



August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Baltimore, MD 21244-8013

RE: CMS-4203-NC

Dear Administrator Brooks-LaSure:

The Healthcare Leadership Council (HLC) appreciates the opportunity to submit comments on the Medicare Advantage (MA) request for information (RFI) to guide policy development and implementation of the program.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC is very supportive of the MA program and the high-quality care it provides to its beneficiaries. MA serves over 29 million¹ older adults and people with disabilities (46 percent of the total Medicare population), with that number expected to grow to 30 million by the end of 2022. This program continues to grow since newly eligible Medicare beneficiaries are overwhelmingly choosing MA plans, likely because of the additional benefits offered and because their previous employer-sponsored health coverage resembled MA. MA plans offer beneficiaries choice, accessibility, and affordability. In addition, MA benefits provide care coordination, disease management tools and enable early intervention that strengthens the ability of its beneficiaries to remain independent and in their own communities. Studies show the

¹ *Contract Summary 2022*, Centers for Medicare and Medicaid Services (June 2022)
<https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenrolatamonthly/contract-summary-2022-04>

MA model outperforms Fee-for-Service (FFS) Medicare on clinical quality measures, improves survival rates, and reduces hospital readmissions.^{2 3 4 5}

A recent survey of MA beneficiaries reports a 94 percent satisfaction rate, with more than nine of 10 respondents being pleased with the coverage they are receiving through their health plan. Additionally, nearly all seniors on MA are satisfied with their network of doctors, hospitals, and specialists. A majority of seniors note that MA lets them see the doctors they want on their own terms and 89 percent agree that MA plans save them money compared to other coverage options.⁶ This is supported by a Milliman analysis that found spending in MA per-member, per-month is nearly \$7 lower than FFS Medicare.⁷ HLC encourages the Centers for Medicare and Medicaid Services (CMS) to consider the following proposals to support the continued success of the program and facilitate the strength and stability of the MA program:

Advance Health Equity

Supplemental Benefits

HLC applauds CMS' efforts to reduce health inequities for all Americans. Currently, 90 percent of people in MA plans that offer prescription drug coverage are enrolled in a plan with a quality rating of 4 or more stars, which is higher than previous years.⁸ As CMS works to develop additional proposals to advance health equity across the MA and Part D programs, we encourage the continuation of existing policies that support health equity in the United States and Puerto Rico. Existing policies include access to telehealth services, in-home care, and supplemental benefits that address social determinants of health (SDOH) related to food insecurity, social isolation, and transportation needs. These benefits have reduced avoidable hospitalizations, lowered hospital readmission rates, and increased utilization of preventive services.⁹ These innovative and value-based care models are more prevalent in MA than FFS Medicare.

We also recommend CMS provide all health plans more flexibility in targeting supplemental benefits to address social risk factors. Currently, supplemental benefits can only address SDOH if they maintain or improve health function, and SDOH alone cannot be used to determine Special Supplemental Benefits for the Chronically Ill (SSBCI) eligibility. As such, HLC believes Congress should pass H.R. 4074, the "Addressing Social Determinants in MA Act," to enable

² *Quality, Health, and Spending in Medicare Advantage and Traditional Medicare*, AJMC (September 2021) <https://www.ajmc.com/view/quality-health-and-spending-in-medicare-advantage-and-traditional-medicare>

³ *Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States*, PubMed.gov (December 2017) <https://pubmed.ncbi.nlm.nih.gov/29130269/>

⁴ *Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival*, AJMC (February 2017) <https://www.ajmc.com/view/value-based-contracting-innovated-medicare-advantage-healthcare-delivery-and-improved-survival>

⁵ *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*, PubMed.gov (June 2018) <https://pubmed.ncbi.nlm.nih.gov/29944655/>

⁶ *Survey Results: Annual Seniors on Medicare Survey*, Morning Consult (June 2022) [BMA Seniors-on-Medicare-Memo_final3.pdf \(bettermedicarealliance.org\)](#)

⁷ *Value to the federal government of Medicare Advantage*, Milliman (October 2021) [Value to the federal government of Medicare Advantage \(milliman.com\)](#)

⁸ *CMS Releases 2022 Medicare Advantage and Part D Star Ratings to Help Medicare Beneficiaries Compare Plans*, Centers for Medicare and Medicaid Services (June 2022) [CMS Releases 2022 Medicare Advantage and Part D Star Ratings to Help Medicare Beneficiaries Compare Plans | CMS](#)

