



October 14, 2022

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Re: Medicare Program Request for Information on Medicare (CMS-4203-NC)

The Health Care Transformation Task Force (Task Force) appreciates the opportunity to respond to the Request for Information aimed at strengthening Medicare Advantage (MA) in ways that align with CMS's previously released Vision for Medicare and the CMS Strategic Pillars (CMS-4203-NC) (RFI).

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 that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

The Task Force appreciates the opportunity to provide comments related to the future of Medicare Advantage. The MA and Part D programs are successful examples of public-private partnerships that deliver value for beneficiaries, including older adults and people with disabilities, while leading the way on delivery system reform and the move from volume to value in the Medicare program. The comments below begin by addressing topics related to driving innovation to promote person-centered care. These are followed by comments related to advancing health equity, and finally, to expanding access to coverage and care.

Drive Innovation to Promote Person-Centered Care

The attractiveness of the MA program as a value transformation engine emanates from the greater flexibility to engage in advanced risk arrangements, which we believe have greater potential for cost savings and quality improvement. The Task Force supports efforts that drive MA plans away from fee-for-service toward risk-based contracts. Given that MA's market

penetration among beneficiaries continues to grow, we appreciate the opportunity to discuss strategies to support value-based care via MA arrangements, that are focused both on fee-for-service and risk-based methodologies.

Payers and providers – regardless of coverage population – often engage in readiness assessments to gauge whether a value-based partnership could be viable in each market. Over the years, Task Force members have heard both providers and payers say that the other is not ready and/or willing to engage in value-based contracts, and the bottom line is assessing readiness requires case-by-case considerations. **In 2019, the Task Force developed a [Value Partnership Evaluation Tool](#) to support healthcare leaders as they assess potential partner organizations for their readiness to engage in successful value-based partnerships.** Many organizations also use this tool to assess their own readiness and as a benchmarking tool to identify areas for improvement. Because trust lies at the center of all successful value-based arrangements, transparency of stakeholders around readiness and a plan to grow and improve their value-based capabilities and operations over time is important.

Once a desire to pursue a value-based partnership is expressed, a clearly defined set of roles and responsibilities should be established to help foster productive execution. **To aid in this planning, the Task Force developed an [APM Roles and Responsibilities Matrix](#) that helps organizations identify and assign roles and responsibilities for common APM workstreams and activities.** The goal of this matrix is to identify relationships, recognize gaps or overlaps in responsibilities, improve efficiencies and communication, and promote successful operations. In sum, effective planning and management of operations is critical to raising the likelihood of successful partnerships.

The factors that may influence MA plans and providers to move into value-based contracting include:

1. Plan and Provider Readiness for Innovation

MA plans are paid a capitated rate by CMS, but that in and of itself does not make MA plans effective value transformation drivers. It is the plans' ability to innovate and realign network contracting incentives that sets them apart from the restrictions imposed by traditional Medicare's fee-for-service system. Alternate payment arrangements in MA network contracts are growing, resulting in more providers taking accountability for total cost of care and outcomes based on their per member per month amount; this allows them the flexibility to design and deliver care in a way that makes the most sense for their patient populations and communities. This is foundational and integral to APM design.

A more complex question is the degree to which the participants wish to - or are ready to - take on advanced risk arrangements. **Shared savings in upside only arrangements are a good place to start for many partnerships, although a clear path to advanced downside risk arrangements should be set at the outset to ensure all parties move in the right direction.** The reality is advanced risk arrangements are likely to bear more fruit in the long term due to better aligned incentives associated with providers accepting downside risk, which help make care delivery more effective and more efficient. Current MA arrangements with primary care providers willing to accept accountability for total cost of care and utilization rates

of events that are within their control to address (e.g., preventable hospitalizations) are both great places to start and should be used more. MA plans are also experimenting with clinical episode models in key specialty areas like kidney-related services and substance use disorders, which fit into an overall population health type approach to delivering care. How MA plans set goals and define success in these models is worthy of a robust public conversation and shared learning exercises transparent to all stakeholders.

