://news.regence.com/releases/regence-and-aledade-collaborate-to-enhance-rural-primary-care-for-members>

<sup>92</sup> Kelli Scott and Cara C. Lewis; “Using Measurement-Based Care to Enhance any Treatment;” Cogn Behav Pract. (Feb. 2015); available at: <https://doi.org/10.1016%2Fj.cbpra.2014.01.010>

<sup>93</sup> See, e.g., Tong Guo, et al.; “Measurement-Based Care Versus Standard Care for Major Depression: A Randomized Controlled Trial With Blind Raters;” Am. J. Psychiatry (Oct. 2015); available at: <https://pubmed.ncbi.nlm.nih.gov/26315978/>. A study evaluated outpatients with moderate to severe depression treated for 24 weeks under measurement-based care comparative to a control group. The study showed more patients in the measurement-based care group than in the standard treatment group achieved response (86.9% compared with 62.7%) and remission (73.8% compared with 28.8%).

collaboratives, through the Core Quality Measure Collaborative (CQMC) to further the improvement and adoption of quality measures across public and private markets.<sup>94</sup> The CQMC has identified a behavioral health core measure set that addresses areas such as depression, use of antipsychotic medications for serious mental illness, alcohol and tobacco use, opioid use disorder treatment, and follow-up after hospitalization or an emergency room visit for mental illness. Additionally, health insurance providers are working through the CQMC to identify gap areas for future mental health and SUD measures. Adoption and alignment of measures across public and private markets will help drive greater provider use of measurement-based care and participation in value-based payment models.

**Recommendations:**

- **CMS should promote adoption of measurement-based care for behavioral health through value-based models.**
- **Such CMS models could either create financial incentives for performing desired activities or embed measures into program requirements. For example, a value-based model could incorporate nationally recognized quality performance measures, such as initiation of maintenance of antidepressant medication therapy and remission; follow-up after hospitalization for mental illness; and screening for people who are using antipsychotic medication.**

*5. What is the experience for providers who wish to simultaneously contract with MA plans or participate in an MA network and participate in an Accountable Care Organization (ACO)? How could MA plans and ACOs align their quality measures, data exchange requirements, attribution methods and other features to reduce provider burden and promote delivery of high-quality, equitable care?*

Studies show that ACOs with value-based contracts across multiple programs achieve greater savings.<sup>95</sup> For example, when ACOs participated in only Medicare ACO programs, only 65% received shared savings payments and 81% generated savings for the Medicare program. On the other end of the spectrum, for ACOs participating in Medicare, Medicaid, and commercial programs, 92% received bonus payments and 100% generated program savings.

A critical part of encouraging provider participation in value-based models across programs, including simultaneous participation in MA and original Medicare value-based arrangements, is aligning performance measures and reporting. Such alignment reduces provider burden; ensures consistent calculation of measures and results; and provides consumers with better information to

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<sup>94</sup> [https://www.qualityforum.org/CQMC\\_Core\\_Sets.aspx](https://www.qualityforum.org/CQMC_Core_Sets.aspx)

<sup>95</sup> <https://www.healthaffairs.org/doi/10.1377/forefront.20211008.785640>

support their decision making. The CQMC was created to align performance measures used to assess clinician quality across public and private payers. As a first step to alignment, the CQMC created parsimonious core sets of measures for 10 clinical areas known to have high costs, variations in quality, and misaligned measures. The CQMC also recognizes the value in aligning health plan and clinician measurement to improve quality across the healthcare system.

The CQMC has looked to efforts like the MA Star Ratings, the Qualified Health Plan (QHP) Quality Rating System (QRS), and the Adult and Child Medicaid Core Sets to inform its core sets of clinician measures. In its second phase, the CQMC is exploring ways in which it could develop best practices on how to align beyond the measures to the full measurement model including data and exchange standards, performance dashboards, consumer descriptions, approaches to reduce disparities, and the like. This broad-based, multi-stakeholder, public-private collaborative will continue to drive progress toward consensus-based voluntary standards that will advance quality outcomes nationwide.

**Recommendation:**

- **We encourage CMS to look to the CQMC to guide its work to define and track progress on core clinical measures that target high-priority health conditions and services. We welcome the opportunity to engage with CMS on the results of the work of the Health Equity for Value-Based Care Workgroup and to collaborate with HHS on the development and implementation of aligned and actionable measures of health equity.**

*7. What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreement (TEFCA) to support improved health information exchange for use cases relevant to MA plans and providers?*

AHIP and its members wholeheartedly support moving to a health care system where data flow seamlessly among appropriate stakeholders to achieve improved wellness and better health outcomes for all Americans.

Improvements to data exchanges. While the CMS Interoperability and ONC 21<sup>st</sup> Century Cures Act final rules represent important first steps to improving interoperability and data flow across stakeholders, we believe enhancements to these policies could improve the availability and quality of health information for all stakeholders. Key issues include the following:

- One-sided rules. The current Interoperability and Cures Act final rules are one-sided. They require plans to share information with providers, but do not require providers to share information with payers. Better data flow between providers and payers would allow payers to better support consumers during critical moments in their health care journeys. In addition to improving patient care, better data flows between payers and providers could also facilitate better quality measurement. Digital measures and the electronic exchange of information through formats such as application programming interfaces (APIs) could reduce the time and resources required to extract data from patient charts or other forms such as the surveys used to generate patient-reported outcome measures.
  - The current Interoperability and Cures Act final rules require plans to build tools such as APIs to make data available to providers, but providers are not required to use them. The rules also do not ensure EHR vendors will build connections to payer tools in their products. Without these connections, providers may not be able to easily access payer tools as part of their workflow, a significant barrier to adoption.
  - The Payer-to-Payer data exchange policies created by the Interoperability Final Rule include unnecessary data, which increases costs in the health care system and increases the risk of inaccurate data exchanges. We agree that the payer-to-payer exchange provides an opportunity to diminish potential disruptions for consumers changing plans and to help ensure continuity of care. However, mandating the exchange of large amounts of unnecessary data can have the opposite effect, requiring the new health insurance provider to sift through (and store) large amounts of irrelevant information looking for the facts necessary to effectively deliver benefits and care. The focus of the payer-to-payer exchange should be on sharing information that will facilitate the consumer's transition from one impacted payer to the next, including providing information necessary to speed new approvals. To support this, CMS should focus on a subset of key coverage, clinical, demographic, claims, and encounter data exchanged in a standardized form and format, which can be easily integrated into the new payer's systems.
- Original Medicare is currently not included in the payer-to-payer data exchange. In a patient-focused, interoperable world, it does not make sense for original Medicare to remain outside these exchanges. With MA plans covering an increasing share of Medicare beneficiaries, original Medicare urgently needs to build a better way of exchanging data with MA plans. For instance, if MA plans have claims history for beneficiaries who switch from original Medicare, they can streamline PA approvals and prioritize members for medication reviews.

TEFCA. We agree that TEFCA holds promise to improve interoperability, including transforming electronic health information to actionable, interoperable health records, promoting Individual Access Services, and making health data accessible to providers at the point of care. TEFCA is also expected to create efficiencies, thereby promoting potential cost and administrative burden reductions.

At this stage, the TEFCA structure is still a work in progress, but much work is taking place within the health sector to realize TEFCA on a voluntary basis. Ultimately, to be successful, TEFCA will require widescale adoption. However, AHIP and its member plans strongly believe that TEFCA participation should remain voluntary at this time. Health insurance providers have invested significant resources in meeting the requirements of the current interoperability requirements. It would be unreasonable to mandate major modifications so soon after the initial implementation of these requirements. Accordingly, ONC and CMS should consider use cases that encourage health insurance providers to participate in TEFCA but not mandate participation.

Identifying which use cases would be most appropriate for health insurance providers including MA plans is challenging at this time. The full impacts cannot be assessed until the process is finalized and it is known which organizations will be serving as qualified health information networks (QHINs). However, AHIP has identified the following potential voluntary use cases that hold promise for creating positive incentivizes for health insurance provider participation in TEFCA:

- Longitudinal Health Records: Impacted payers have already made full-scale claims data available to consumers through the Patient Access APIs. Through this technology, consumers can access their data and share it with an app of their choosing. TEFCA could be leveraged to build on these capabilities by supporting large scale data exchanges through a secure entity that can integrate claims and clinical data, along with other sources such as patient-reported outcomes, to create actionable information and easy-to-use information for consumers. TEFCA could also support a longer-term initiative, developed in collaboration with the industry, that would allow patient-centered data aggregation from multiple entities. Leveraging TEFCA to help consumers build their health records can also protect patient privacy and security while streamlining data flow for all stakeholders. For example, the flow-down provisions of the Common Agreement could fill an important gap in protecting individuals' privacy as many third-party apps are not covered by HIPAA.
- Payer-to-Payer Data Exchange: As CMS reconsiders the payer-to-payer exchange and develops new rulemaking, payers could be provided with the option of meeting the new requirements through TEFCA. By sending data through QHINs, payers would not have to build out extensive point-to-point connections, making the payer-to-payer data exchange

more efficient and reducing the burden of implementation. This could also alleviate some of the current technical challenges such as a lack of digital endpoints and accurate patient matching. Given that the Recognized Coordinating Entity (RCE) expects to onboard QHINs in 2022, it may benefit all parties to delay the payer-to-payer exchange implementation deadline to enable payers to leverage TEFCA to meet these requirements.

**Recommendations:**

- **CMS and ONC should add new requirements in the Interoperability and Cures Act Final Rules to require health care providers to share data with plans.**
- **If CMS proposes requirements for plans to build APIs to support functions like PA, we urge CMS and ONC to establish specific requirements for EHR developers to include these functions in their technologies as part of the Certified Electronic Health Record Technology (CEHRT) program and for providers to use such technology as part of the Merit-based Incentive Payment System (MIPS) and information blocking regulations. CMS could also explore ways to incentivize health care providers to share other administrative data with payers that can improve consumer tools like provider directories by streamlining collection of information and improving its accuracy. For technology to achieve its full potential, it must be adopted and used by all stakeholders.**
- **We recommend that CMS revisit the Payer-to-Payer data exchange policies created by the Interoperability Final Rule to ensure data accuracy and minimize burden. CMS should separate the goal of creating longitudinal consumer health records from the goal of supporting consumer transitions between payers. Consumer data beyond that which is needed for care coordination among payers is, and should remain, a component of the Patient Access API rather than the payer-to-payer exchange. CMS should also include original Medicare in payer-to-payer data exchange.**
- **In expanding interoperability provisions to include MA plans, we recommend CMS develop an API that allows MA plans to access data from Parts A and B of original Medicare to show the government's commitment and stake in data exchange. Such an API should be aligned to TEFCA, which would help accelerate TEFCA adoption overall.**
- **TEFCA participation should remain voluntary. However, ONC and CMS should ensure the inclusion of use cases in TEFCA that will make such voluntary participation attractive not only to healthcare providers but to payers as well. For example, to encourage adoption and ensure TEFCA realizes its potential, CMS and**

**ONC should advance use cases that address unmet needs or could leverage technology to reduce burden. By meeting these needs, ONC and CMS could foster desire by health insurance providers and other stakeholders to join TEFCA and facilitate nationwide data sharing. Specific pilots for plans and providers can be tried for MA, particularly in integrated delivery systems and value-based networks where interoperable data can be leveraged to provide better services to consumers.**

*8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?*

Value of Star Ratings. The MA Star Ratings program incentivizes plans to achieve high performance on quality and plays a vital role in helping millions of diverse individuals continue to have access to high-quality, coordinated care, affordable benefit offerings, and options they deserve and rely on. The Star Ratings program is a complex, rigorous quality incentive program that includes 40 measures in the program that plans are scored on and over 40 measures on display. The measure set includes administrative measures developed by CMS, process and outcomes-based quality measures developed by the NCQA and Pharmacy Quality Alliance (PQA), beneficiary experience of care measures from surveys, and other measures.