⁹ *Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-For-Service Medicare*, Better Medicare Alliance (December 2020) [BMA-High-Need-Report.pdf \(bettermedicarealliance.org\)](#)

health plans to offer certain supplemental benefits only available to chronically ill enrollees, to enrollees with low-income or socioeconomic risk factors. In addition, the Medicare Plan Finder (MPF) has been a valuable decision-making tool for beneficiaries in choosing a health plan best suited for them. To empower beneficiaries to fully take advantage of the new benefits that plans provide, we recommend CMS modify the MPF to show comprehensive summaries of available supplemental benefits.

Additionally, the current MA financial structure allows health plans to fund supplemental benefits through rebates. We believe the Center for Medicare and Medicaid Innovation (CMMI) could test the expansion of access to supplemental benefits by increasing the rebate percentages for plans offering SSBCI benefits, which would enable health plans to further address health-related social needs, in addition to improved data collection and analysis.

Improve Data Capture in Support of Health Equity

HLC encourages CMS to focus its efforts on standardizing SDOH data capture and measurement, leveraging resources currently available to providers, and reducing administrative burden across programs. Despite the numerous initiatives to address SDOH in patient care, providers still struggle to incorporate addressing SDOH into care delivery because they lack the necessary data capabilities to uniformly assess and identify potential social risk factors among all patients. We encourage CMS to work with stakeholders to continue to advance social risk screenings through assessment tools to develop data sharing best practices, while avoiding mandates that would stifle the evolution and advancement of social risk screening tools.

HLC also recommends CMS consider increasing education for providers on the use of existing billing codes for SDOH. CMS could offer this education while developing additional codes for social needs care that could be made available across Medicare, Medicaid, and private insurance providers. This approach would help to incentivize increased screening, which can help facilitate referrals for social services. CMS should also evaluate existing ICD-10 Z codes which identify non-medical factors that may influence a patient's health status, such as food, housing, transportation, education, violence, social support, health behaviors and employment. CMS should consider updating and promoting existing agency recommendations about how these Z codes can be utilized to measure improvement in outcomes and consider funding mechanisms that will allow for consistent usage and reimbursement.

We encourage CMS to consider ways to leverage interoperability and health information technology to foster data flow on social risk. To truly address social needs and reduce healthcare disparities, we need national data and exchange standards that permit stakeholders from across the healthcare industry to report and exchange information. Such information should ideally be available in real-time and at the point of care, not only when a claim is submitted. However, it will take time to fully transition to an interoperable healthcare system. In the meantime, administrative data plays a role in facilitating information exchange. Using Z codes can allow providers to better define the SDOH needs of patients, standardize this data, and facilitate interoperable data exchange among healthcare providers, payers, and other stakeholders to collaborate and provide support and interventions.

We also recommend CMS support additional efforts to improve health and wellness, which is critical to SDOH and the prevention and treatment of chronic diseases. This includes vision, dental, and physical activity currently covered by supplemental benefits and health related services. Physical activity is one of eight pillars to achieve healthy behavior according to the

American Heart Association.¹⁰ As MA plans and FFS Medicare currently offer supplemental benefits for gym memberships; we request that exercise programs be expanded beyond gym membership since there are now a variety of ways to engage in physical exercise.

Expand Access: Coverage and Care

Telehealth Access

HLC thanks CMS for their continued support for coverage of telehealth services. Telehealth continues to be widely used by patients. In 2020, over 52 million Medicare beneficiaries had a physician appointment through a virtual platform.¹¹ We appreciate CMS' work to implement provisions of the Consolidated Appropriations Act of 2022 to extend current telehealth waivers an additional 151 days once the public health emergency (PHE) expires. This will provide a much-needed bridge to delivering consistent care. However, we continue to support permanent expanded use of telehealth and encourage CMS to work with Congress on further improving access to virtual care. Additionally, we support CMS' decision to waive the in-person requirements to access mental health services through telehealth. In-person requirements can lead to limitations in care and create unnecessary patient burdens.¹² HLC encourages CMS to examine how to ensure that these patients can continue to receive these services, so as not to experience reductions in care delivery.

We also recommend CMS permanently allow Hierarchical Condition Category codes to be collected through audio-only telehealth visits for the documentation of diagnosis codes used for the calculation of MA risk scores. Such guidance is consistent with CMS' decision to allow audio-only telehealth for 90 FFS Medicare services and designate certain audio-only services as valid for data submission under the Affordable Care Act.