2. Multi-Payer Alignment

Foundational to the evolution from FFS to value-based payment is alignment across traditional Medicare and MA. Under traditional Medicare, the largest value-based payment program is the Medicare Shared Savings Program (MSSP), yet MSSP primarily operates on a shared savings approach which still uses a fee-for-service chassis. The CMS Innovation Center's Direct Contracting/ACO Realizing Equity, Access, and Community Health (REACH) models provide opportunities for more advanced risk arrangements, including capitation and global budget arrangements, yet those cohorts are now set and no new opportunities to participate are currently contemplated. As a result, MSSP remains a good first step to attract reticent providers into the program. MA has greater promise in this regard due to the potential for moving providers into advanced risk given the programs flexibilities in paying specific network providers without having to be selected for a particular CMMI model.

Multi-payer alignment is also desirable in the context of quality measurement. Providers find it inefficient and burdensome to have to collect and report on different, voluminous sets of measures from other payers. **The Task Force believes that value-based arrangements are best served by a parsimonious set of measures applied consistently across payers and population types, and that alignment in this area is both desirable and potentially achievable for providers across MA, Medicaid, commercial, duals and traditional Medicare, and across payment models.** The demographics and care delivery needs across the populations in the products mentioned above are relatively consistent, so setting a uniform set of parsimonious quality measures is possible. This is also an area where the different CMS divisions could collaborate to help create more efficiency and effectiveness among payers and providers.

The Task Force is currently engaging with its members to understand best practices around multi-payer alignment. One lesson learned to date is that there are parts of value-based arrangements that represent proprietary or commercial sensitive behavior, and thus, are not well suited for alignment. However, there are other parts of these arrangements that are not viewed as competitive and for which greater standardization would be welcome. Given the reach of Medicare, Medicaid, and commercial products, payers are well positioned to help drive greater alignment, which would help create greater uptake of value-based models across all populations, including commercial populations.

Finally, there is an ongoing conversation about how best to develop consistent and aligned benchmarking and risk adjustment methodologies. For the MSSP program, current benchmarking policies have not been effective at maintaining long term participation due to their "ratcheting" effect. The CY 2023 Medicare Physician Fee Schedule Proposed Rule offers

welcome relief in this regard and sets a path toward administrative benchmarks that is likely to create a more effective long-term approach to maintaining provider participation in MSSP. The MA program may avoid this problem given the flexibility of contracting and the ability to pursue model design elements that are best suited for a particular arrangement, plan/provider relationship, or market demographics. Both programs should provide similar opportunities for provider-led and payer-led efforts to innovate on value-based arrangements.

3. Leveling the Playing Field

The Task Force strongly believes there should be a level playing field between MA and ACOs, such that both programs have similar opportunities to achieve value-based care. In response to the CY 2023 MA Advance Notice, the Task Force commented 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 consider ways to level the playing field most appropriately across all Medicare models and programs**, which may include payment methodologies as well as requirements for bearing financial risk. The Task Force has ongoing work in this area and will offer additional perspectives on leveling the playing field between MA and traditional Medicare once fully developed.

4. Meaningful Measurement of Value-Based Contracting

The Health Care Payment Learning and Action Network (LAN) conducts a yearly assessment of how plans are progressing in their value-based care journeys by reporting the percentage of existing arrangements that fall into the different categories of the LAN's APM framework. This information is helpful to understanding the types of value-based care arrangements that are prevalent in the marketplace and the different levels of risk sharing that are deployed in such models. **[The Task Force recently sent a letter to CMS](#) with guidance on the concept of a MA value-based care measure**, including recommendations to better understand how MA plans define and assess success in value-based care arrangements. CMS could facilitate this activity through a series of listening sessions or other forums where MA plans and their network providers address these topics in a substantive way.

5. Engaging Specialists to Contract in MA

Over the past several years, the MA program has seen an emergence of primary care providers with advanced risk arrangements to improve management and coordination of patient care. These arrangements are successful in providing a central point of engagement for patients that allow them to better manage their care. As noted above, but worth repeating here, **engaging specialists in value-based care arrangements for the large part is still an unmet opportunity to test advanced risk arrangements**. The MA program provides fertile ground for testing these types of arrangements and the possibilities of nesting clinical episode models within accountable care.