MA plans with Star Ratings of at least 4 stars receive increased funding as an incentive to achieve high performance. In turn, high performing plans use Star Ratings rebate funds to reduce cost-sharing and offer additional benefits to Medicare enrollees. For example, MA plans can offer dental, vision, and hearing aid benefits, as well as other benefits, including those that can address socioeconomic barriers to health.

Star Ratings is one of many factors reflected in the MPF tool to help Medicare enrollees choose between available plans in their service area. For enrollees unfamiliar with the MA Star Ratings program, the MPF tool has a pop-out feature that describes the Star Ratings score as the overall rating of plan quality and performance and there is also a link to more detailed information for enrollees who are interested to learn more about the Star Ratings program and measures.

Given the value of the Star Ratings program to MA enrollees, AHIP has serious concerns with certain proposals for significant changes, such as MedPAC's replacement proposal<sup>96</sup> which "could negatively impact most plans."<sup>97</sup> MedPAC's proposal focuses on a small set of outcomes measures, lacks appropriate risk adjustment for social risk factors, and would limit the number of quality bonus plans. In turn, the proposal could result in fewer additional benefits offered by plans or increase cost sharing requirements for Medicare enrollees. AHIP strongly opposes

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<sup>96</sup> MedPAC, Replacing the Medicare Advantage quality bonus program, June 2020.

<sup>97</sup> Avalere, MedPAC Proposes Replacement for MA Star Ratings Program, August 2020.

changes to the MA Star Ratings program that would negatively impact Medicare enrollee benefits and choices.

We have several recommendations below for improving the Star Ratings program.

**Recommendations:**

- **AHIP strongly supports the overall design of the MA Star Ratings program.**
- **We renew our prior recommendation that the MA Star Ratings measure set focus on evidence-based clinical quality measures and patient experience measures. We do not support the inclusion of compliance-related measures as we have indicated in prior comment letters.<sup>98</sup>**
- **The following are additional AHIP recommendations for targeted improvements that would further the goals of enhancing quality while avoiding negative impacts on enrollees:**
  - **Improvements to the CAHPS survey. MA plans value the data generated by enrollee experience surveys and strive to provide the best experience possible for their beneficiaries. We remain concerned, however, that declining response rates to the Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys will skew results. This will cause unfair penalties under provider and plan quality measurement programs based on CAHPS and provide consumers with misleading information about enrollee experiences. We recommend CMS pursue a comprehensive evaluation and field testing of improvements to the CAHPS survey and propose improvements based on findings and results for public comment. Components of this approach include the following:**
    - **Discuss with AHIP and MA plans possible accommodations for 2023 MA Star Ratings during the second preview period. Such options (e.g., retain the current weighting of CAHPS measures at two or institute a hold harmless for affected contracts) should account for the impact of low response rates on CAHPS measure scores, especially as the results will be more heavily weighted this year in comparison to prior years. CMS should also ensure there are meaningful differences between cut points for CAHPS measures.**
    - **Assess the impacts of COVID-19 and other factors on CAHPS survey response rates and survey results for 2023 MA Star Ratings. These findings**

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<sup>98</sup> <https://www.ahip.org/documents/AHIP-CY2023-AN-Comment-Letter-with-Wakely-Analysis-Final.pdf>

should be shared with health insurance providers and other stakeholders to ensure full transparency about the impacts.

- **Continue working with the Agency for Health Research and Quality (AHRQ) and NCQA to research longer-term solutions to improve the CAHPS survey and response rates. Potential approaches could include creating a web-based response option; reducing the length of the survey; increasing sample size; and revising the questions to better reflect the current health care delivery system, including use of telehealth and non-physician clinicians. Additionally, removing questions from surveys outside a health insurance provider's control or with low reliability and validity would make room on the survey for questions that could be used to measure emerging quality issues and address health equity concerns without increasing the burden on respondents.**
- **Continue work to align measures. We also strongly support alignment of measures across quality measurement programs for plans and providers, where appropriate. Thus, we believe this fresh review of CAHPS should be applied across the board to all survey versions, including HCAHPS.**
- **Provide more actionable data. We also have heard from our members that it would be helpful if CMS could provide more actionable data from the CAHPS surveys (e.g., results specific to provider groups) so that plans can be more targeted in their activities for improving enrollee experience.**
- **Other Star Ratings improvements. We look forward to engaging with CMS on additional Star Ratings improvements including:**
  - **Disaster Relief Policy Considerations. We support consideration of enhancements to the disaster relief policy, including extending the policy to cover a wider range of local and federal disaster or emergency declarations and providing relief for plans subjected to a disaster that spans more than one year and for new plans impacted by a disaster or emergency during their first year of ratings, while not adversely impacting unaffected plans.**
  - **CAI Methodology Support and Improvements. We continue to support the use of the Categorical Adjustment Index (CAI) methodology as an interim solution to account for disparities in MA plan performance associated with socioeconomic status (SES), including adjustments based on low-income subsidy and dual eligible (LIS/DE) and disability status. We welcome engagement with CMS to address volatility some plans have experienced in**

**their scores from year to year and consider other changes. For example, CMS should hold plans harmless from a reduction in Star Ratings due to the CAI and ensure this adjustment is more impactful. We also look forward to engaging with CMS to develop a long-term solution.**

- **Cut Points Methodology Improvements.** To ensure the diverse Medicare population has access to high-quality plan options, we continue to recommend CMS consider setting cut points for Star Ratings measures well in advance of the measurement period. This would enable MA plans and their network providers to better manage their quality care and health equity improvement efforts. Additionally, we ask CMS to delay implementing a change to the cut point methodology scheduled to take effect for 2024 Star Ratings that would exclude performance “outliers” when setting cut points. This technical change could adversely impact scores and should not be considered until concerns with the methodology are addressed and the agency ensures cut points reflect meaningful differences.
- **HOS Improvements.** The two Health Outcomes Survey (HOS) measures, **Improving or Maintaining Physical Health and Improving or Maintaining Mental Health**, are on the display page for 2023 Star Ratings. We continue to recommend CMS engage with AHIP and our members on improvements being made to these measures, including assessment of adjustments for addressing the significant variability in plan performance year to year and reliability issues with patient reported outcome measures.

*9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?*

AHIP strongly supports CMMI’s interest in designing and testing new and innovative care delivery and payment models to increase quality and more equitable, person-centered care, particularly for enrollees with serious illness. Approximately 80% of older adults are living with at least one chronic condition, and nearly 70% live with at least two chronic conditions.<sup>99</sup> Research has shown that many of these older adults are more likely to fall behind in managing their health and suffer from social determinants of health.

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<sup>99</sup> <https://www.ncoa.org/article/get-the-facts-on-healthy-aging>

Health insurance providers have a track record of success in efforts that include integrating and coordinating care for patients, mitigating the harm of chronic diseases, addressing the needs of vulnerable individuals, applying evidence-based clinical practices, and promoting clinically sound drug usage. As an example of how MA plans are working to better address the needs of members, one national insurance provider implemented a pilot for MA members living with multiple chronic conditions and complex congestive heart failure and diabetes in Kentucky, Pennsylvania, and West Virginia. These multi-disciplinary care teams, which bring together a diverse set of experiences and clinical knowledge, include a nurse, pharmacist, social worker, and a behavioral-health specialist.<sup>100</sup> Another national plan is piloting a program for its MA members in New York who live with chronic conditions by expanding access to health services in members' homes. Examples of the types of care members can receive under the program include acute and urgent services such as wound care, lab draws, catheter maintenance, and adherence to medication therapies, as well as medication management, home safety checks, and health screenings. The personalized services also include member access to 24/7 availability from a dedicated Landmark health care provider. Ongoing nutrition, medication therapy, and emotional and mental health support will help ensure members receive a comprehensive continuum of care. As part of that care, in-home providers will also share data with members' primary care physicians.<sup>101</sup>

Common definitions. To further support such innovations, CMMI could take the lead in developing a common set of definitions and goals around such initiatives. One example would be specifics about how the agency defines person-centered care, including what successful person-centered care looks like, and how enrollees would define person-centered care. Ensuring all partners have a common understanding of successful models is a key foundation for progress.

Having a set of agreed-upon definitions helps facilitate collaboration. One model is the HCP-LAN, which works to create standardized definitions related to value-based care. Its APM framework<sup>102</sup> has been used by health insurance providers, state Medicaid agencies, and researchers in their respective work to evaluate and promote adoption of value-based models. The HCP-LAN recently solicited public input on a standardized definition of "accountable care" and assessment tool evaluating commitment to accountable care.<sup>103</sup> AHIP appreciates both the HCP-LAN's efforts to create common frameworks and definitions, as well as the opportunity to provide feedback at the development stage.

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<sup>100</sup> <https://press.humana.com/news/news-details/2021/Humana-Launches-Humana-Care-Support-Pilot-to-Help-Medicare-Advantage-Members-to-Better-Manage-Their-Chronic-Conditions/default.aspx#gsc.tab=0>

<sup>101</sup> <https://www.landmarkhealth.org/aetna-and-landmark-health-working-together-to-bring-in-home-health-services-to-medicare-advantage-members-in-new-york/>

<sup>102</sup> Health Care Learning Action Network. APM Framework. <https://hcp-lan.org/apm-framework/>.

<sup>103</sup> For more information, see <https://hcp-lan.org/public-feedback/>.

