January 4, 2023
Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS–4205–P: CY 2025 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) CY2025 Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4205-P) ("Proposed Rule").

The Task Force is a consortium that supports 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 better health and better care at reduced costs. 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 quality measurement, health equity, behavioral health, supplemental benefits, and dually eligible patients.

I. Quality Measurement

CMS seeks to align all quality and value-based care programs with the Universal Foundation (UF) quality measures. CMS established these measures in 2023 to serve as the foundation across all programs, with additional program-specific quality measures to be added

as needed. To achieve the goal of establishing UF measures in MA, CMS has submitted several quality measures for consideration in future Star Ratings, including:

- Initiation and engagement of substance use disorder treatment
- Adult immunization status
- Depression screening and follow up for adolescents and adults
- Social need screening and intervention

If approved through the review process, CMS would add these as future Star Ratings measures through future rulemaking.

The Task Force supports efforts to align quality measures across payers and programs, as we have shared in previous comments on the CY2024 MA advanced notice proposed rule. We support CMS' work on the UF measures as a means of identifying a parsimonious number of meaningful quality measures that are applicable to multiple patient populations. We support CMS' approach of selecting fewer, better measures that help standardize reporting requirements and allow for comparisons across programs. However, we believe that CMS has opportunities to refine certain UF measures over time. For example, many state and federal regulations prevent plans and providers from sharing behavioral health data, which limits MA plans' ability to intervene on UF measures related to depression and substance use disorder. In addition, the adult immunization measure relies on immunization registries, which may be incomplete. In the interest of continual improvement, CMS should continue to monitor and improve upon the UF measure set as appropriate.

II. Health Equity

CMS proposes to incorporate health equity into the utilization management process for MA plans. Specifically, CMS proposes that MA plans must add a person with expertise in health equity to their Utilization Management Committees. CMS further proposes that MA plans conduct and report publicly on prior authorization for enrollees with social risk factors.

The Task Force supports the proposal that MA plans should include a member with expertise in health equity. We further support the CMS definition of expertise in health equity, which includes applicable degrees or credentials, as well as experience studying disparities, leading organization-wide health equity policies, or leading health equity advocacy efforts. This definition allows MA plans flexibility to draw on staff with a variety of skillsets and experiences in health equity, while ensuring that this critical perspective informs the work of the committee.

Due to the Task Force's diverse membership, we do not take a position on the second policy. However, as a general principle, the Task Force is committed to transparency in health care.

III. Behavioral Health

CMS proposes to increase access to behavioral health providers. Beginning January 1, 2024, two new behavioral health provider types will be eligible to bill Medicare: mental health counselors and marriage and family therapists. CMS proposes that MA plans establish a new facility-specialty type called Outpatient Behavioral Health, which would include these two new provider types, as well as Opioid Treatment Program providers, Community Mental Health Centers and other behavioral health providers. The Outpatient Behavioral Health provider type would be subject to network adequacy rules, including time and distance requirements. If plans include providers that deliver care using telehealth, they will receive a 10-percentage point credit towards the time and distance standard.

The Task Force shares CMS' commitment to improving behavioral health care, and we recommend that CMS refine the proposed policies to increase their effectiveness. The Task Force and its members are committed to increasing access and quality for behavioral health care, as we previously commented in response to the CY2024 MA proposed rule. However, we are compelled to reiterate our concerns about the nationwide behavioral health provider shortage. As a result of this shortage, fewer than half of people with a mental illness were able to access care when they needed it in 2021.[1] The shortage is particularly pronounced in rural and dense urban areas.[2]

To address this shortage of behavioral health providers, the Task Force recommends several modifications to the Proposed Rule's policies:

- Add clinical psychologists and social workers to the new Outpatient Behavioral Health provider type (rather than keeping them in the general practitioner category). This will create a more comprehensive category that will help plans increase access to care by contracting with all available behavioral health providers in their region.
- Consider increasing the telehealth credit, in recognition of the fact that many behavioral health providers now offer telehealth services. By 2021, 36 percent of all behavioral health outpatient visits that included behavioral health treatment were delivered via telehealth, compared to just 5 percent of non-behavioral health visits. For rural patients, 55% of all behavioral health visits were delivered via telehealth, compared to 35% for urban patients.[3]

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[1] Substance Abuse and Mental Health Services Administration. *2021 NSDUH Detailed Tables.* January 4, 2023. https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables

[2] Counts, N. "Understanding the U.S. Behavioral Health Workforce Shortage." *Commonwealth Fund.* May 18, 2023. https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage

[3] Lo J, Rae M, Amin K, et al. "Telehealth has Played an Outsized Role Meeting Mental Health Needs during the COVID-19 Pandemic." *Kaiser Family Foundation*. Mar 15, 2022. https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/

- CMS should apply appropriate enforcement discretion for MA plans that can document provider shortages that prevent them from meeting network adequacy requirements, with information on how the plan intends to meet their population's behavioral health needs (*e.g.*, increased use of telehealth in regions with shortage areas).