6. **Data Infrastructure Investments**

For MA plans and providers to successfully transition from FFS to value-based payment requires a robust data infrastructure built for interoperable communications beyond the care that takes place within the four walls of one clinic or institution. MA is also known for its desirable coverage of supplemental benefits, including transportation, food, and other non-clinical services and supports. Thus, having bilateral (or multilateral), timely sharing of data between payer and provider, and between providers and community-based organizations, is crucial. MA organizations have been innovative in their use of data and analytics to understand the health status of their Medicare beneficiaries.

This data infrastructure could be readily applied to improving APM performance by identifying those who are at a high risk of a cardiac event, asthma exacerbation or progression of their diabetes, and intervening early. **We urge CMS to consider ways that it can help scale such examples as the partnership between payers and analytics companies, to support compliance more efficiently with collection and submission of Healthcare Effectiveness Data and Information Set (HEDIS) measures for the MA population.** The same analytic capabilities used to better identify targets for resource optimization and enhance members outcomes and satisfaction can be translated into other value-based payment models. In the case of MA, these efforts are helping plans identify gaps in cancer screening and diabetic care management which allow them to connect beneficiaries with providers earlier in their disease course.¹ This type of agile data gathering, sharing, and analysis is critical in improving outcomes of patients under an APM, and to shoring up success for payers and providers in MA.

While initiatives are underway to address the interoperability of healthcare data, additional work to advance efficient and secure data movement is needed. A recent U.S. Office of the National Coordinator for Health Information Technology (ONC) report highlighted that while overall health information exchange has increased between office-based physicians, there is less exchange between small-practice physicians.² This may be due to financial and technical barriers inhibiting adoption and use of health information technologies across provider group sizes.

Recognizing this issue goes beyond MA and is a system-wide issue, MA provides an opportunity for ONC and CMS to approach additional rulemaking on interoperability; **we recommend the following:**

- Include financial and technical incentives to support all relevant healthcare stakeholders. Prior incentives and support for health Information Technology (IT) adoption did not include all healthcare stakeholders, such as Mental Health and Substance Use Disorder (MH/SUD) providers and community services. Smaller provider groups with less financial and technical resources may also benefit.

¹ The Journey to 4-Star Performance: How Data Analytics Make the Difference, Healthcare Innovation, <https://www.hcinnoationgroup.com/analytics-ai/article/21237641/the-journey-to-4star-performance-how-data-analytics-make-the-difference>

² <https://www.healthit.gov/data/data-briefs/interoperability-among-office-based-physicians-2019>

- Require all relevant stakeholders to participate in the interoperability provisions such as the payer-to-payer data exchange. The current data exchange mandate does not apply to CMS, VA, or DoD. To reach the goal of enabling beneficiaries to create and move their longitudinal health records across payers, all payers should be involved to achieve the goals of interoperability.
- Encourage alignment and support with CMS and ONC interoperability initiatives, such as use of Fast Healthcare Interoperability Resources (FHIR) and the operationalization timelines set under the Technical Exchange Framework and Common Agreement (TEFCA), enabling relevant stakeholders to send and receive health care data in a standardized, secure way with reduced burden.
- Explore options to encourage bi-directional exchange between healthcare stakeholders, where appropriate.

7. Improving the Star Ratings Program

In 2023, 51 percent of all MA plans (that included Part D coverage) were rated at least four stars,³ leading some commentators and beneficiary groups to question how meaningful the current measures are in terms of allowing for differentiation of plans based on quality. **One strategy for driving improvement in the Star Ratings program area is to modernize the collection of patient experience data**, thereby improving the system’s consumer-oriented focus. Modernization could include updating the CAHPS survey language to reflect enrollee diversity, fielding the CAHPS survey via email, and providing more granular detail on CAHPS results to plans to support quality improvement efforts.⁴ Other recommendations regarding the Star Ratings program are included in the Health Equity section below, on page 8.