Rural access. In addition, an important area of focus for new CMMI models should be improving access to care for rural populations, including expanding the availability of MA plans and the benefits they provide. A recent report from MedPAC finds that almost all Medicare beneficiaries residing in rural areas have access to at least one MA plan in 2022. However, the same report confirms that rural beneficiaries enroll in MA at lower rates than their urban counterparts: MA penetration in rural areas ranges from 33% to 41%, compared with MA penetration of 51% in metropolitan areas.<sup>104</sup> Improving access to MA in rural areas is an important step in reducing health disparities, ensuring equity in access to cost protections and supplemental benefits, and improving health outcomes for rural residents.

While MA plans are working to make MA available to beneficiaries in rural areas, difficulties in building provider networks that meet CMS' network adequacy requirements, along with higher costs of providing access in rural areas, makes it challenging to offer reduced premiums, lower cost sharing, and valuable supplemental benefits in these areas. For example, rural beneficiaries are less likely to have access to a \$0 premium MA plan (beyond the standard Part B premium) that includes prescription drug coverage.<sup>105</sup>

#### **Recommendations:**

- **As noted in response to prior questions, AHIP recommends that CMMI pursue more multi-payer demonstrations; urges the agency to leverage private sector tools, capabilities, and expertise by involving private payers in the beginning stages of model design rather than solely seeking participation from payers at the implementation stage; and notes that timely, clear information about model details is critical.**
- **We recommend CMMI develop a demonstration focused on enhancing the ability of MA plans to offer attractive plan designs in rural areas where higher costs or other barriers now limit such designs. Components of such a demonstration could include: increased network adequacy flexibility; an elimination of the benchmark cap created by the Affordable Care Act for MA plans in rural areas so enrollees have access to the supplemental benefits that result from MA plan efficiencies and higher Star ratings; increased rebate percentages to address the higher costs of delivering benefits in rural areas; calculation of MA benchmarks using only those beneficiaries who are eligible to enroll in MA; and enhanced rebates for plans that pay higher rates to providers in Health Professional Shortage Areas, or when MA**

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<sup>104</sup> Medicare Payment Advisory Commission. A Data Book: Health care spending and the Medicare Program. July 2022. [https://www.medpac.gov/wp-content/uploads/2022/07/July2022\\_MedPAC\\_DataBook\\_SEC\\_v2.pdf](https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf)

<sup>105</sup> Id.

**plans provide funding to build telehealth treatment capacity to providers in medically underserved areas.**

Supplemental benefits flexibility. MA plans have used the flexibilities provided by the Bipartisan Budget Act of 2018 to offer SSBCI to enrollees with chronic illnesses—benefits such as structural home modifications, expanded transportation services, grocery delivery, or social needs benefits—all with the aim of removing social barriers to improved health. These supplemental benefits allow plans to address whole-person health by reaching beyond traditional health benefits to address the social and economic needs that have a very real, though indirect, impact on access to care and health outcomes. However, plans could do more to help address enrollees’ social determinants of health if granted greater flexibility in determining eligibility for “non-primarily health-related” supplemental benefits.

**Recommendation:**

- **We encourage CMMI to design a model that allows plans the flexibility to offer non-primarily health-related supplemental benefits to enrollees based on the individual’s income, as determined by eligibility for partial Medicaid benefits and/or functional need.**

Behavioral health integration. As discussed above in our response to question 4 under Section B, Expand Access: Coverage and Care, an important area of focus for health insurance providers including MA plans has been integrating mental health support into primary care settings. Integrated behavioral health care blends care for medical conditions and related behavioral health factors, such as mental health and SUD, life stressors and crises, or stress-related physical symptoms that affect a patient’s health and well-being.<sup>106</sup> Integration of behavioral health care with primary care has been identified by many stakeholders as a strategy not only to improve access and quality, but also to reduce disparities and promote equity.<sup>107</sup>

**Recommendation:**

- **We recommend CMS support team-based care to improve access and optimize the existing workforce by exploring alternative payment models through CMMI that support behavioral health integration.**

*10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity?*

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<sup>106</sup> [https://ahiporg-production.s3.amazonaws.com/documents/202202-AHIP\\_IB\\_Behavioral\\_Health\\_Integration-004.pdf](https://ahiporg-production.s3.amazonaws.com/documents/202202-AHIP_IB_Behavioral_Health_Integration-004.pdf)

<sup>107</sup> Id.

**Recommendation:**

- **As mentioned in previous sections, we recommend that CMS expand the eligibility criteria for SSBCI through the CMMI MA-VBID demonstration. For example, the eligibility criteria for SSBCI could be expanded to include partial duals and enrollees who demonstrate functional need.<sup>108</sup> Expanded eligibility criteria for supplemental benefits would ensure that more Medicare enrollees in need receive these important benefits.**

*11. What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID Model? What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?*

**Recommendation:**

- **AHIP supports CMMI’s testing of the inclusion of the Part A hospice benefit within the MA benefits package through the hospice benefit component of the VBID model. We support continued testing of the model and look forward to continued engagement with CMMI and AHIP member plans participating in the model on potential improvements and expansion of the model.**

*12. What issue specific to Employer Group Waiver Plans (EGWPs) should CMS consider?*

EGWPs are a type of MA plan through which employers offer benefits to retirees, including Medicare covered services and additional benefits determined by the employer. They offer employers an opportunity to combine Medicare’s covered medical services, prescription drug coverage, and valuable supplemental benefits to their retirees in an efficient, cost-effective way.

EGWPs play an important role for both employers and retirees, ensuring access to integrated health coverage and benefits that satisfy both Medicare requirements and employer commitments to employees. More than five million beneficiaries receive their Medicare benefits through an MA EGWP, more than double the number of a decade ago, a testament to the value these products offer to employers seeking to provide retiree health benefits despite growing costs and economic pressures.<sup>109</sup>

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<sup>108</sup> <https://atiadvisory.com/wp-content/uploads/2021/12/Two-Pager-Policy-Recommendations-for-the-Administration-to-Advance-Non-Medical-Supplemental-Benefits.pdf>

<sup>109</sup> Kaiser Family Foundation. Medicare Advantage in 2022: Enrollment update and key trends. August 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>.

**Recommendations:**

- **AHIP generally supports CMS' policies designed to ensure EGWPs are able to provide innovative benefits along with Medicare-covered services. However, we believe CMS should change the way EGWP payments are calculated by removing negative margin bids when calculating bid-to-benchmark ratios for EGWPs. The inclusion of these negative margin plans in the calculation lead to payment rates that do not accurately reflect the expected experience of EGWP plans and jeopardize the important benefits EGWPs provide to beneficiaries and employers.**
- **CMS should offer continued flexibility to EGWPs so that they can meet the needs of both employers and beneficiaries who receive care through them.**
- **CMS should also allow EGWPs to participate in the VBID model.**

**D. SUPPORT AFFORDABILITY AND SUSTAINABILITY**

Overview of AHIP response: In this section we highlight the tremendous successes of the MA program in providing access to affordable, high-quality health care. The growth of the program is a testament to the value MA offers to all beneficiaries, including those with chronic illnesses that require care management and those with low incomes who rely on MA's access to additional benefits at little or no cost. Given these successes, our response emphasizes the need for CMS policies that support further program growth and ensure plans have the flexibility and tools to continue improving quality and innovating on behalf of their enrollees. We include data and studies that show MA plans deliver Medicare benefits and services far below original Medicare's costs; provide higher quality care; and offer enhanced benefits compared to original Medicare. We include a detailed explanation of why an appropriate comparison between MA and original Medicare would affirm that MA costs less, on average, than original Medicare. We discuss how MA plans are working to ensure efficiency in payment and recommend improvements to payment methodologies, including longstanding AHIP positions on benchmarks and ESRD payments. We also address various risk adjustment issues, including the proposed risk adjustment data validation (RADV) rule.

*1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?*

The value of MA: better cost, better quality. As data from MedPAC shows, MA plans deliver Medicare benefits far more efficiently than original Medicare. MedPAC's estimate for 2022 is that MA costs are, on average, 15% lower than original Medicare for delivering Part A and B

Medicare benefits.<sup>110</sup> Based on Medicare Trustee estimates of fee-for-service (FFS) Medicare spending,<sup>111</sup> that 15% translates into more than \$65 billion in reduced costs in 2022 alone. A portion of those savings is retained by the federal government and a portion is provided to MA enrollees in the form of reduced cost sharing, coverage of prescription drug benefits, and additional benefits not provided by the original Medicare program such as dental, vision, hearing, transportation, and supplemental benefits targeted at the needs of chronically ill enrollees.

These data show that private plans, using tools such as provider networks, care management, and value-based payment to drive greater efficiency, are delivering Medicare benefits for less money than the original Medicare program, which relies on government-established payment rates with limited oversight of efficiency and quality.

In addition to providing care at lower cost, numerous studies show MA plans provide higher quality care for their enrollees. Peer-reviewed research has found that MA plans outperform traditional Medicare across a range of metrics, including better access to preventive care and better clinical outcomes.<sup>112</sup> For example, MA enrollees are more likely to receive important preventive services like annual wellness exams and cognitive screenings than their counterparts in original Medicare.<sup>113</sup> And MA has been shown to provide better quality of care on various clinical quality measures.<sup>114,115</sup>

We acknowledge there have been criticisms, based primarily on annual analyses performed by MedPAC, that allege total government spending on the MA program is higher on average than costs for original Medicare. According to MedPAC's most recent estimates, MA payments are

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<sup>110</sup> Medicare Payment Advisory Commission. March 2022 Report to the Congress.

<https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>.

<sup>111</sup> The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. June 2022. <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>

<sup>112</sup> DuGoff, Eva, Rabak, Ruth, Diduch, Tyler, et al. Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. *The American Journal of Managed Care* 27(9). September 2021.

<sup>113</sup> Jacobson, Mireille, Thunell, Johanna, and Zissimopoulos, J. Cognitive Assessment at Medicare's Annual Wellness Visit in Fee-For-Service and Medicare Advantage Plans. *Health Affairs* 39 (11): 1935–1942. November 2020.

<sup>114</sup> Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.

<sup>115</sup> Agarwal, Rajender, Connolly, John, Gupta, Shweta, et al. Comparing Medicare Advantage and Traditional Medicare: A Systematic Review. *Health Affairs* 40(6): 937-944. June 2021.

about 4% higher, on average, than original Medicare spending in 2022 when estimates relating to risk adjustment coding are taken into account.<sup>116</sup> However, these criticisms are misplaced.