Broadband Access

Improving access to broadband is an important component in addressing digital connectivity and health outcomes for everyone, particularly minorities in underserved areas and rural communities. The COVID-19 PHE has highlighted the importance of equitable access to broadband services. As states imposed stay-at-home orders, consumers required alternative sources to remain connected with healthcare professionals so they could continue to receive important care – this was particularly critical for people, such as those with chronic conditions, who require access to consistent, continuous care to manage their overall health. Additionally, many home digital health products offered today work most effectively with a sufficient and sustained connection. As the Infrastructure Investment and Jobs Act included provisions to advance digital connectivity, CMS should continue to partner with agencies such as the National Telecommunications and Information Administration and the Federal Communication Commission to better target communities in need and work to reduce existing health disparities. HLC encourages CMS to pursue options that increase Medicare beneficiaries' connection to and use of digital tools, such as supporting cellular devices programs and incorporating digital literacy.

Behavioral Health Services

We support CMS' proposal to expand the behavioral health workforce to allow practitioners such as marriage therapists, social workers, and professional counselors to practice at the top

¹⁰ *Life's Essential 8* comprises two major areas: *Health Behaviors and Health Factors*, American Heart Association (February 18, 2022), [Life's Essential 8 | American Heart Association](#)

¹¹ HHS reports 52.7 million Medicare telehealth visits during pandemic, American Hospital Association (December 6, 2021), <https://www.aha.org/news/headline/2021-12-06-hhs-reports-527-million-medicare-telehealth-visits-during-pandemic>.

¹² *Overview on In-Person Requirements*, American Telemedicine Association (June 14, 2021), <https://www.americantelemed.org/wp-content/uploads/2021/06/ATA-Overview-of-In-Person-Requirements-1.pdf>.

of their license. These professionals provide essential healthcare services to millions of patients and allowing them to practice without direct supervision requirements will strengthen the number of healthcare practitioners available, particularly in underserved communities. We believe more can be done to encourage diversity within the behavioral health workforce. Incentives should be created for medical schools to place greater emphasis on behavioral health services, including scholarships, loan forgiveness or tuition reimbursement programs.

HLC also supports CMS' efforts to improve mental health treatment through the use of coordinated care. Integrating mental health treatment within primary care visits has been shown to have benefits for patient health outcomes. By treating mental health challenges separately from other medical conditions, patients miss out on the benefits of care coordination. For example, separating care creates logistical challenges related to seeking care from different providers. Notably, 67 percent of patients do not typically receive treatment from their primary care providers (PCPs) for mental health challenges, while 80 percent of those patients visit a PCP at least once a year.¹³ Studies have found that integrating these appointments leads to a 16 percent reduction in the use of separate behavioral health services that can be handled by a PCP.¹⁴ Additionally, patients suffering from depression saw an average of \$3,300 in decreased costs over a two-year period when mental healthcare was integrated into primary care visits.¹⁵ Combining primary care and mental healthcare has proven successful with certain patients and should be encouraged when appropriate.

Hospital-at-Home

HLC remains supportive of the hospital-at-home program and the flexibility for beneficiaries to receive acute-level healthcare services in their home environment, when preferred by the patient and clinically appropriate. The CMS waiver flexibilities that enable this model of patient-centered care are tied to the duration of the COVID-19 PHE. Therefore, there is great need to ensure continuity of care, and patients and their healthcare providers need greater certainty and predictability for this important care delivery option. We support the extension of this waiver and encourage CMS to work with Congress to extend the program post PHE. Specifically, CMS should work with Congress to pass H.R. 7053/S. 3792, the "Hospital Inpatient Services Modernization Act," which would extend the current waiver flexibility for two years after the PHE ends.

Drive Innovation to Promote Person-Centered Care

Star Ratings

HLC supports the goals of the Star Ratings program to provide beneficiaries with key information about MA and Part D plans' quality. If CMS proposes changes to the Star Ratings system, we recommend CMS conduct a study of all Stars measures to determine how each measure should be adjusted to accurately account for social risk factors. CMS should also coordinate with other measure stewards such as the Agency for Healthcare Research and Quality and the National Committee for Quality Assurance to improve survey questions and resulting adjustments to better account for health equity. In addition, we recommend CMS publish results on the impact of the Categorical Adjustment Index in adjusting for populations with high SDOH needs, and encourage CMS to work with stakeholders to develop a timeline toward a permanent solution.