8. Continued VBID Innovation

The CMS Innovation Center is currently operating the MA Value-Based Insurance Design (VBID) model, which is testing a broad array of MA plan innovations and shows how MA could serve as a chassis to refine how value-based care is operationalized through APM development.⁵ As MA plans continue to increase enrollment and innovation, their potential to serve as an APM incubator and move providers along the value-based payment continuum will continue to grow and help facilitate a path forward for value-based care across all covered populations.

The Task Force encourages CMS to consider authorizing the MA VBID model beyond 2024 to support plans’ efforts to strengthen and develop new benefit offerings specially targeted at meeting SES and health needs of underserved beneficiaries. This includes evolving the MA Value-Based Insurance Design (VBID) Model to allow participants to test additional eligibility criteria such as: English as a second language, county or Plan Benefit Package (PBP) level, poverty level (instead of Low-Income Subsidy (LIS) level, age, place of

³ <https://www.cms.gov/newsroom/news-alert/cms-releases-2023-medicare-advantage-and-part-d-star-ratings-help-people-medicare-compare-plans>

⁴ Measuring Patient Experience of Medicare Advantage Beneficiaries: Current Limitations of the Consumer Assessment Tool and Policy Recommendations, [BMA-Patient-Experience-Policy-Report-FIN.pdf \(bettermedicarealliance.org\)](#)

⁵ Medicare Advantage Value-Based Insurance Design Model, CMS Innovation Center, <https://innovation.cms.gov/innovation-models/vbid>

residency/environment, level of education, family/social support, and when cohort outcomes vary from other cohorts or available benchmarking data (as that is often a warning sign that an intervention is needed). Additionally, with appropriate policies in place, we support continued testing of the Hospice benefit in the MA VBID Innovation Center Model.

Advance Health Equity

1. Data Collection

Addressing health inequities begins with collecting person-level data on individuals' race, ethnicity, language, sexual orientation and gender identity, disability status, socio-economic status, and geographic location. Person-level demographic data are critical for the purpose of stratifying clinical process and outcome measures to gain a granular understanding of the inequities in care, and disparities in outcomes, that fall along demographic and other characteristics' lines. Without these data points, it is extremely difficult for CMS, MA plans, and network providers to understand the factors that are driving enrollees' health status and outcomes, and the gaps in care that they are experiencing. With comprehensive person-level data, MA plans can identify the benefits, as well as care delivery modalities that will best suit enrollees and implement strategies and interventions to maximize effective patient care.

Health plans, hospitals, and clinicians are currently following various federal and state requirements for demographic and social needs data collection related to Medicare, Medicaid, Qualified Health Plans, and others, and additional proposals are being floated. **The Task Force believes that any approach that is applied to MA should be aligned and standardized – to the extent feasible – across federal programs.** This will empower the health care system to collaborate on shared health equity goals, measure progress towards those goals, and better serve individuals and communities. We are encouraged by the ongoing iterations and updates to the United States Core Data for Interoperability (USCDI) to increase standardized data exchange and recommend the Medicare enrollment forms align with these data standards.

While MA plans and network providers can play a role in verifying or collecting missing data, **Task Force members believe CMS should consider being the primary collector of this type of person-level data through the Medicare enrollment process or other targeted CMS data collection initiatives or partnerships.** The ability to educate Medicare enrollees about the purpose of the data collection and establish the trust with enrollees to provide accurate information should at least begin when they sign up for the Medicare program. Further, this approach would serve to not only increase the availability of reliable data but also may reduce the possibility of plans and providers collecting conflicting data which will hinder effective care delivery. **Related to this, we recommend CMS support interoperability infrastructure improvements that allow for data to be more easily shared between plans and providers.**

Finally, **the Task Force encourages CMS to solicit and review existing best practices being implemented in the field to increase the volume and accuracy of person-level self-reported data.** These practices include not only the data collection process itself, but the

foundational efforts to build trust between providers/payers and patients that enables information collection and provide support to payers and providers to enable their ability to successfully capture these data.