In addition to the modifications above, we recommend that CMS explore longer-term solutions to the behavioral health provider shortage. Policy options include expanding Medicare and Medicaid funding for behavioral health services and providers, including (1) peer recovery specialists, (2) addressing scope of practice laws to ensure providers are practicing at top of license, (3) supporting behavioral health integration with primary care, including enhanced payment rates for collaborative care models ,and (4) increasing graduate medical education for behavioral health specialists.

IV. Supplemental Benefits

CMS seeks to ensure that supplemental benefits offered by MA plans are appropriate and likely to improve or maintain patients' health and functional status. To achieve this goal, CMS proposes that plans must demonstrate that the supplemental benefits they offer are supported by "relevant acceptable evidence." CMS defined the term to mean peer-reviewed research that shows a specific supplemental benefit impacts health or functional status, including randomized controlled trials, prospective cohort studies, and meta-analyses. Plans would be required to establish a bibliography of this evidence at the time of their bid, which would be available to CMS upon request. The new requirements would apply to supplemental benefits that pertain to care delivery, but would not apply to benefits that reduce patient out-of-pocket costs.

The Task Force and its members strongly support supplemental benefits because they have the capacity to address patients' health related social needs. However, we believe CMS should modify the proposal to support innovation and ensure that patients receive a wide array of benefits to address their needs. We recommend the following refinements to better meet CMS' policy goal of ensuring that supplemental benefits increase patients' health and functional status:

- CMS should develop a list of supplemental benefits that have a strong peer-reviewed evidence base. For example, some supplemental benefits related are well-established in the academic literature (e.g., transportation, medically tailored meals, in-home supports). Creating and maintaining such a list would encourage uptake of supplemental benefits with a proven track record. This would create clear guidance for large and small plans alike and reduce burden for smaller plans to produce individualized evidence-bases for generally acceptable benefits.
- In cases where the peer-review evidence is still developing, CMS should allow MA plans to submit evidence from other sources, such as claims-based analyses or case studies

published by providers, payers or patient advocacy organizations. Peer-reviewed research often requires years of lag time between conducting an intervention, analyzing the data, and getting published through the peer-reviewed process. In addition, research on health-related social needs is often less comprehensively represented in the academic literature, due to historic under-funding for this type of intervention. Due to this lag time and relative lack of research, innovative solutions to address health related social needs may not yet be established in peer-reviewed research. Therefore, CMS should consider other forms of evidence to promote patients' access to a broad array of supplemental benefits that are reasonably expected to improve health and functional status.

The Task Force shares CMS' goal of ensuring that patients receive supplemental benefits that can improve their health and functional status. We believe that the refinements we propose will better help CMS achieve this policy goal. In addition, the Task Force believes a broader federal policy effort is needed to properly address the patient needs that MA supplemental benefits are designed to impact. For example, blending funding from related federal funding sources such as transportation and agriculture would help ensure MA supplemental benefits are sustainable long term.

V. Dually Eligible Patients

CMS proposes multiple policies intended to increase the proportion of dually eligible patients that have integrated Medicare and Medicaid managed care plans. While many of the proposed policies are technical changes, two policies relate directly to patients' lived experiences:

- CMS proposes that patient out-of-network cost-sharing be capped at the in-network limits. For most dually eligible patients, out-of-network cost-sharing is paid by state Medicaid programs. However, there are specific dually eligible patients that are responsible for paying the cost-sharing out-of-pocket when they see out-of-network providers (*e.g.*, patients who are not Qualified Medicare Beneficiaries). In addition to reducing out-of-pocket costs for these patients, the proposed policy would decrease the financial strain on state Medicaid programs while increasing reimbursement to out-of-network providers that treat dually eligible patients, which may improve access.
- CMS proposes to update the Medicare Plan Finder website, so that MA plans that are integrated with Medicaid Managed Care plans will show the additional benefits available through Medicaid (*e.g.*, dental, transportation, and certain home and community-based services).

The Task Force and its members strongly support the need to reduce patient out-of-pocket costs, particularly for dually eligible patients and other patients with high health-related social needs. While most dually eligible patients do not have to pay out-of-network cost sharing, we believe CMS' proposal will protect the patients that do experience

these out-of-pocket costs. In addition, we support CMS' goal of increasing patients' access to a wide range of providers.

The Task Force supports improvements to the Medicare Plan Finder website, to make it more user-friendly for patients. We believe CMS' proposal to include the full range of benefits available for integrated plans will help patients understand the available plans and make an informed decision. In addition, we recommend that CMS include supplemental benefits on the website, as we stated in our previous comment letter on the CY2024 MA proposed rule.

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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.

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