March 4, 2022

Meena Seshamani
Deputy Administrator and Director
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Dr. Meena Seshamani:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Advanced Notice of Methodological Changes for CY 2023 for Medicare Part C and D (Advanced Notice).

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our Advanced Notice comments include one general comment regarding the impact of MA rate setting and then several comments on the proposed new measurement concepts and methodological enhancements for future years.

***

Attachment II. Changes in Payment Methodology for Medicare Advantage (MA) and PACE for CY 2023

Section L. Normalization Factors

CMS notes an expected average change in MA revenue of 7.98 percent, with 3.5 percent of this change tied to the MA risk score trend. The Task Force is not commenting on the average

change of MA revenue, nor the percentage tied to the risk score trend. Rather, we comment on the policy variations between MA risk score adjustments and similar adjustments made in traditional Medicare's alternate payment models. The Task Force recommends that CMS establish parity across all Medicare models and programs when it comes to capping risk score growth. For example, the MA risk score is updated annually, whereas the percent growth rate for other CMS/CMMI models – such as the newly release ACO Realizing Equity, Access, and Community Health model – are capped for a certain number of years, to not grow more than three percent every two years of the model. Alignment across MA and other CMS/CMMI models (in risk score caps and other model elements) can reduce confusion and burden at the participant level as well.

Attachment IV. Updates for Part C and D Star Ratings

Potential New Measures Concepts and Methodological Enhancements for Future Years

The Task Force supports the direction of several proposals intended to improve health equity and eliminate health disparities. Health equity has been - and continues to be - a major Task Force priority. We support addressing these issues in the MA program, acknowledging that MA serves as a powerful catalyst for innovation and can serve as an example for both traditional Medicare and Alternative Payment Models (APMs) developed by the Center for Medicare and Medicaid Innovation (CMMI).

- Stratified Reporting (Part C and D): CMS is considering expanding efforts to report differences in contract performance on additional Star Ratings measures for subgroups of beneficiaries with social risk factors (SRFs), including by disability, LIS status, and DE status through confidential reports in Health Plan Management System (HPMS) to organizations and sponsors. Currently, contract-level HEDIS and CAHPS data stratified by race and ethnicity are publicly available on CMS' Office of Minority Health website. This proposal is intended to lead to improvements both within contracts and the ability for beneficiaries to choose the best contract to address their SRF, which may not be the same as the best plans overall.

  The Task Force supports this move to advance transparency and additional stratification of measures based on differences in contract performance.

- Health Equity Index (Part C and D): To further measure MA contracts' movement toward achieving health equity, CMS is proposing to develop a Health Equity Index that would enhance the Star Ratings. CMS seeks feedback on the feasibility and utility of incorporating data from the Area Deprivation Index (ADI) into the Health Equity Index. CMS also seeks feedback on adding a reward factor for those organizations that serve a certain percentage of enrollees with SRFs and score above a to-be-established health equity index baseline. If implemented, the Health Equity Index-based reward factor would replace the current reward factor which rewards for consistent high Star Ratings performance.

  The Task Force is supportive of incorporating data from the Area Deprivation Index into the Health Equity Index in the short erm. CMS should also be aware of other resources for similar data, such as the Social Vulnerability Index (SVI), which ranks each census tract on

15 social factors and groups them into four themes (socioeconomic status; household composition and disability; minority status and language; and housing type and transportation).

One notable difference is that the SVI includes race as a factor, whereas the ADI does not include race or ethnicity. Each index has different strengths: the ADI is better suited for looking at social disadvantages within specific neighborhoods, whereas the SVI is better suited to assessing larger geographic regions. Depending on the data needed for the health equity index calculations, we urge CMS to look at other existing methods to determine which is best suited for the task. While the gold standard for data collection is self-reported data from patients, the Task Force acknowledges that this can be a burden on providers and many health systems do not possess the necessary infrastructure to collect this type of information. While health systems work toward this goal, the Area Deprivation Index – or something similar - is an adequate tool to fill in data gaps needed for the Health Equity Index calculations.

The Task Force supports both proposals to create a Health Equity Index and to include a new reward factor to incentivize plans to focus on achieving health equity for enrollees. Task Force members, however, are concerned that an immediate switch to the Health Equity Index and its related reward factor would not allow MA plans adequate time to adapt. The Task Force recommends that CMS first calculate and report the Health Equity Index score to providers before linking it to payment, and phase in the new reward factor over several performance years.

- Measure of Contracts' Assessment of Beneficiary Needs (Part C): To better understand how MA contracts are measuring their beneficiaries needs – specifically at-risk beneficiaries – CMS proposes assessing whether a contract's enrollees have had their health-related social needs assessed. CMS proposes to use a standardized screening tool – such as the one developed by CMS for the Accountable Health Communities Model – that screens for housing instability and food insecurity, among other social risk factors. Currently, MA plans are required to have arrangements that make community and social services generally available through contracting and noncontracting providers in the area served by the MA plan, and to make a best-effort attempt to conduct an initial assessment of enrollee's health care needs within 90 days of enrollment date.

  The Task Force supports requiring plans to use a standardized tool to screen for enrollees' health related social needs. Another method to screen enrollees for social needs is to require MA organizations to ask social needs questions during the annual Health Risk Assessment. The Task Force is submitting comments on the CY 2023 MA and Part D proposed rule in support of the proposal to require that housing, food insecurity, and transportation questions be added to MA organizations' Health Risk Assessments which would also be a meaningful glidepath to achieving the goals described here.