- MedPAC’s estimate of original Medicare spending fails to make an appropriate apples-to-apples comparison of the programs. For example, MedPAC’s analysis improperly includes beneficiaries who are not eligible to enroll in MA. In order to enroll in an MA plan, an individual must be eligible for and enrolled in both Parts A and B of Medicare. As we note in more detail below, the failure to account for these differences in the underlying population results in biased estimates that suggest average spending in original Medicare is lower than it would be if based on the MA-eligible population. MedPAC’s spending analysis also ignores the maximum out-of-pocket (MOOP) protection that applies to MA plans but not original Medicare. A forthcoming study by Wakely Consulting Group finds that if a MOOP were included in original Medicare, average costs in original Medicare would increase by 3.5%, while including only those enrolled in both Parts A and B of original Medicare would increase original Medicare costs by 5.9%. Taken together, these two differences show that actual FFS costs for the appropriate population and appropriate set of required benefits are more than 9% higher than MedPAC estimates and result in a very different conclusion about MA costs relative to original Medicare.
- MedPAC’s analysis is based on projected spending for the coming year, rather than on actual spending. Actual spending in a given year, particularly for original Medicare, is likely to differ from projections due to unanticipated utilization due to higher or lower incidence of illness, changes in the cost of drugs, or Congressional actions that change the amount Medicare pays providers. A 2020 MedPAC analysis purported to show that average MA spending over the previous decade exceeded average spending in original Medicare.<sup>117</sup> However, a subsequent analysis by Health Management Associates found that MedPAC’s analysis was flawed. After correcting for those flaws, HMA’s analysis showed that over the past decade average MA spending in fact was consistently below that of original Medicare.<sup>118</sup>
- In addition to direct comparisons between MA and original Medicare spending, it is important to consider the role that MA plays in helping providers move away from

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<sup>116</sup> Medicare Payment Advisory Commission. March 2022 Report to the Congress. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf)

<sup>117</sup> Burton, Rachel, and Morein, Molly. MedPAC September 2020 Public Meeting: Context for Medicare payment policy. September 2020. [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/meeting-materials/medpac\\_context\\_sept\\_2020.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/meeting-materials/medpac_context_sept_2020.pdf)

<sup>118</sup> Health Management Associates. Memo to Anthem Public Policy Institute. November 18, 2020. <https://www.ahip.org/documents/20201118-Anthem-PPI-MedPAC-Spending-Estimates-Memo.pdf>

volume-based payment to provide more efficient value-based care. Numerous studies have demonstrated the “spillover” effects of MA; in areas where MA penetration is high, providers treat all their patients as efficiently as they treat MA patients, resulting in lower original Medicare spending.<sup>119,120,121</sup> Those effects should be taken into account in spending comparisons of the programs.

- AHIP has consistently raised concerns that CMS is not appropriately calculating MA benchmarks from an actuarial perspective. Those benchmarks not only improperly reduce payments to MA plans; they lead to a false comparison of the programs because comparisons between MA payments and original Medicare payments are typically based on those benchmarks. As noted above, a Medicare beneficiary must have both Part A and Part B to be eligible for MA plan enrollment, yet CMS calculates rates based on enrollees with either Part A or Part B. Data show that enrollees with only Part A coverage on average have significantly lower Part A costs than those with both Part A and Part B. Actuarial principles require that an estimate of the benchmark represent what an enrollee in MA would cost in original Medicare. Research from HMA, an independent consulting firm, found that in 2018, 14% of beneficiaries in original Medicare were enrolled in Part A only, and that the share has grown over the past decade, making the disparity greater every year that CMS fails to make the change.<sup>122</sup> By using claims experience from original Medicare beneficiaries who are not eligible to enroll in MA, CMS is calculating benchmarks that do not appropriately estimate what would have been paid for the same beneficiary had they remained in original Medicare.<sup>123</sup>
- Critics fail to acknowledge the chronic and growing underpayment for ESRD enrollees. AHIP has repeatedly highlighted to CMS that payment rates for enrollees with ESRD do not adequately cover the costs of providing care to those enrollees in the MA program. We believe fair comparisons of the program should take into account the unique factors affecting ESRD. Specifically, the highly concentrated dialysis provider market leverages network adequacy requirements to demand unfair contracting terms from MA plans for

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<sup>119</sup> Park, S., Langellier, B., Burke, R., et. al. “Association of Medicare Advantage Penetration With Per Capita Spending, Emergency Department Visits, and Readmission Rates Among Fee-for-Service Medicare Beneficiaries with High Comorbidity Burden.” *Medical Care Research and Review*. 78(6): 703-712. <https://journals.sagepub.com/doi/abs/10.1177/1077558720952582>.

<sup>120</sup> Feyman, Y., Pizer, D. Frakt, A. “The persistence of medicare advantage spillovers in the post-Affordable Care Act era.” *Health Economics*. November 2020. <https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4199>

<sup>121</sup> Baicker, K., Chernew, M., and Robbins, J. “The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization.” *Journal of Health Economics*. Volume 32(6): 1289-1300. <https://www.sciencedirect.com/science/article/abs/pii/S0167629613001124?via%3Dihub>

<sup>122</sup> Health Management Associates. Memo to Anthem Public Policy Institute. November 18, 2020. <https://www.ahip.org/documents/20201118-Anthem-PPI-MedPAC-Spending-Estimates-Memo.pdf> .

<sup>123</sup> CMS has made this adjustment to the benchmark rates for Puerto Rico since 2012.

dialysis services, while the original Medicare program sets its prices without regard to negotiation and therefore is unaffected by such market distortions.<sup>124</sup> The lack of competition is compounded by outdated conditions of participation for dialysis providers that hamper increased use of home dialysis. In addition, MOOP limits apply to ESRD costs in MA but not to such costs in the FFS program. This has resulted in many MA plans incurring costs for dialysis services well above original Medicare rates, with MLRs in excess of 1 for these enrollees (well above average MLRs for other enrollees).<sup>125</sup> A recent Health Affairs article found that MA plans paid 27% more, on average, than Medicare's FFS payment rates for ESRD. The article also found that the higher prices were predominantly attributed to two large national dialysis providers.<sup>126</sup> An analysis by Wakely Consulting Group found that in 2020, average MLRs for ESRD enrollees were 28% higher than MLRs for non-ESRD enrollees.<sup>127</sup> Moreover, the problem will likely get worse, as CMS projects that by 2023 almost 1% of all MA enrollees will have an ESRD diagnosis, a 48% increase from 2020. As the share grows, it becomes increasingly more likely that higher costs of caring for these enrollees can result in higher premiums or reduced benefits for all plan members.

The problem of inadequate ESRD payment is exacerbated by the fact that ESRD disproportionately affects people of color and low-income beneficiaries. For example, according to the United States Renal Data System 2021 Annual Report, the incidence of ESRD was 3 times higher among blacks than whites in 2019<sup>128</sup>, while other research has shown lower rates of access to pre-ESRD kidney care for low-income populations. Further, data show people with other serious illnesses such as diabetes and heart disease are at greater risk of developing kidney disease and ESRD. Inadequate payments for ESRD mean that enrollees are more likely to see higher premiums, reduced benefits, and fewer resources available to coordinate care and manage the complex needs associated with multiple chronic illnesses.

- Legislative and regulatory changes are making certain parts of the MA program more costly. For example, most MA plans apply savings toward payment of Part D coverage

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<sup>124</sup> Two companies own over 70% of all dialysis centers. See: Milliman. Medicare Advantage: Eight critical considerations for every organization as ESRD eligibility expands in 2021. December 2019. Available online at: <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicare-advantage-eight-critical-considerations.ashx>

<sup>125</sup> See: [https://www.ahip.org/documents/AHIP-2021-Advance-Notice-Comment-Letter\\_WakelyReport.pdf](https://www.ahip.org/documents/AHIP-2021-Advance-Notice-Comment-Letter_WakelyReport.pdf)

<sup>126</sup> Lin, E., By, B., Duffy, E., et al. "Medicare Advantage Plans Pay Large Markups to Consolidated Dialysis Organizations." *Health Affairs* 41, No. 8 (2022): 1107–1111. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.02009>

<sup>127</sup> Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. March 2022. Available online at: <https://www.ahip.org/resources/2023-medicare-advantage-advance-notice>

<sup>128</sup> See: <https://adr.usrds.org/2021/supplements-covid-19-disparities/14-racial-and-ethnic-disparities>.

for their enrollees. However, changes in the recently passed Inflation Reduction Act, combined with a series of regulatory changes in recent years including the mandate for including pharmacy discounts in point-of-sale prices, will place significant pressure on Part D premiums. Those pressures in turn will limit the additional benefits MA plans can offer or result in higher premiums.

In summary, MA payment policy currently works to promote high-quality, cost-effective care for enrollees and the Medicare program. As noted, the MA program is able to deliver identical benefits more cost-effectively than original Medicare; delivers higher quality care than original Medicare; serves a population with greater diversity, lower income, and more medical needs than original Medicare; and delivers significantly more benefits and savings for enrollees at total spending that on average is below original Medicare (when appropriate adjustments are made to ensure a fair comparison).

Thus, any policy changes that CMS may explore with respect to payments or quality need to build on (and not undermine) these successes. For example, payments to MA plans must continue to reflect the expected health care costs of enrollees and create incentives for continued quality improvement. Risk adjustment and the Quality Bonus Program (QBP), together with benchmarks based on the costs of providing care through the original Medicare program, form the foundation of a payment system that promotes equity in payment across sociodemographic groups and health conditions and ensures that all enrollees benefit when plans provide high quality care.

#### **Recommendations:**

- **AB Benchmarks:** We urge CMS to revise the way all MA benchmarks are determined to include only individuals enrolled in Parts A and B in calculating FFS costs and MA benchmarks.
- **ESRD:**
  - **State-based rates.** In the 2023 Advance Rate Notice, CMS discussed a potential change to the way ESRD benchmarks are set. The change would move from the current state-based ESRD rates to Core-Based Statistical Area (CBSA) rates and would address a long-standing concern that state-based ESRD benchmarks mask large disparities in ESRD costs within a state. CMS did not finalize the change and will continue calculating ESRD benchmarks at the state level. AHIP supports the use of CBSAs or another sub-state geographic unit as the basis for calculating MA ESRD benchmarks. To address the impact of sub-state rating areas, CMS should apply an adjustment to the rates in rural and underserved areas to ensure access to care for enrollees. Similar to the use of rate

- adjustments in rural areas in many Medicare FFS payment systems, such an adjustment here would reflect the higher costs of providing care and building adequate networks in areas with fewer providers.**
- **MOOP**. We urge CMS to fully reflect the costs of ESRD in MOOP limits. In a final rule published earlier this year, CMS set a schedule for incorporating the full impact of ESRD costs on MOOP limits in future years, but also applied a cap on the amount MOOP limits may increase each year. For 2023, that cap results in far less of the ESRD costs being reflected in the MOOP than CMS' stated policy. As a result, MA plans serving larger shares of ESRD enrollees face higher costs and greater pressure to raise premiums and reduce benefits for all enrollees.
  - **ESRD**. We urge CMS to take additional steps to address the inadequacy of payments for ESRD enrollees overall. As the number of ESRD enrollees in MA grows, the need for benchmarks that fully reflect the costs of care MA plans face in ensuring high quality care for these enrollees will increase, and failure to act will lead to diminished benefits and higher costs for all enrollees. We also recommend CMS modernize the Conditions for Coverage (CfC) for ESRD facilities to support innovations in self-care, home dialysis, and telehealth for dialysis patients; remove barriers and streamline regulations for home-focused providers to expand patient access to home dialysis and self-dialysis; and promote access to care through alternative delivery sites.
  - **Part D**. CMS should focus on ways to limit further premium pressures under the Part D program.