2. Meaningful Enrollee Engagement

Data is not the only means to understanding beneficiaries' needs and priorities. There is tremendous value in hearing directly from the enrollee community through vehicles such as MA Enrollee Advisory Councils (EACs) and on governing bodies. **The Task Force urges CMS consider the following in the support of more effective beneficiary engagement:**

- Provide EAC participants – via the MA plan – with information on the impact they can have on policy and decision-making
- Encourage MA plans to facilitate EACs in such a way (in terms of time, location, and ability for audio/video participation) that allows as large a cross-section of beneficiaries as possible to participate. Further, encourage MA plans to provide beneficiaries with incentives to compensate for their time and effort in preparing for and participating in an EAC.
- Encourage MA plans to recruit and train beneficiaries to enable them to engage meaningfully.

3. Screening for Social Drivers of Health

CMS has demonstrated through rulemaking over the past two years that screening for social drivers of health – including housing status, food insecurity, and transportation – is a top priority. For example, the CY 2023 MA final rule requires an assessment of individuals' physical, psychosocial, and functional needs as part of the Health Risk Assessment (HRA) for all Special Needs Plan (SNP) enrollees.

MA plans currently have the flexibility to include SDOH-related questions in the HRA in a non-standardized format, which allows them to craft questions in ways that best suited for their beneficiary population or targeted intervention initiative. We support this flexibility yet also **recommend CMS consider strategies for standardizing these data – once submitted – to allow the Agency to best assess the effects of SDOH on MA beneficiaries.**

The Task Force also encourages CMS to recognize the value of in-home HRAs in screening for SDOH and addressing beneficiary needs. In many cases the socio-economic status (SES) needs of a beneficiary may not be apparent in the clinical setting or a beneficiary may be reluctant to share this information as part of a medical visit. We recommend the data collected from home-based HRAs continue to be used for gaining important clinical and SDOH information on plan members as well as for risk adjustment purposes. Also, MA support networks should conduct HRAs not just on new enrollees, but rather every three-to-five years on existing enrollees to ensure that collected information is still relevant, accurate, and actionable.

We suggest CMS support plans and providers in the collection of SDOH data, including education, training, and outreach. CMS could also consider building incentives in its quality programs to place greater value on the collection of these data.

Finally, while the Task Force fully supports more emphasis on plans' role in assessing enrollee health related needs, we also acknowledge that screening alone is insufficient. The true measure of how well enrollees' needs are supported is based on the rate at which beneficiaries are connected with community services through the plans' care coordination supports. Given that plans and providers only have so much ability to influence enrollee uptake of these supports, **CMS policy should balance the desire to incentivize action to connect supports without penalizing for lack of utilization.** Thus, we recommend that CMS explore how it can provide plans and providers with necessary supports to identify and connect enrollees based on their needs. In addition, to the extent possible based on voluntary beneficiary response rates, we recommend that CMS encourage or incentivize health plans to refer and collect data on how these social needs were met, to improve quality of care and outcomes.

4. Leveraging the Star Ratings Program to Address Health Equity

The Star Ratings program was intended to incentivize quality improvement and public accountability, and provide beneficiaries with a valuable tool to assist in choosing the best health plan for their individual needs. A comparable comprehensive quality measurement system does not exist in traditional Medicare. To advance health equity and drive a focus on whole-person-centered care, **we recommend CMS continue to provide plans with stratified Star Ratings data and explore potential measures for the Star Ratings system that account for access to and the provision of care, supports, and services addressing social risk factors.**

CMS should conduct a study to determine how contract-level Star Ratings scores could be adjusted to accurately account for social risk factors. The results could be made public and a proposal on how to adjust Star scores should be part of transparent stakeholder process, with public meetings and comment opportunities.

5. Improve How SDOH is Accounted for in Star Ratings

CMS has acknowledged that the Agency's interim adjustment to reflect the impact of SDOH (as proxied by the number of LIS beneficiaries and dual eligible beneficiaries enrolled in a plan) on plan contracts – the Categorical Adjustment Index (CAI) – has had a limited impact on the Star Ratings program. CMS developed the CAI as an interim analytical adjustment while the Agency developed a long-term solution. No such solution has yet been proposed.

