



February 13, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-4201-P: CY 2024 Policy and Technical Changes to the Medicare Advantage and
Medicare Prescription Drug Benefit Program

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) CY 2024 Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4201-P) ("Proposed Rule").

The Task Force is a consortium of health care 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.

Our comments focus on the Proposed Rule's sections related to health equity, the Star Ratings program, translation and accessibility requirements, utilization management and prior authorization, marketing, and behavioral health.

I. Health Equity

MA Provider Directories

CMS currently requires that the MA provider directory include a specific set of data elements, including provider office/practice location, provider specialty type, whether a provider is accepting new patients, and/or information on how a beneficiary can contact a provider to learn if they are accepting new patients. While not required, CMS also encourages providers – in accordance with best practices – to self-report data on other elements such as non-English languages spoken within the practice, and accessibility for people with physical disabilities. CMS proposes codifying these best practices into requirements, which would align the MA provider directory with the required elements in the Medicaid provider directory. Required data elements in this provision include providers’ cultural and linguistic capabilities (including languages) that reflect the [HHS Office of Minority Health Definition of Cultural and Linguistically Appropriate Services \(CLAS\)](#): services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.

The Task Force supports this proposal, and appreciates CMS’ recognition of how critically important it is – when seeking to address health inequities – that beneficiaries have information on how to access culturally congruent care.

Under existing practices, because there is no centralized source for updating provider directories, providers are inundated with requests from each payer to update information in a way that creates significant administrative waste. For this reason, our members are supportive of CMS’ initiative to explore how to create an efficient process for populating provider directories in a way that would only require providers to update information at one location, instead of separately with each payer. This approach will lead to more accurate provider directories and reduce administrative waste.

The Task Force also supports CMS’ proposal to require providers who offer medications for opioid use disorder (OUD) to be indicated as such in the MA provider directory, but acknowledges the challenge of identifying prescribers of medication for opioid use disorder. Finally, we recommend CMS withdraw the proposed requirement that MA organizations identify certain providers in their provider directories who have obtained a SAMHSA and DEA waiver to treat patients with OUD with medication. The passage of the most recent Omnibus bill eliminated the requirement that providers obtain an “X-Waiver” for the purpose of prescribing MOUD. This legislation enabled all licensed prescribers to prescribe MOUD, eliminating the need and ability for payers to designate which prescribers can prescribe MOUD.

Digital Health Education for MA Enrollees Using Telehealth

The Proposed Rule describes CMS’ goal to improve health equity in telehealth services, i.e., “making changes in digital literacy, technology, and analytics to help telehealth providers reach the underserved communities that need it most.” Digital health literacy in this context is defined as “the ability to seek, find, understand, and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem.” To address these challenges, CMS proposes requiring MA organizations to screen enrollees for the purpose of identifying those with low digital health literacy and subsequently offering them digital health education to improve access to medically necessary, covered telehealth benefits. Under this new

requirement, MA organizations would have the flexibility to design their own screening process and tool.

The Task Force shares CMS' concern regarding low digital health literacy and its impact on access to care – particularly for underserved populations – and appreciates the Agency's recognition that requiring MA organizations to conduct this screening should be designed with a flexible approach. **The Task Force supports this proposal as described in the Proposed Rule, namely allowing MA organizations to use a range of screening tools. Further, we support the Agency's plan for how to monitor the implementation and impact of this requirement, via requesting statistics from MA organizations, for the purpose of CMS being able to develop best practices.** At the same time, we recommend CMS maintain flexibility with reporting as plans determine how to effectively screen for digital health literacy and measure engagement in education, particularly given that many plans may work with community-based organizations (CBOs) to provide the beneficiary with assistance/education. Toward this end, the Task Force encourages CMS to provide support for plans in partnering with CBOs and community leaders in underserved communities to identify/target best practices for digital health education.