*2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?*

If CMS were to explore potential methodological changes in the risk adjustment system, including ways that risk adjustment could drive health equity and address SDOH, we urge the agency to consider several key issues:

- **MA plans assume financial risk**. Risk adjustment is an essential component of a fair and equitable payment system that incentivizes plans both to enroll individuals regardless of their health care needs and to find ways to improve the health of sicker enrollees. The MA payment system requires that plans assume financial risk for the individuals choosing to enroll in the plan. To ensure that all plans have an incentive to enroll eligible

individuals, regardless of their level of medical need, payments are adjusted to reflect the relative risk of the plan's enrollees.

- Risk adjustment ensures access to care and benefits. Risk adjustment is an essential component of an equitable system for improving enrollee health. Having a complete inventory of enrollees' health conditions and risks is essential to the MA plan's ability to integrate care, manage chronic conditions, improve wellness, and ensure quality of care. Risk adjustment is especially vital in ensuring that all enrollees have access to a similar level of care and benefits, regardless of their ability to pay. Diagnosis codes come from physicians and other health providers, who have the most frequent, immediate, and personal interactions with patients. Without risk adjusted payments, the availability of reduced cost sharing, enhanced care management and coordination services, or supplemental benefits that help improve overall health would be based entirely on an individual's ability to pay higher premiums for a plan that includes such services. Risk adjusted payments ensure that plans have resources to provide these benefits to all enrollees. In this way, risk adjustment is a core precept of an equitable health care system.
- Original Medicare is the wrong benchmark. Original Medicare is the wrong benchmark for comparing the appropriateness of MA plan coding practices because the MA payment system promotes more accurate coding to support coordinated and integrated care. While diagnosis codes submitted by MA plans for their enrollees' medical conditions are used by CMS to determine enrollee risk scores, and comprehensive coding of enrollee health conditions is important for quality of care in MA, coding is often considered less important by providers in the original Medicare program (where payment depends largely on the service provided, rather than the patient's diagnosis).

Moreover, the risk adjustment system is designed to encourage MA plans to focus on treatment of chronic diseases, unlike the original Medicare program. Among the tools MA plans use to identify chronic conditions and diseases are health risk assessments (HRAs) and chart reviews. CMS considers HRAs a best practice for all MA plans and requires them for SNPs. Chart reviews are also an important tool that reduces provider burden. Several reports critical of MA coding have focused on the use of diagnosis codes identified through HRAs and chart reviews. Importantly, none of these reports find that diagnoses resulting from HRAs or chart reviews are incorrect. Instead, the criticisms are based on the fact that providers receiving payment through the original Medicare program do not conduct health risk assessments or chart reviews because they are not paid based on a patient's diagnoses, but on the services performed.

- RADV rule. CMS' proposed approach to RADV is improper and should be withdrawn. In 2018, CMS issued a proposed rule that would make significant changes to MA RADV audits. The agency has indicated an intent to finalize a rule by November 1, 2022. In comments to the agency urging CMS to withdraw the rule, AHIP pointed out multiple problems with CMS' proposal:
  - Fails to account for errors in FFS Medicare data: The Medicare Act requires CMS to adjust payments to MA plans for risk factors, including health status, to ensure "actuarial equivalence."<sup>129</sup> Analyses by multiple leading actuarial, statistical, and health care experts concluded that to meet this actuarial equivalence standard, CMS must adjust any discrepancies found in MA plan documentation to reflect the rate of errors in FFS data submitted by Medicare providers. In its technical study, CMS found significant errors in the FFS data. In 2012, CMS also agreed that this "FFS adjuster" was needed. However, CMS reversed its view in the 2018 proposed rule and proposed to apply RADV without adjustment.
  - Applies retroactively: CMS proposed to apply the regulation retroactively to hundreds of RADV audits, some that date back to plan year 2011 and have data more than a decade old. Retroactive rulemaking is unfair, inappropriate, and legally impermissible.
  - Calculates plan-wide recoupments based on a small sample of enrollees: CMS proposed to use the audit results from a small sample of enrollees to project discrepancies in an MA plan's broader population (known as "extrapolation"). CMS does not have the statutory authority to do so in MA. Further, the methodology CMS proposed to use is seriously flawed.
  - Relies on informal guidance: Key elements of CMS' RADV methodology are published only through sub-regulatory guidance and will not be issued through formal rulemaking. This violates the requirements of the Administrative Procedures Act and the Social Security Act.<sup>130</sup>
  - Undermines confidence in the MA program: The RADV proposal undermines confidence in CMS' willingness to be a fair partner with the private sector. It injects uncertainty and risk into the system. If finalized, the rule could cause seniors and hardworking taxpayers to see higher costs, reduced benefits, and fewer MA plan options.

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<sup>129</sup> 42 USC 1395w-23(a)(1)(C)(i)

<sup>130</sup> 42 USC 1395hh(e)(1)(A)

- Improper payment rates. Analysis of improper payments in the Medicare program conducted by the Department of Health and Human Services (HHS) each year consistently shows the net improper payment rate in MA is far below that of original Medicare. The Agency Financial Report for fiscal year 2021, for example, included data that shows the net improper payment rate in MA (3.18%) was only about half that of original Medicare (6.04%).<sup>131</sup> Importantly, the report found that more than a third (35%) of all payments identified as ‘improper’ in MA were actually underpayments, or amounts HHS found should have been paid to MA plans based on enrollee diagnoses that were not initially reported to CMS. In contrast, less than 2% of improper payments in original Medicare were identified as underpayments.
- Audio-only encounters. Risk adjustment codes from audio-only telehealth encounters should be permitted. We have previously expressed concerns with CMS’ policy that does not allow diagnosis codes identified in the course of a patient encounter conducted via audio-only to be counted for risk adjustment purposes. Audio-only encounters are an important source of care for all enrollees but are especially vital for low-income and rural beneficiaries.<sup>132</sup> Refusing to allow diagnosis codes gathered during audio-only encounters leads to lower risk adjusted payments to plans that serve larger numbers of disadvantaged enrollees and results in fewer dollars available to support the care needs of the enrollees or provide supplemental benefits.
- Other sources of diagnoses. CMS does not currently allow plans to use information from sources beyond medical claims even though such information can identify and confirm enrollee health conditions. The full portrait of a person’s health cannot always be obtained through medical records alone. There are other sources that offer a view into a person’s health, including information from disease management programs, prescription drug data, telehealth, and remote monitoring services. The inability for MA plans to use such alternative sources of data can penalize plans for diagnoses attributed to enrollees who in fact have those conditions based on objective data.
- Risk adjustment for SDOH. AHIP supports CMS efforts to explore model changes to address SDOH, but there are many challenges that need to be addressed before such an approach is implemented. In the Advance 2023 Rate Notice, CMS solicited input on potential future enhancements to the model to address the impacts of SDOH on beneficiary health status by incorporating additional factors that predict the relative costs

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<sup>131</sup> Department of Health and Human Services. Agency Financial Report: Fiscal Year 2021. <https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf>

<sup>132</sup> Centers for Medicare & Medicaid Services. COVID-19 Experiences Among the Medicare Population. Summer 2020. <https://www.cms.gov/files/document/medicare-current-beneficiary-survey-summer-2020-covid-19-data-snapshot.pdf>

of MA enrollees. AHIP supports such an effort. However, to appropriately account for SDOH in the risk adjustment model, CMS must be able to identify and measure social risk factors fairly and accurately for all beneficiaries. As noted in Section A, Advance Health Equity, above, there are still many challenges with collecting and acting on SDOH data, including delays in standards development, a lack of existing infrastructure for collecting, storing, and sharing SDOH data, a lack of provider awareness about available codes for documenting SDOH, and barriers in EHRs.

**Recommendations:**

- **We reiterate our strong belief that CMS should 1) withdraw the 2018 RADV proposal, 2) close out prior audits, 3) develop an appropriate FFS adjuster that reflects input from industry stakeholders, and 4) apply any changes to the RADV audit methods prospectively so MA plans can incorporate them into bids. Going forward, the contract-level RADV audit process must be completed more swiftly, and notifications and appeals processes should occur in a more timely manner.**
- **We encourage CMS to allow plans to use information from sources beyond medical claims to identify and confirm enrollee health conditions. The full portrait of a person's health cannot always be obtained through coding alone. There are other sources that offer a view into a person's health, including information from disease management programs, prescription drug data, telehealth, and remote monitoring services.**
- **We continue to urge CMS to allow diagnosis codes identified during audio-only encounters to be reported for risk adjustment purposes.**
- **Should CMS move forward on accounting for social risk factors in the risk adjustment model, CMS should identify approaches most likely to generate comparable information for all enrollees to ensure that any risk adjustment for SDOH is fairly and consistently applied. One option may be to use data available for all Medicare beneficiaries at the time of enrollment or captured through CMS' administrative processes rather than relying on information collected through provider claims, surveys, or other data collection instruments that are not universal or standardized. For example, a beneficiary's zip code could be used as a proxy for certain social risk factors and is readily available from administrative data. As noted above, there are significant barriers to provider collection of SDOH data. And even if physicians and other providers could overcome those barriers, asking them to collect and code social risk factors for all patients will add significant burden to providers already overworked by non-clinical tasks. Further, relying on information**

collected through providers could exacerbate disparities if adjustments depend on access to providers with sufficient resources to collect, document, and report the information.