  While the Task Force fully supports more emphasis on plans' role in assessing enrollee health related needs, we also posit that screening alone is insufficient. Since MA

organizations cannot always adequately address reported social needs (without partnership from well-resources Community-Based Organizations), we recommend CMS first focus on whether health plans have the appropriate data on social needs to improve quality of care and outcomes. The Task Force supports CMS developing in the future a measure that assesses a plans development of programs and policies to address social needs, and the success of these programs, based on factors within a plan's control, that can eventually be included in the Star Ratings.

- Screening and Referral to Services for Social Needs (Part C): The National Committee for Quality Assurance (NCQA) is developing a measure to assess health system screening for unmet food, housing, and transportation needs, and referral for those that screen positive. The Task Force supports CMS' proposal to use this as either a display or future Star Rating measure in the MA program. One challenge Task Force enrollees have cited in their work on addressing health equity is the lack of standardized measures available and little knowledge on first steps to addressing health equity. Using the NCQA measure would provide some visibility into the needs of a plan's beneficiary population, allowing for more targeted interventions to be developed.
- Value-Based Care (Part C): In this proposal, CMS expresses interest in developing a measure that focuses on the percentage of providers in MA plans that are in value-based contracts and what types of contracts are being used. The Task Force believes that MA acts as a driver for value transformation, and therefore supports this move to collect more information on MA and value-based contracts.

  We recommend CMS consider using the Health Care Payment Learning and Action Network's (LAN) Alternative Payment Model Framework as a starting point for the measure. Using this framework, CMS should measure MA provider participation in Framework's Category 2 versus Category 3 and 4 to see how advanced value-based contracts are in MA. This is an important distinction as Category 3 and 4 payment models tie a financial incentive directly to a cost reduction (i.e., the participating provider shares in savings or losses), whereas Category 2 just tie bonuses to quality improvements. In the future, the Task Force would also like to see additional policies to incentivize MA plans to enter into value-based agreements with their provider networks.

A general recommendation for MA that is not addressed by any current proposal is to add peer support specialists, Community Health Workers (CHWs), and other paraprofessionals as permissible supplemental benefits to address health equity in MA. Given the health equity push, and the benefits of peer support specialists and CHWs, the Task Force recommends looking to incorporate these benefits into MA in future years[1, 2, 3].

[1] https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf
[2] https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.302987
[3] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/1828743

The Task Force applauds CMS for moving to address health equity in MA plans. While more will be needed to fully achieve health equity, the Advanced Notice's proposals would provide a good foundation to direct plans toward more equitable care delivery.

***

The Task Force appreciates the opportunity to respond to the Advance Notice. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with any questions.

Sincerely,

Angela Meoli
Senior Vice President, Network Strategy & Provider Experience
Aetna, A CVS Health Company

Claire Mulhearn
Chief Communications and Public Affairs Officer
agilon health

Sean Cavanaugh
Chief Commercial Officer and Chief Policy Officer
Aledade, Inc.

Shawn Martin
Executive Vice President & Chief Executive Officer
American Academy of Family Physicians

Maria Stavinoha
Payment Innovation Director, Network Optimization
Anthem, Inc.

Jordan Hall
Executive Vice President, Accountable Care Operations
ApolloMed

David Terry
Founder & Chief Executive Officer
Archway Health

Patrick Holland
Chief Financial Officer
Atrius Health

Jamie Colbert, MD
Senior Medical Director, Delivery System Innovation and Analytics
Blue Cross Blue Shield of Massachusetts

Todd Van Tol
Senior Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Troy Smith
Vice President of Healthcare Strategy & Payment Transformation
Blue Cross Blue Shield of North Carolina

James Grana
Vice President, Value Based Care
Blue Cross Blue Shield of South Carolina

Laura Fox
Director, Payment Innovation
Blue Shield of California

Alex Goolsby
Vice President, Network Management & Provider Partnership Innovation
Cambia Health Solutions

Stephanie Graham
Senior Solutions Lead
Clarify Health

Shelly Schlenker
Executive Vice President, Chief Advocacy Officer
CommonSpirit Health

Emily Stewart
Executive Director
Community Catalyst

Colin LeClair
Chief Executive Officer
Connections Health Solutions

Mark McClellan, MD, PhD
Director
Duke Margolis Center for Health Policy

Ashley Ridlon
Vice President, Health Policy
Evolent Health

Frederick Isasi
Executive Director
Families USA

Zahoor Elahi
Chief Operating Officer
Health [at] Scale

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

Ami Parekh
Chief Medical Officer
Included Health

David Nace
Chief Medical Officer
Innovaccer

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Sara Rothstein
Vice President, Population Health Management
Mass General Brigham

Ryan Anderson, MD
Interim Vice President, Clinical Care Transformation
MedStar Health

Nathaniel Counts
Senior Vice President, Behavioral Health Innovation
Mental Health America

Sinsi Hernández-Cancio
Vice President for Health Justice
National Partnership for Women & Families

Blair Childs
Senior Vice President, Public Affairs
Premier

Jake Woods
Manager, Accountable Care Models
PSW

Srin Vishwanath
CEO
OPN

Jordan Asher, MD
Senior Vice President and Chief Physician Executive
Sentara Healthcare

Kim Holland
Senior Vice President, Government Affairs
Signify Health

Jim Sinkoff
Deputy Executive Officer and Chief Financial Officer
Sun River Health

Emily Brower
SVP Clinical Integration & Physician Services
Trinity Health

Debbie Rittenour
Chief Executive Officer
UAW Retiree Medical Benefits Trust

Judy Zerzan, MD
Chief Medical Officer
Washington State Heath Care Authority