Our members urge CMS to provide additional detail and guidance on how digital health literacy will be defined. For example, does it include broadband access, access to a smartphone, ability to access a telehealth platform and/or an Electronic Medical Record (EMR), or ability to evaluate online health resources with the goal of making decisions based on that information? Further, what arrangements will CMS accept regarding digital health education, and to what extent will MA organizations be supported in partnering with outside organizations to provide the educational services needed. Finally, Task Force members suggest that CMS assess the extent to which proxy access is utilized. Proxy access is particularly important for this population and during this period of transition to expanded virtual care options. It is also key to ensuring access to care is maintained in geographic areas and systems that have yet to reach an ideal standard telehealth accessibility.

We also encourage CMS to confirm that the Agency is using the World Health Organization definition to measure digital health literacy and provide flexibility as health plans innovate to expand access to telehealth, digital access, and digital literacy in the Medicare population. **Given that there are currently different definitions, standards, and vocabulary around digital health literacy, we encourage CMS to form a working group to develop research-driven standards and further studies. We also encourage the government to do annual assessments of digital health literacy across the Medicare population to help inform best practices in the working group using the eHealth Literacy Scale (eHEALS).** The last such national study was published in 2003. We have found the eHEALS 8-item measure of consumers' knowledge, comfort, and perceived skills at finding, evaluating, and applying electronic health information to health problems is a helpful benchmark to inform this work.^{1 2}

¹<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1794004/#:~:text=The%20eHEALS%20is%20an%208,health%20information%20to%20health%20problems>.

²<https://www.jmir.org/2006/4/e27>

II. Star Ratings Program

Weighting of Patient Experience Measures in the Star Ratings Program

CMS proposes to reverse a policy in the MA and Part D CY 2020 Final Rule that served to increase the weight of the patient experience/complaints and access measures from 2 (which was established in the CY 2018 Final Rule) to 4.

The Task Force is unable to reach a consensus position among its diverse set of patient, provider, payer, and purchaser members on a specific weight for CAHPS and patient experience in the Star Ratings program and encourages CMS to continue finding ways to incorporate the beneficiary experience into Star Ratings. **The Task Force recommends CMS refrain from implementing significant year-over-year changes in the Star Ratings measure weights and methodology, and that CMS provide greater consistency and predictability in the ratings methodology calculations.**

Health Equity Index Reward

In an effort to encourage MA organizations to better identify and then address disparities in care provided to enrollees with a particular social risk factor (SRF), CMS proposes to implement a health equity index (HEI) in the Star Ratings program. The index would reward contracts for obtaining high measure-level scores for the subset of enrollees with specified SRFs. We agree that the existing reward factor could be improved to better gauge how measures can account for social risk factors in the Star Ratings system, and we believe a system that focuses exclusively on rewards (instead of a combination of rewards and penalties) is the best approach.

As noted in our [CY 2023 comments on the MA Advance Notice](#), the Task Force supports the creation of a Health Equity Index as a means of incentivizing plans to focus on achieving health equity for enrollees. While we commend CMS for working to address health equity beyond the parameters of the current reward factor, we are concerned that the proposal as described could lead to the following perverse incentives and unintended consequences:

- **Working against health equity goals by lowering Star Ratings and reducing revenue available to help beneficiaries:** CMS' proposal to modify the HEI reward to be a two-sided approach would have the net impact of making it more difficult for plans to fairly receive the higher Star Ratings they have earned. These Ratings help generate the revenue for supplemental benefits – such as medically tailored meals, transportation, and in-home supports – that go even farther to address health-related social needs. CMS' penalties would reduce revenue for the plans that serve the beneficiaries who need these resources the most.
- **Discouraging enrollment of beneficiaries with social risk factors in C-SNPs:** C-SNPs are designed to provide targeted and tailored access to care and care coordination for beneficiaries with specific CMS-defined chronic conditions. Because CMS proposes enrollment thresholds for the HEI reward that disqualify smaller contracts, the proposed revisions would create an incentive for health plans to enroll certain beneficiaries in larger non-SNP contracts, who would be best served by the tailored care coordination available in SNPs.