To advance health equity and drive a focus on whole-person-centered care, **we urge CMS to better account for access to and the provision of care, supports, and services addressing social risk factors in the Star Ratings program.** To this end, we believe the Agency should conduct an updated study which analyzes the impacts of the CAI on the Star Ratings program and on health plans. After the results are published, CMS should convene stakeholders to analyze and collaborate on a permanent solution. We also recommend CMS

conduct a study to evaluate how contract-level Stars Ratings measures could be adjusted to accurately account for social risk factors. Similarly, results should be made public and a proposal on how to adjust measures should be developed collaboratively with extensive public stakeholder input.

The Task Force supports CMS' proposal, as per the CY 2023 MA and Part D Advance Notice, to report differences in contract performance for subgroups of beneficiaries with social risk factors (SRFs) – including by disability, Low Income Subsidy (LIS) status, and Dual Eligibility (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's Office of Minority Health website. This proposal would improve transparency of information and support beneficiaries in choosing the best plan to address their SRF. The Task Force supports this move to advance transparency and additional stratification of measures based on differences in contract performance, assuming verification of accuracy.

We recommend CMS collaborate with MA plans and measure stewards like the Agency for Healthcare Research and Quality (AHRQ) and National Committee for Quality Assurance (NCQA) to update and improve the survey. The survey can be improved to ensure it takes into account the evolving health care system, the diversity of the MA population and growing use of technology (especially due to the COVID-19 pandemic), to better account for health equity, or lack thereof.

Expand Access: Coverage and Care

1. Ensure Access to Telehealth

The Task Force believes **CMS should establish permanent coverage of telehealth services, including identifying situations when it may be appropriate to waive the first in-person visit requirement.** Similarly, there may also be situations where it would be appropriate to waive the requirement that patients have a pre-existing in-person relationship with a provider to establish a treatment relationship for mental telehealth services. We believe that waiving this requirement is especially beneficial as workforce shortages result in beneficiaries relying on virtual visits for their mental/behavioral health needs.

To further ensure equitable access to telehealth, the Task Force recommends CMS collaborate with healthcare providers to identify and address barriers, such as the lack of access to devices that facilitate digital communications. Lack of internet access in rural and underserved urban communities is foremost among these barriers. Technical literacy is another barrier, as is lack of access to end-user devices (*e.g.*, tablets and laptops).

We encourage HHS to seek Congressional action to make permanent certain telehealth waivers and flexibilities once the COVID-19 Public Health Emergency (PHE)

ends. We also support the Interstate Medical Licensure Compact (IMLC)—an expedited licensure pathway for physicians who seek to practice medicine in multiple states.

2. Consumer Decision-Making Tools

CMS seeks input on the tools enrollees use to effectively choose between different Medicare coverage options and among different MA plans. CMS also asks for input, later in the RFI under the “Driving Innovation to Promote Person-Centered Care” section, on how beneficiaries use the MA Star Ratings and how the program can be improved. These questions are inherently connected. MA enrollees’ need for consumer-friendly tools that help differentiate between plans becomes increasingly important as the number of MA plan offerings grows. In 2021, the average Medicare beneficiary⁶ had nearly 33 MA plans from which to choose. The Medicare Plan Finder at www.medicare.gov is useful for showing enrollees their estimated annual in-network out-of-pocket costs, but beyond that, does not display detailed information on coverage policies related to specific benefits. (e.g. specialist visits, tests labs and imaging, hospital services, skilled nursing facility stays, and preventive services).