- **Given the importance of getting health equity and risk adjusted payments right, CMS should discuss potential approaches to accounting for SDOH in the risk adjustment through a white paper or similar report, with an opportunity for comment and stakeholder input, similar to the approach CMS has taken for risk adjustment for Exchange plans.**
- **We encourage CMS to consider administrative improvements to how public input on the risk adjustment model is obtained. In particular:**
  - **We continue to recommend that CMS establish a technical expert panel (TEP) on the MA risk adjustment model to address issues such as FFS normalization and any model recalibration activities and invite AHIP and MA plans to participate on the TEP. This TEP would be an excellent approach for considering alternative methodologies to developing the FFS normalization factor or how recalibration of the risk adjustment model using ICD-10 data should be undertaken. Such a collaboration would also allow for substantive analysis and discussion of changes to the risk adjustment model outside of the annual Advance Notice process. There are many examples of TEPs and other Federal Advisory Committees across the FFS Medicare payment systems, including for the Medicare Physician Fee Schedule as well as for hospital outpatient payment, clinical diagnostic laboratory tests, and the ESRD prospective payment system. We urge CMS to consider taking a more collaborative approach to the risk adjustment model and look forward to working with the agency to improve the MA program.**
  - **We strongly encourage CMS to provide advance notice, including modeling and analysis, and comment opportunities to stakeholders for any proposed changes to the risk adjustment models moving forward. Plans should have at least 60 days to consider and comment on potential changes to the risk adjustment models and associated methods, which would allow them the opportunity to analyze the impact of proposed changes and offer more meaningful feedback to CMS.**

*3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?*

Key data. In its most recent Data Book, MedPAC notes that as of early 2022, 49% of Medicare beneficiaries eligible to enroll in MA had opted to receive their Medicare benefits through MA.<sup>133</sup> This reflects the rapid rise in the share of the Medicare population choosing MA—going from 22% of all Medicare beneficiaries in 2008 to 46% in 2022. Moreover, in addition to the overall growth of the program, about 46% of all those eligible for both Medicare and full Medicaid benefits are enrolled in MA and almost two-thirds of those eligible for Medicare and partial Medicaid benefits are enrolled in MA.<sup>134</sup> In total, 11 million dually-eligible individuals rely on MA, with the number of enrollees in special needs plans designed to address the needs of dually-eligible enrollees more than tripling over the past decade.<sup>135</sup>

The continued rise in the share of Medicare beneficiaries enrolled in MA means that in a growing number of counties and states, MA is now the dominant form of Medicare. As of July 2022, MA penetration exceeded 50% in 26% of counties, accounting for about 54% of all MA enrollees.<sup>136</sup> The shrinking number of individuals in original Medicare in some counties raises questions about the stability and reliability of MA benchmarks based on spending of individuals in original Medicare. AHIP encourages CMS to engage in dialogue with stakeholders about ways to address declining numbers of original Medicare beneficiaries and the implications for benchmark calculations. We stand ready to work with the agency to consider possible ways of ensuring benchmarks remain stable and reliable.

Implications. These enrollment numbers have clear implications for CMS as it considers potential policy changes. They confirm that seniors and people with disabilities value what the MA program offers, including reduced cost sharing for Medicare benefits; a limit on annual out-of-pocket spending that provides enrollees with financial peace-of-mind; supplemental benefits that address serious gaps in Medicare’s benefit structure (including coverage for important benefits like dental, vision, and hearing); care coordination and disease management services for individuals with chronic illnesses; better health outcomes; and an integrated package covering medical, prescription drug, and supplemental benefits. They also confirm how critical the MA program is for low-income and vulnerable populations, including those dually eligible for Medicare and Medicaid and those with chronic care needs.

Further, this enrollment growth offers the potential for expanding the efficiencies the MA program offers to more seniors and people with disabilities. As noted earlier in this section, the MA program uses better care management, value-based contracts with providers, and other tools

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<sup>133</sup> Medicare Payment Advisory Commission. A Data Book: Health care spending and the Medicare Program. July 2022. [https://www.medpac.gov/wp-content/uploads/2022/07/July2022\\_MedPAC\\_DataBook\\_SEC\\_v2.pdf](https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf)

<sup>134</sup> [Id.](#)

<sup>135</sup> [Id.](#)

<sup>136</sup> AHIP analysis of CMS July 2022 MA contract enrollment files. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData>

to reduce the cost of delivering original Medicare benefits and provide enhanced benefits at no additional cost to taxpayers or the Medicare program. Even MedPAC projects total payments to MA plans—for all services and benefits, including core Medicare services and added benefits and protections—on average are at parity with original Medicare spending if their projections about coding intensity are disregarded.<sup>137</sup> As explained previously (see Section D, question 1), appropriate adjustments to MedPAC methodology in fact show average payments to MA are below those for original Medicare. Moreover, if Congress were to try to add additional benefits to original Medicare to match those in MA, the cost would be prohibitive. For example, the Congressional Budget Office in 2019 projected that adding only dental, vision, and hearing benefits through the original Medicare program would raise Medicare spending by almost 6% when fully implemented, at a cost of \$348 billion over 10 years.

In addition, growth in MA is bringing higher-quality care to the Medicare population. Peer-reviewed research has found that MA plans outperform traditional Medicare across a range of metrics. They include better access to preventive care and better clinical outcomes than for enrollees in original Medicare,<sup>138</sup> including:

- important preventive services like annual wellness exams and cognitive screenings;<sup>139</sup>
- quality of care on various clinical quality measures;<sup>140,141</sup>
- improved survival rates with lower costs;<sup>142</sup>

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<sup>137</sup> Medicare Payment Advisory Commission. March 2022 Report to the Congress. March 2022.

<sup>138</sup> DuGoff, Eva, Rabak, Ruth, Diduch, Tyler, et al. Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. *The American Journal of Managed Care* 27(9). September 2021.

<sup>139</sup> Jacobson, Mireille, Thunell, Johanna, and Zissimopoulos, J. Cognitive Assessment at Medicare's Annual Wellness Visit in Fee-For-Service and Medicare Advantage Plans. *Health Affairs* 39 (11): 1935–1942. November 2020.

<sup>140</sup> Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.

<sup>141</sup> Agarwal, Rajender, Connolly, John, Gupta, Shweta, et al. Comparing Medicare Advantage And Traditional Medicare: A Systematic Review. *Health Affairs* 40(6): 937-944. June 2021.

<sup>142</sup> Mandal, Alope K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

- reduced hospital admissions and readmissions as well as patient days spent in rehabilitation facilities and nursing homes;<sup>143,144,145,146</sup> and
- lower hospital use in the last days of life.<sup>147</sup>

Studies have also found better outcomes for MA enrollees with specific chronic diseases when compared to patients with traditional Medicare, such as lower mortality and reduced utilization for MA members with ESRD;<sup>148</sup> fewer emergency room visits and hospitalizations and better quality scores for MA enrollees with diabetes and cardiac disease;<sup>149</sup> and shorter lengths of stay and fewer hospital readmissions for MA enrollees who experience a hip fracture.<sup>150</sup>

In total, these successes demonstrate that MA growth has had a tremendously positive impact on the overall Medicare program. CMS should exercise caution in making additional changes. It should focus efforts on policies that support further program growth and ensure plans have the flexibility and tools to continue improving quality and innovating on behalf of their enrollees.

#### **Recommendations:**

- **MA's enrollment numbers, financial efficiency, and quality successes, combined with high satisfaction rates,<sup>151</sup> show the program is working well, including for diverse and low-income populations. Accordingly, CMS should ensure that it exercises significant caution when considering potential changes. Such changes should be supported by clear evidence justifying a change; and CMS should ensure**

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<sup>143</sup> Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoS Med* 15(6): e1002592.

<sup>144</sup> Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

<sup>145</sup> Jung DH, DuGoff E, Smith M, Palta M, Gilmore-Bykovskiy A, Mullahy J. Likelihood of hospital readmission in Medicare Advantage and Fee-For-Service within same hospital. *Health Serv Res.* 2020;55:587–595.

<https://doi.org/10.1111/1475-6773.13315>

<sup>146</sup> Schwartz, Aaron L., Slaoui, K., Foreman, R., et al. Health Care Utilization and Spending in Medicare Advantage vs. Traditional Medicare: A difference-in-difference analysis. *Jama Health Forum.* 2021; 2(12): e214001.

<sup>147</sup> Teno, Joan M., Gozalo, Pedro, Trivedi, Amal N. et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. *JAMA* Published online June 25, 2018.

<sup>148</sup> Powers, Brian W., Yan, Jiali, Zhu, Jingsan, et al. The Beneficial Effects of Medicare Advantage Special Needs Plans for Patients with End-Stage Renal Disease. *Health Affairs* 39(9): 1486–1494. September 2020.

<sup>149</sup> Landon, Bruce E., Zaslavsky, Alan M., Saunders, Robert, et al. A comparison of relative resource use and quality in Medicare Advantage health plans versus traditional Medicare. *American Journal of Managed Care* 21(8): 559-566. August 2015.

<sup>150</sup> Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoS Med* 15(6): e1002592.

<sup>151</sup> In a recent survey 93% of seniors reported they were satisfied with their Medicare Advantage coverage. [https://ahiporg-production.s3.amazonaws.com/documents/202112\\_AHIP-MAResearch.pdf](https://ahiporg-production.s3.amazonaws.com/documents/202112_AHIP-MAResearch.pdf)

**they do not undermine the elements that enrollees value. CMS must make stability for MA enrollees a key priority. To further those goals, we urge CMS to consider the recommendations AHIP has provided in this and other sections of the RFI response.**

- **In addition, the successes of the MA program suggest CMS might consider focusing efforts on additional ways to bring the tools that MA plans use to achieve greater cost efficiency while achieving better health outcomes for members to those still enrolled in the original Medicare program. MA plans will always be far more flexible, innovative, and efficient than original Medicare. However, CMS can still work with MA plans and other stakeholders to identify particular MA plan practices or programs—e.g., around care coordination and management—that might help original Medicare enrollees.**

*4. Are there additional considerations specific to payments to MA plans in Puerto Rico or other localities that CMS should consider?*

Puerto Rico. The MA program is critically important in Puerto Rico. The vast majority of Medicare beneficiaries in Puerto Rico are enrolled in MA plans (82 percent in 2022). Many of these beneficiaries have low incomes and enroll in plans to receive more care coordination and affordable Part D coverage, which otherwise may not be affordable due to the statutory prohibition on providing Part D LIS to beneficiaries in the territories.

AHIP is deeply concerned about the large disparity in payment rates between Puerto Rico and the mainland. The unusually low FFS expenditures for Puerto Rico, which now serve as the basis for MA benchmarks, and the significant rate cuts for Puerto Rico put into place by the Affordable Care Act (ACA), jeopardize the continued availability of the comprehensive coverage provided by MA plans operating on the island to the low-income populations they serve.