¹³ Alexander Kieu, *Now More Than Ever, Mental Health Care Needs Family Medicine*, American Association of Family Physicians (May 2021), <https://www.aafp.org/fpm/2021/0500/oa1.html>.

¹⁴ *Benefits of Integration of Behavioral Health*, Primary Care Collaborative, <https://www.pccpc.org/content/benefits-integration-behavioral-health>.

¹⁵ *Id.*

Data Interoperability

HLC thanks CMS for their proposals to encourage further participation in the Trusted Exchange Framework and Common Exchange (TEFCA) to promote nationwide data exchange, including incentivizing TEFCA participation. TEFCA will create a baseline standard for entities to quickly share information among stakeholders, while ensuring that healthcare information receives robust privacy and security protections. HLC encourages CMS to continue work with other agencies such as the Office of the National Coordinator for Health Information Technology (ONC) to support implementation of TEFCA while recognizing any potential implementation challenges in light of the COVID-19 pandemic and a protracted inflationary market. As we approach broader TEFCA implementation, we also ask CMS, ONC, and related entities to consider the needs of HIEs and healthcare stakeholders to ensure a smooth and successful transition. HLC encourages further discussions and development to optimize this voluntary nationwide network and how it is used relevant to MA plans and providers.

Value-Based Care

HLC has long supported a move toward value-based care because of the opportunity it presents to provide better, more affordable care to beneficiaries while protecting the solvency of the Medicare program. MA organizations are transforming care and driving quality through value-based contracts with providers. Value-based contracting tools achieve both quality and affordability for beneficiaries. We appreciate CMMI's efforts to develop models to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more patient-centered care. We encourage CMMI to continue to examine how to use value-based payment models to improve overall care and reduce health disparities and incorporate more value-based elements such as utilization metrics into FFS Medicare. Currently, there are variations in payment models and how SDOH are reimbursed. HLC believes it is important to move to value-based care payment models, where reimbursement is contingent upon the quality of the care provided rather than the service.

As CMMI develops and implements more demonstrations, however, providers should not be compelled to join demonstrations before the model protocols apply nationally, and even then, with caution. Mandatory participation is often advocated to overcome "adverse selection." There is little evidence of any systematic selection, and if there ever is it can be mitigated through the payment system. Mandatory participation is often suggested for ease of evaluation. MedPAC observed that there is little empirical evidence of provider manipulation of demonstrations. There have been, however, several other issues that affected model outcomes other than selection or manipulation of the model. The most common and most important of the observations was the failure to set the right parameters for incentives such as payments and bonuses. Mandatory participation requirements may decrease support for a model or may put undue burden on certain providers and beneficiaries.

Support Affordability and Sustainability

Risk Adjustment

Accurately capturing beneficiaries' health status for risk adjustment enables MA plans to ensure the complex health needs of beneficiaries are addressed and allows health plans to deliver flexible and tailored benefits, manage chronic conditions, and address SDOH. The risk adjustment process is subject to data validation checks. However, we are concerned that CMS' proposed Risk Adjustment Data Validation (RADV) audit methodology does not account for the different documentation standards between MA and FFS Medicare leading to uncertainty due to inaccurate and inflated audit recoveries. We encourage CMS to work with stakeholders to develop a fair, accurate, and predictable RADV methodology.

End-Stage Renal Disease Benchmark Accuracy

HLC continues to urge CMS to ensure ESRD costs are accurately reflected in MA payment. We are concerned that the current rate setting methodology will undermine benefits and costs for all MA enrollees. HLC encourages CMS to consider a benchmark adjustment for rural and medically underserved areas to increase beneficiaries access to high quality MA plan options.

Engage Partners

HLC encourages CMS to continue its collaboration and partnerships with the public and private sector to strengthen the MA program. We believe CMS should improve their process for relaying policy updates to stakeholders, providing sufficient comments, guidance, and lead time to ensure effective analysis, feedback, and implementation of future rules and regulations.

HLC looks forward to working with CMS on steps to improve the Medicare Advantage program. If you have any questions, please don't hesitate to contact Debbie Witchey at dwitchey@hlc.org or 202-449-3435 with any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Mary R. Greal".

Mary R. Greal
President