- **Undermining improvements in health equity in a majority of Group Retiree contracts:** Under the proposed enrollment thresholds for beneficiaries with social risk factors, some contracts would not have access to the HEI reward, even if they are advancing health equity. By potentially rendering these contracts as ineligible for the reward, it would be more difficult for these contracts to achieve high Star Ratings. Any revisions to the HEI reward framework should ensure Group Retiree contracts qualify to ensure that plans working to improve health equity can appropriately achieve high Star Ratings.³
- **Creating an incentive for beneficiary selection:** CMS has worked to mitigate any incentive for health plans to target or avoid cohorts of beneficiaries in its contracts. CMS' proposed "net zero" approach would incentivize selection for the purpose of maximizing the HEI reward, which would work against CMS' goal of eliminating incentives to enroll specific cohorts of beneficiaries in the risk adjustment program.

The Task Force recommends that CMS implement an HEI reward framework that meaningfully rewards health plans for improving health outcomes of historically marginalized populations. Such an approach would mitigate the unintended consequences described above. Specifically, we recommend CMS implement a health equity incentive approach for which all contracts could be eligible (i.e., removes enrollment thresholds) and is not two-sided. We also recommend that CMS allow for a phased-in implementation of the HEI reward before determining whether it constitutes an appropriate replacement for the current reward factor, whereby plans would receive either the current reward factor or the HEI reward.

Finally, the Task Force supports CMS exploring how a standardized data source that captures geographic variation in social risk factors – such as the Area Deprivation Index – could be incorporated into the Health Equity Index in the short term. 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.

Another resource for CMS to explore is 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. Given that the health equity index is calculated at the beneficiary level, we support CMS in evaluating the feasibility of using other existing methods to determine which is best suited for the task.

³ <https://repositorio.uc.cl/xmlui/bitstream/handle/11534/47031/Precarious%20Employment.pdf>

III. Strengthening Translation and Accessible Format Requirements for Required Materials and Content

The Proposed Rule describes the current requirements that MA organizations must meet, including translating required materials into any non-English language that is the primary language of at least five percent of individuals in a plan benefit package service area. MA organizations must also provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills, to ensure these individuals have an equal opportunity to benefit from the services in question. Currently, beneficiaries must request materials or auxiliary aids and services each time they are needed; in addition, oversight activities indicate that Special Needs Plans (SNPs) do not always translate individualized care plans into enrollees' preferred languages.

The Task Force supports CMS' proposed policy to address what are viewed as very real barriers to enrollees' ability to access information and subsequent care. **We support CMS' plan to require MA plans to provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least five percent of individuals in a plan benefit package service area and in accessible formats using auxiliary aids and services.** As noted in the Proposed Rule, this new requirement should result in both enrollees being able to make their request for accessible materials through different touch points, and that they continue to receive information in an accessible format for the duration of their enrollment in the plan.

While the Task Force supports broadening patients' access to materials in their preferred language or format, our members acknowledge that the timeline for preparing different types of materials varies. To ensure CMS' proposal can be achieved, we suggest splitting the proposal into two phases:

1. **First, for model (i.e., standardized) materials, we support CMS' plan to require MA plans to provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least five percent of individuals in a plan benefit package service area and in accessible formats using auxiliary aids and services.** As noted in the Proposed Rule, this new requirement should result in both enrollees being able to make their request for accessible materials through different touch points, and that they continue to receive information in an accessible format for the duration of their enrollment in the plan.
2. **Second, for non-standardized communications that need to be individually translated or converted into an aid, we recommend CMS establish a stakeholder workgroup that includes translation contractors to discuss how turnaround times can be improved and which communications can be translated fast enough to meet the need of the beneficiaries.** For translation/aid contractors, the current turnaround time can be as much as four weeks for the most complex requests, such as foreign-language brail. This approach would ensure that CMS is balancing the need for quick communication with the needs of beneficiaries to receive information in the needed language/format.