For the past several years, as part of the annual rate notice process, CMS has proposed adjustments to the calculation of benchmarks in Puerto Rico. These adjustments include:

- Accounting for the fact that a higher proportion of beneficiaries in Puerto Rico than beneficiaries elsewhere do not have any claims during a year. CMS analysis of claims from 2012-2016 found that 14.5% of beneficiaries in Puerto Rico had no claims during the year, compared with 6% of beneficiaries nationwide.
- Including those beneficiaries enrolled in both Part A and B of Medicare in calculating the benchmarks. CMS has noted that beneficiaries residing in Puerto Rico must take

affirmative action to enroll in Part B, unlike beneficiaries elsewhere who are automatically enrolled in Part B unless they opt out.

However, even after these adjustments, MA benchmarks in Puerto Rico are significantly lower than elsewhere, and make it difficult for MA plans to offer benefit packages that serve the needs of Puerto Rico enrollees, particularly low-income enrollees.

**Recommendations:**

- **AHIP supports the annual adjustments CMS has been making in recent years through the rate notice process. However, rather than re-propose them on an annual basis, CMS should make these adjustments permanent through rulemaking. This would provide greater certainty going forward to MA enrollees and plans in Puerto Rico. As part of this approach, CMS can allow for changes in the specific adjustment amount due to the high share of beneficiaries in Puerto Rico with no claims, to account for new data that becomes available.**
- **We encourage CMS to explore additional options for increasing MA benchmark rates for Puerto Rico to achieve greater parity with FFS rates on the mainland. Such an adjustment is needed to ensure that plans in Puerto Rico can maintain benefits for the low-income populations they serve.**

*5. What are notable barriers to entry or other obstacles to competition within the MA market generally, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program?*

By numerous metrics MA is a market with robust and growing competition. For example, annual reports from MedPAC show the number of organizations competing to offer MA plans grew by 15% over the past decade (2012-2021), while the average number of MA plans offered per county increased by 68% over the same period. Further, a hallmark of strong competition is lower prices. The MA market has seen lower costs and more choices for beneficiaries: Over 95% of Medicare beneficiaries have access to a plan that integrates Medicare’s medical and prescription drug coverage for no premium beyond the required Part B premium, and the number of integrated plans offered in the MA market has more than doubled in past decade.<sup>152</sup> Further,

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<sup>152</sup> AHIP. “Medicare Advantage Markets Offer Competition, Affordability, and Choice.” [https://ahiporg-production.s3.amazonaws.com/documents/202111-AHIP\\_MACCompetition-v04.pdf](https://ahiporg-production.s3.amazonaws.com/documents/202111-AHIP_MACCompetition-v04.pdf)

bids continue to decline and available supplemental benefits continue to rise.<sup>153</sup> It is clear: the MA program stands as an example of using private sector competition to deliver lower costs and better benefits to individuals.

Competition issues. That said, there are factors relating to competition—particularly competition in provider markets—that can affect the ability of health insurance providers to enter the program or expand into new markets. For example:

- Consolidated provider markets can reduce the options available for new entrants to form networks.<sup>154</sup> Dominant providers may be unwilling to engage in the type of innovative partnerships that have brought so many benefits to MA beneficiaries.
- Consolidated provider markets also raise costs for new products. AHIP launched a policy roadmap earlier this year to create healthier markets and improve health care affordability and access for Americans through improving competition.<sup>155</sup> Our roadmap includes potential solutions to address our concerns around the growing trend of consolidation among health care providers, including when hospitals and venture capital-funded groups acquire specialty physician practices, which can lead to higher costs, reduced patient choice, stifled innovation, and loss of physician autonomy. Historically, hospital-owned practices have been paid higher reimbursement rates compared to independent physician practices. The prospect of higher reimbursement rates is seen as a contributing factor to consolidation, as hospitals have an economic incentive to purchase independent physician offices and convert them to hospital-based facilities to receive higher rates at those locations.<sup>156,157</sup> In fact, by 2020, the majority of physicians in the U.S. (50.2%) worked outside of private practice.<sup>158</sup> In addition to higher rates, this trend impacts the market more broadly: Hospitals that gain increasing market power can negotiate higher prices

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<sup>153</sup> Medicare Payment Advisory Commission. March 2022 Report to the Congress.

<https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>

<sup>154</sup> 2004 DOJ-FTC Report, Improving Health Care: A dose of competition.

<https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf>

<sup>155</sup> <https://www.ahip.org/news/press-releases/ahip-launches-new-policy-roadmap-to-create-healthier-markets-improve-health-care-affordability-and-access-for-every-american>

<sup>156</sup> Government Accountability Office (GAO); “Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform” (Dec. 2015); GAO-16-189. <https://www.gao.gov/assets/gao-16-189.pdf>

<sup>157</sup> MedPAC Report to Congress, Chapter 3 (March 2015); available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/chapter-3-hospital-inpatient-and-outpatient-services-march-2015-report-.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-3-hospital-inpatient-and-outpatient-services-march-2015-report-.pdf); MedPAC Report to Congress, Chapter 6 (June 2022); available at: [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_Ch6\\_MedPAC\\_Report\\_to\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf).

<sup>158</sup> American Medical Association (AMA); “Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020;” available at: <https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf>

from health insurance providers in the absence of competition from physician offices. Higher cost care settings can impose considerable financial burden on patients through higher out-of-pocket payments at the point of care and potentially higher health insurance premiums. Consumers often face lower co-pays for a visit to a physician's office than a visit to a hospital facility, where they may have to pay cost sharing for a facility fee, in addition to cost sharing for professional services. Further, provider consolidation is not associated with improved health outcomes<sup>159</sup> but is associated with higher physician prices.<sup>160</sup> While CMS and Congress have taken incremental steps to reduce higher reimbursements to hospital-owned practices through so-called "site neutral" payments, several barriers have hampered the impacts of those changes.<sup>161</sup>

- Government policies can create significant costs or uncertainties for new entrants. They include some requirements that are ill-suited or outdated.<sup>162</sup> They also include the risk of CMS continuously imposing new or altered MA program requirements, sometimes without adequate notice, administrative flexibility, or implementation timelines. These administrative approaches reduce predictability and increase risk.

Vertical Integration in MA. In general, MA plans and other health insurance providers need to respond to demands of enrollees (and in some cases, entities like employers and state Medicaid programs) for capabilities to help defray health care costs, stretch their benefit dollars, and improve patient outcomes. MA organizations may determine that leveraging some of those vital resources under a "single roof" achieves those objectives. They may, for example, allow enhanced disease management and care coordination programs through more effective sharing of medical and/or prescription drug claims data, and smoother transitions across patient settings. This reflects a pro-competition response to competitive dynamics in a complex, evolving set of markets.

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<sup>159</sup> See, e.g., Marah Noel Short, Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality;" *Medical Care Research and Review* (Feb. 2019); available at: <https://journals.sagepub.com/doi/10.1177/1077558719828938>; TG Koch, BW Wendling, NE Wilson; "The Effects of Physician And Hospital Integration On Medicare Beneficiaries' Health Outcomes;" *Rev Econ Stat.* 2020:1-38. doi:10.1162/rest\_a\_00924.

<sup>160</sup> James Godwin, et al.; "The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence;" *Inquiry* (Mar. 2021); available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7940736/>

<sup>161</sup> For example, Congress limited the ability of new off-campus hospital-based departments to receive higher reimbursement rates under the Outpatient Prospective Payment System (OPPS) and instead required CMS to reimburse them under another fee schedule, such as the Physician Fee Schedule (PFS), but Congress permitted existing facilities to continue receiving higher reimbursements. Moreover, CMS determined it is not logistically feasible to pay hospital-based departments under the PFS, and thus continues to pay non-expected locations under the OPPS; the OPPS rate is reduced, it is still higher than the PFS rate.

<sup>162</sup> Id.

The regulatory structure of the MA program includes safeguards through which CMS can protect against bidding and other program concerns that could arise when MA plan services are provided through related parties. They include reporting and other requirements for related parties which CMS indicates in the MA bid pricing tool are designed “to ensure that financial arrangements between the MA organization and related parties (i) are not significantly different from the financial arrangements that would have been achieved in the absence of the relationship, and (ii) do not provide the opportunity to over- or under-subsidize the bid.”<sup>163</sup> Other protections include CMS review of plan bids on an annual basis; and medical loss ratio requirements and reporting that limit plan administrative costs and profits.

**Recommendations:**

- **Policy and administrative changes by CMS to address these issues could lead to even more competition in the program. For example:**
  - **Additional flexibility with respect to network adequacy, including the use of technologies such as telehealth, can provide plans with a greater capacity to offer products in markets with limited provider competition.**
  - **Longer implementation timelines and more predictability on program requirements and operations can reduce the risks for new entrants.**
  - **CMS should pursue provider payment policies to drive affordability. In particular:**
    - **We encourage CMS to evaluate the effects of its site neutral payment policies, such as how many locations are excepted from reduced payments, and encourage CMS to evaluate whether it can go further in implementing site neutral payment reform within its statutory authority. AHIP strongly supported and appreciates CMS’ policy enacted through the 2019 outpatient prospective payment system final rule to implement site neutral payments for the clinic visit service for all off-campus hospital-based locations, including those that were grandfathered under the statute.**
    - **We encourage CMS to assess ways to bring full parity to payments to non-excepted locations and evaluate the practicality of reimbursing them under the Medicare Physician Fee Schedule. To the extent possible, CMS should**

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<sup>163</sup> Centers for Medicare & Medicaid Services. “Instructions for completing the Medicare Advantage bid pricing tools for contract year 2023.” <https://www.cms.gov/medicarehealth-plansmedicareadvtspeccratestatsbid-forms-instructions/2023>.

**release information about how these policies has impacted the MA program specifically.**

- **CMS should evaluate data to assess the extent to which services are continuing to shift to excepted off-campus provider-based departments.**

*6. Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?*

Throughout this letter we document the many actions MA plans are taking to address health equity and help enrollees overcome SDOH. It is important for CMS to ensure plan programs to address SDOH are appropriately recognized in the MLR, to encourage investments in those programs, and to avoid penalizing plans when those investments result in reduced utilization and spending.

**Recommendation:**

- **We encourage CMS to provide plans with maximum flexibility to include SDOH-related expenses in the MLR numerator.**

*7. How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks?*

Health plans have a strong record of working with CMS and other federal partners in identifying and working to prevent fraud, waste, and abuse, and in implementing tools to enhance program integrity.