The increase in MA plans offering primarily health related, Special Supplemental Benefits for the Chronically Ill (SSBCI), and COVID-19 benefits from 2019 to 2021 is true progress in pursuit of value-based care. These expanded supplemental benefits contribute to the essence of what a person-centered health care system should be. To ensure beneficiaries can make fully informed decisions, **we recommend CMS modify the Medicare Plan Finder (MPF) to show comprehensive summaries of available supplemental benefits to support transparency, inform beneficiaries’ plan choice, and empower beneficiaries to fully take advantage of the new benefits that plans are providing.**

We also recommend CMS review the accuracy of how SSBCI and VBID benefits appear on the MPF and other sites that are distilled from Medicare.gov due to how benefits are entered into and publicly reported through existing software. We recommend CMS conduct ongoing working sessions with MA plans to support Agency efforts to upgrade the web-based version of the software to include greater capacity for the system to accurately report the full range of available benefits to stakeholders.

Finally, MA plans should ensure that the benefits and coverage information they provide meets health literacy standards and is easy for the average consumer to navigate and understand.

3. Increasing Transparency of Decision-Making Information

Currently, the MPF limits the number of supplemental benefits shown which prevents beneficiaries from having all the information needed to make informed enrollment decisions. **The Task Force recommends CMS modify the MPF to make available comprehensive summaries of available supplemental benefits, including clearly delineating those that are “primarily health-related” benefits and SSBCI.** Other suggestions include clearly depicting

⁶ <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/> and <https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/>

supplemental benefit plan design options that require beneficiaries to make additional decisions once enrolled (e.g., MA plans that require beneficiaries to select a limited number from a menu of supplemental benefits). Since Medicare call centers and online eHealth providers also use the MPF to support enrollment, these design changes can have far-reaching positive impact.

4. Support Health Care Access for Rural Communities

In some communities, a shortage of health care professionals makes it difficult for people to obtain the personalized care they need. This is especially true for rural areas, where the number of health care providers is declining, and patients may not be able to find high-quality or accessible health care providers or facilities that reflect their cultures or experiences. Rural communities often contend with high levels of poverty, food insecurity, and other social drivers that lead to health inequities, and thus are significantly affected when appropriate care teams and supports are not available in their areas.

The Task Force recommends CMS and CMMI explore integrating a comprehensive approach to rural health equity in existing and future models. This approach should encourage public-private partnerships that engage the community and increase provider collaboration in rural areas through Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), and Indian Health Centers to increase equitable access to providers and address SDOH (e.g., reimburse members of the community, such as family caregivers, for providing non-emergency transportation, expand access and affordability of broadband services coupled with digital literacy, and leverage colleges/universities to assist older adults with technology for purposes of telehealth, social engagement, etc.). Finally, the approach should increase supplemental benefit flexibility to allow plans to expand these offerings to individuals with needs related to SDOH, and incentivize providers and beneficiaries to utilize audio-video and audio-only telehealth services (where appropriate), and remote patient monitoring to expand the availability of care in the home. This is particularly important for beneficiaries in rural areas with complex conditions and related increased health care needs.

5. Expand Criteria for Supplemental Benefits Eligibility

To expand access to care, CMS should explore the potential for allowing MA plans to offer supplemental benefits based on beneficiary identified SDOH risk factors, such as socioeconomic status, regardless of whether an enrollee is diagnosed with one of the chronic conditions that determine supplemental benefit eligibility. If necessary, **CMS should advocate that Congress make any appropriate statutory changes. We also suggest CMS develop policies that support greater coordination between CMS, plans, and state Medicaid agencies on Medicare and Medicaid benefits.** CMS should work with plans and other stakeholders to develop educational materials on the value of integrated plans and the supplemental benefits tailored to meet the needs of the dual eligible population in particular and such efforts should be coordinated with states. We also recommend giving MA plans the flexibility to innovate and redesign supplemental benefits and program offerings to address unmet needs for mental health treatment and substance use disorders.

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The Task Force appreciates the opportunity to respond to this RFI. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to these comments.

Sincerely,

**The Health Care Transformation Task
Force**

ABOUT THE HEALTH CARE TRANSFORMATION TASK FORCE

Health Care Transformation Task Force is a unique collaboration of patients, payers, providers and purchasers working to lead a sweeping transformation of the health care system. By transitioning to value-based models that support the Triple Aim of better health, better care and lower costs, the Task Force is committed to accelerating the transformation to value in health care. To learn more, visit WWW.HCTTF.ORG.

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