The Task Force also supports CMS' proposal to extend this requirement to Fully Integrated Dual Eligible Special Needs Plans (FIDEs), Highly Integrated Dual Eligible Special Needs Plan (HIDEs) and Applicable Integrated Plans (AIPs) to translate required materials into languages required by the Medicare translation standard.

IV. Utilization Management Requirements and Use of Prior Authorization

The Proposed Rule references data, as well as a recent Office of the Inspector General report, indicating that MA prior authorization requirements are creating undue burden for patients seeking to access covered services in a timely manner. Overall, the Task Force recognizes these concerns and supports the establishment of clearer expectations and guardrails related to MA plan utilization management policies and practices in pursuit of the goal of avoiding inappropriate denials. This entails establishing coverage policies based on peer reviewed medical evidence, and clinical guidelines built on said evidence.

The Task Force requests that CMS consider the following suggestions in finalizing the prior authorization policies:

- **Build Upon Existing Efforts to Improve Prior Authorization (PA) Policies:** The evolution of prior authorization policies is important to advance effective and efficient value-based care. CMS notes in the Proposed Rule that it supports gold carding programs, which are policies used by MA plans to relax or reduce prior authorization requirements for contracted providers that have demonstrated a consistent pattern of compliance with plan policies and procedures. CMS then encourages further adoption of gold carding policies to exempt providers from prior authorization.

Gold card policies are important step forward when coupled with monitoring and audit functions, yet more can be done to improve prior authorization in MA. CMS should consider testing additional flexibilities for plans and provides to address the time and burden associated with current prior authorization processes, including the automation of prior authorization to create a more efficient and time-sensitive system. The current lack of end-to-end real-time automation of prior authorization between payers and providers perpetuates inefficiencies and negative impacts on clinical outcomes. Task Force payer members have conducted promising pilots that provide evidence of the improvements that come from automating this process and allowing plans greater real time access to underlying clinical data that supports requests.

When appropriate, the Task Force supports the streamlining or exemption of prior authorization through Gold Card or similar programs. In other instances, CMS should encourage adoption of automated systems that allow for more timely responses to PA requests emanating from other providers or weed out PA requests for items or services for which PA is not required by plans.

We note that CMS' Proposed Rule on Advancing Interoperability and Improving Prior Authorization Processes⁴ represents a meaningful first step in improving adoption of electronic prior authorization. It is important that CMS ensure that advances in automating and creating greater efficiencies represents a consistent effort across CMS policymaking.

- **Address the need for greater interoperability:** CMS should support the implementation of interoperable infrastructure to facilitate greater efficiency in priority authorization reviews and information exchanges. The Task Force will submit comments in response to the CMS-0057-P, "*Advancing Interoperability and Improving Prior Authorization Process for Medicare Advantage Organizations*" cited above, and looks forward to supporting CMS'

⁴ <https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability>

efforts to align the interoperability innovations in that proposed rule with the MA program in general.

V. Medicare Advantage and Part D Marketing

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 beneficiary⁵ 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 Task Force supports the following policies in the Proposed Rule, as they align with the objective of providing greater transparency of information to MA enrollees.**

- Restricting the use of superlatives in marketing materials unless substantiating supporting current data are provided to enrollees with the materials, building upon guidance finalized in the CY 2021 MA and Part D rule.
- Requiring MA plans to not misrepresent “savings” to beneficiaries on prescription drugs, where the savings is calculated based on the usual and customary price another individual without prescription drug coverage would pay.
- Requiring that an agent: 1) explain the effect of an enrollee's enrollment choice on their current coverage whenever an enrollment decision is made, and 2) share key pre-enrollment information with potential enrollees when processing telephone enrollments.
- Require simplification of plan comparisons by requiring medical benefits to be in a specific order and listed at the top of a plan's summary of benefits.