- Many AHIP members who participate in the MA program are also members of the Health Care Fraud Prevention Partnership (HFPP), a voluntary, private-public partnership between the federal government, state and local government agencies, law enforcement, private health insurance plans, employer organizations, and healthcare antifraud associations. The HFPP works to conduct cross-payer analysis of health care data, detect fraud, waste, and abuse across public and private sectors, and reduce unnecessary health care spending.
- Medical management is another key component of program integrity. The Institute of Medicine has estimated that 10 to 30 percent of health care spending is wasted on excessive testing and treatment.<sup>164</sup> According to MedPAC, Medicare fee-for-service

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<sup>164</sup> National Academies of Sciences, Engineering, and Medicine. 2010. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press. <https://doi.org/10.17226/12750>.<https://nap.nationalacademies.org/catalog/12750/the-healthcare-imperative-lowering-costs-and-improving-outcomes-workshop-series>

beneficiaries receive a significant amount of “low-value” care, with conservative estimates of cost ranging from \$2.4 billion to \$6.9 billion per year.<sup>165</sup> AHIP strongly supports the use of medical management including PA to promote high-value care that is safe, effective, and evidence-based care for patients; and to reduce wasteful (and potentially harmful) low-value care. Americans deserve affordable coverage choices that allow them to get the high-quality care they need at a price they can afford on a timely basis. That means ensuring that health care providers focus on value and outcomes—not the volume of services. Quality, safety, and value are undermined by unnecessary, low-value care; wide variations in the use of unproven treatments; or the use of treatments for patients other than those for whom it is clinically appropriate.

**Recommendations:**

- **We encourage CMS to continue supporting and collaborating in the work of the HFPP to allow its members to strengthen program integrity by working together to prevent fraud, waste, and abuse.**
- **We reiterate recommendations from elsewhere in this comment on improvements to PA systems and processes that can facilitate access to necessary care for patients and make it easier for providers to use PA tools to enhance quality of care, while ensuring that health care dollars are used efficiently and effectively.**

*8. What new approaches have MA plans employed to combat fraud, waste, and abuse, and how could CMS further assist and augment those efforts?*

Health insurance providers are adopting new approaches and techniques to combat fraud, waste, and abuse via rule-based analytics and artificial intelligence. Sophisticated fraud software is a critical component to identifying fraud, waste, and abuse in MA (and all lines of business). The rules and analytic models in such tools are constantly updated to reflect new delivery modes (such as telehealth) and as service issues arise (e.g., COVID-19 related issues). We appreciate CMS’ support for these efforts and encourage continued partnership in fighting fraud, waste, and abuse.

**Recommendation:**

- **We encourage CMS to continue to provide forums and information sessions that address emerging fraud trends that impact the Medicare program and that highlight updates to regulations related to fraud, waste, abuse, and program**

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<sup>165</sup> Medicare Payment Advisory Commission. March 2021 Report to the Congress. [https://www.medpac.gov/wp-content/uploads/2021/10/mar21\\_medpac\\_report\\_ch4\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch4_sec.pdf)

**integrity overall. These actions are effective methods to support and augment ongoing plan program integrity efforts and actions.**

## **E. ENGAGE PARTNERS**

Overview of AHIP response: In this section we offer recommendations on ways CMS can improve transparency and engagement with MA plans, including earlier opportunities for input and collaboration on major initiatives, more lead time on program changes to align with bidding cycles and operational needs, and more CMS townhalls and user group calls. We also reiterate recommendations on ways to enhance consumer engagement through improvements to the CAHPS survey and to expand supplemental benefits flexibility so plans can be more responsive to the specific needs of the communities they serve. In addressing the questions below, we have identified ways CMS can build stronger rapport with partners and improve beneficiary understanding of the program and available benefits.

*1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?*

We believe the following steps will greatly help CMS to increase MA transparency and promote engagement with MA plans.

- Adequate lead time and sufficient details. MA plans need adequate lead time and sufficient details on changes to MA and Part D program rules based on new legislation or regulatory requirements. Plans need time to understand CMS' goals and intent for potential changes, and to analyze impacts and provide meaningful feedback. They also need sufficient time after the release of final requirements to incorporate changes into the bid process and to operationalize changes by the applicability dates (including updating contracts with providers and other affected entities). Bidding and implementation issues can be extremely difficult if program requirements for an upcoming year are issued close in time to the bid submission deadline or in some cases even after bids are submitted (for example, late changes in original Medicare payment rates affect MA plans, which are required to pay such rates for out-of-network services).
- Timely engagement. AHIP believes that CMS should increase the level of timely, detailed engagement with stakeholders. As a practical matter, it can be extremely difficult for CMS to pivot away from proposals that have been developed after the expenditure of considerable agency time and resources, particularly when statutory deadlines are

implicated. The earlier in the process CMS provides information to stakeholders to allow for detailed input on critical policy and operational changes under consideration, the more likely CMS can incorporate that information into its decision-making process before it is not feasible or practical for the agency to consider alternatives.

One example of the importance of timely engagement involves the major changes to the Part D program in the Inflation Reduction Act of 2022. Many changes will present serious cost pressures and implementation challenges for Part D. Moreover, more than 90% of MA enrollees are in integrated MA-Prescription Drug (MA-PD) plans.<sup>166</sup> The higher costs for offering the Part D benefit could have significant carry-over impacts in the MA program, leading to reduced benefits and/or increased premiums. With the continued growth of the Medicare program and the success and popularity of MA and Part D, we urge CMS to engage with health insurance providers and develop policies that support the overall stability of the programs and facilitate continued growth, value, and innovation for consumers and taxpayers.

- Improvements to MPF tool. As we note in our responses under questions 1 and 2 under Section B, Expand Access: Coverage and Care, in recent years CMS has made strides to modernize the MPF tool and improve beneficiary experience through increased transparency and usability. However, AHIP supports additional changes as we discussed under Section B to increase transparency and ensure consumers are more fully informed about their Medicare coverage choices.
- Improvements to MA Star Ratings. As we note in our response to question 8 under Section C, Drive Innovation to Promote Person-Centered Care, AHIP has several recommendations on ways CMS can make targeted improvements to the MA Star Ratings program. For example, if CMS were to set cut points for Star Ratings measures well in advance of the measurement period it would enable MA plans and their network providers to better manage their quality care and health equity improvement efforts, allow for greater methodological transparency, and allow plans and their network providers to better understand the goals for each Star Ratings measure.

#### **Recommendations:**

- **CMS should engage with plans on possible payment methodology or compliance/operational changes before release of the advance rate notice, regulatory proposals, or other CMS guidance.**

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<sup>166</sup> CMS. Monthly Contract and Enrollment Summary Report. August 2022. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolldata/monthly/contract-summary-2022-08>.

- **CMS should ensure that the advance rate notice provides sufficient information about the rate development process and methodology to enable plans to assess and comment on the methodology. In addition, CMS should provide specific information about whether and how changes in original Medicare payment rates, particularly those that are legislatively directed and intended to be short-term, are reflected in upcoming MA payment rates.**
- **CMS should issue final rules and requirements for the upcoming plan year no later than the date for release of the final rate notice in early April so that plans can assess and incorporate applicable costs into their bids and have the time necessary to implement changes.**
- **Regulatory and sub-regulatory guidance that imposes material changes in costs or new operational requirements should be released far in advance of relevant bid deadlines and applicability dates for the requirements.**
- **CMS should implement enhanced collaborative processes for major initiatives. For example, the Part D program reforms in the Inflation Reduction Act of 2022 have significant operational, compliance, and other implications for plans and their business partners as well as other stakeholders. CMS should engage with stakeholders early and often, including through industry work groups, to identify and address policy, operational, and compliance implications and issue necessary CMS regulations, final requirements, and guidance well in advance of the effective dates for the Part D provisions and the affected bid cycle.**
- **CMS should consider additional improvements to the search and comparison functions of the MPF tool, particularly to improve cost comparisons between MA and original Medicare. CMS could conduct a stakeholder survey to gather information on possible improvements to MPF.**
- **CMS should return to the use of predetermined cut points for the MA Star Ratings program.**
- **CMS should increase the frequency of user group calls with MA plans on regulatory and policy changes, such as Star Ratings. In this forum, CMS can share critical information about key program requirements and changes, including explaining and clarifying key changes. The forum allows plans to ask questions about the impact of the changes on specific methodologies and policies. Such opportunities can also minimize the number of questions that CMS may receive at later points. (For example, an annual user group call on Star Ratings in advance of the preview**

**periods could also help to minimize the number of questions and issues that are raised by plans during the preview periods.)**

*2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?*

CMS Town Halls. We believe that CMS Town Hall meetings announced through the Federal Register are a helpful way for the agency to notify multiple stakeholders about important program policy proposals that require active engagement and discussion among diverse stakeholders. Town Halls sponsored by CMS would also promote collaboration among stakeholders. Interested parties should be notified through advance notice and encouraged to attend to present their comments and recommendation during the meetings.

**Recommendation:**

- **AHIP recommends that CMS convene more Town Hall meetings with multiple stakeholders to promote active engagement and collaboration.**

*3. What steps could CMS take to enhance the voice of MA enrollees to inform policy development?*

Improvements to CAHPS survey. The MA program currently obtains input from MA enrollees through various sources, including the CAHPS survey. We believe the most effective way for CMS to enhance such input is by improving the accuracy and process around the CAHPS survey.

AHIP members have informed us that CAHPS survey responses have been declining for several years, and this year's data is particularly worrisome. While we are still working to understand the causes of the decline in response rates, CAHPS vendors have noted that the COVID-19 pandemic and ongoing postal delivery issues likely have had an impact. Further, consumers are increasingly hesitant to open unsolicited mail or answer phone calls from unfamiliar numbers. Increased virtual visits may also affect responses as consumers may not consider them when responding.

Health insurance providers recognize the importance of assessing consumer experience. It helps to ensure consumers have access to high-quality care and coverage that meets their needs, and to identify where to focus efforts to improve the health care system. As such, the CAHPS survey should be updated and improved to maximize accurate responses.

**Recommendations:**

- **CMS should pursue comprehensive evaluation and field testing of improvements to the CAHPS survey and propose improvements based on those findings for public**

**comment. CMS should consider expanding its testing of a web-based tool for CAHPS, which may better align with how consumers want to respond to the survey.**

- **Additional recommendations related to CAHPS are included in our response to question 8 under Section C.**

*4. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?*

Support and expansion of supplemental benefits. As indicated in our comments to another section of this RFI (see our responses to questions 2 and 9 under Section A), AHIP continues to strongly support the expansion of supplemental benefits that MA plans are permitted to offer, as well as flexibility for offering certain benefits to more enrollees. This would ensure that more Medicare enrollees in need receive these important benefits. Expanding supplemental benefits to address additional needs for more populations would allow MA plans to be more responsive to the specific needs of the communities they serve. It would also support our mutual goals to advance health equity under MA.

**Recommendation:**

- **We recommend that CMS expand the types of supplemental benefits MA plans may offer (e.g., Part D benefits) through regulation and expand the eligibility criteria through the CMMI MA-VBID demonstration.**