The Task Force does have concerns with proposals that would make it more difficult for consumers to have a face-to-face sales interaction. Not only do beneficiaries largely prefer meeting with an agent/broker face-to-face, but those who enroll following a face-to-face conversation exhibit a lower rate of disenrollment, and fewer complaints. Specifically, the following CMS proposals would inhibit face-to-face sales, and we recommend withdrawing:

- **Separating educational events from sales events**, which would require beneficiaries wait or go to a different location to have a sales conversation. This would be particularly challenging for low-income beneficiaries—that have less free time and access to transportation—to pick the plan that best meets their needs.
- **A 48-hour wait time between the Scope-of-Appointment being filled out and the sales conversation**, which would also create a barrier, particularly to the large share of beneficiaries who wait towards the end of the open enrollment period to pick a plan.

The increase in MA plans offering primarily health related Special Supplemental Benefits for the Chronically III (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**

⁵ <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/>

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 meet health literacy standards and is easy for the average consumer to navigate and understand and that there are transparent opportunities for follow up when questions arise.

VI. Behavioral Health

The growing need for behavioral health care services, coupled with shrinking access to affordable care, is one of the many tremendous challenges facing our health care system. **The Task Force applauds the administration's commitment to ensuring MA plans offer sufficient access to behavioral health service providers, and supports the following proposals for strengthening network adequacy requirements in this area:**

- Expanding general access to services standards to include explicitly behavioral health services.
- Clarifying that some behavioral health services may qualify as emergency services and must not be subjected to prior authorization.
- Extending current requirements for MA organizations to establish programs to coordinate covered services with community and social services to behavioral health services programs.

Regarding the proposal to add clinical psychology, licensed clinical social worker, and prescribers of medication for Opioid Use Disorder as specialty types that will be evaluated as part of network adequacy reviews, and making these specialties eligible for the 10-percentage point telehealth credit toward the percentage of beneficiaries that reside within published time and distance standards, the Task force recommends 1) moving the implementation to January 2025, to allow MA plans one year to identify and develop a network of these new provider types. In addition, we strongly suggest that once implemented, CMS apply appropriate enforcement discretion for this requirement. In other words, a plan should not be at risk if it can provide evidence that behavioral workforce shortages conflict with compliance.

Regarding the proposal to codify standards for wait times that apply to both primary care and behavioral health services, the Task Force supports standards that serve the goal of expanding access to behavioral health providers in Medicare. However, we ask that CMS provide further explanation for how these wait time standards will not result in unintended consequences by limiting access to care by creating hurdles for network participation among providers.

In operationalizing these policies, Task Force members recommend that CMS explore other strategies and methodologies to measure access to behavioral health care, in addition to time and distance standards. For example, practices in which physical health and behavioral health providers are co-located in one geographic practice location may not meet certain time and distance standards but can offer other efficiencies and improve access for beneficiaries.

Finally, any discussion of behavioral health care access cannot ignore the fact that there is a severe shortage of behavioral health workers in the U.S. health care system. By 2030, it is projected that there will be a 20 percent decrease in supply of adult psychiatrists; it is also projected that there will be a 15 percent increase in demand for addiction counselors, but only a 3 percent increase in supply.⁶ Adjusting time and distance standards is a band-aid and not a true solution to the behavioral health access crisis facing the country. In 2022 the Task Force submitted [comments in response to CMS' RFI](#) on strengthening MA in ways that align with the Agency's Vision for Medicare and the CMS Strategic Pillars; the comments expressed support for CMS to establish permanent coverage of telehealth services. The letter goes on to state that waiving this requirement is especially beneficial as workforce shortages result in beneficiaries relying on virtual visits for their behavioral health needs. The Task Force continues to support this recommendation.

The Task Force appreciates the opportunity to respond to the Medicare Advantage and Part D Programs Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to these comments.

Sincerely,

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⁶ <https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health>

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