Analysis of Medicare Advantage Request for Information Opportunity

September 8, 2022

On August 1, 2022, the Centers for Medicare and Medicaid Services (CMS) published a Request for Information (RFI) that sought input from the public regarding various aspects of the Medicare Advantage (MA) program. Responses to this RFI may be used to inform potential future rulemaking or other policy development. Below, we compiled key topics and themes from various health plan trade associations (e.g., AHIP, ACHP), provider groups (e.g., APG, NAACOS), consumer organizations (e.g., Justice in Aging, Center for Medicare Advocacy), think tanks (e.g., Brookings, AEI), and other stakeholders. In all, CMS received over 4,000 comments but only about 800 are currently posted publicly.

The most common topics and themes from across all groups include:

- Prior Authorization
- Network Adequacy
- Risk Adjustment (e.g., In-Home Health Risk Assessments, Coding Adjustment)
- MA Marketing Practices
- Star Ratings Program
- Health Equity/Social Determinants of Health (SDOH)
- Value-Based Care
- Telehealth

Other topics and themes addressed but not as frequently include:

- Price Transparency
- Physician Burden
- Dual Eligible Special Needs Plans (D-SNPs)
- Race, Ethnicity, and Language (REL) Data Collection
- MA vs. Medicare Shared Savings Program (MSSP) Standardization

Health plan groups focused on improvements to the Star Ratings Program, risk adjustment, and network adequacy, as well as opportunities to address SDOH. Provider groups mainly focused on ways to improve prior authorization, reduce physician burden, address reimbursement issues/payment reform, and drive value-based care adoption (i.e., better aligning MA and MSSP).

Type	Organization	Key Topics/Themes	Summary
Health Plan Trades/Groups	Association for Community-Affiliated Plans (ACAP)	SDOH adjustment for D-SNPs, Star Ratings Program, Medicaid continuous eligibility	• ACAP encourage CMS to consider adopting the SDOH Adjustment for Integrated D-SNPs as a pilot or demonstration program. An adjustment factor for FIDE and HIDE SNPs would provide additional funds to be used to offer more SDOH services as supplemental benefits. • ACAP is supportive of CMS' exploration of stratifying Star Ratings measures by dual eligible status, LIS, and disability status, and the public reporting of this data. CMS should modify the Star Ratings to adjust for between-contract differences between D-SNPs and non-SNP MA plans that are due to underlying population differences rather than actual differences in the quality of care provided by plans. • Dually eligible beneficiaries are at risk of losing their Medicaid coverage (known as churning) if they do not submit renewal paperwork on time or if they experience a change in eligibility due to a change in income or assets. ACAP continues to work with Congress to pass legislation to guarantee 12-month continuous Medicaid eligibility.
	Alliance of Community Health Plans (ACHP)	SDOH, health risk assessments, telehealth, network adequacy, value-based care, Star Ratings Program, MA marketing practices, price transparency, prior authorization, risk adjustment, encounter data	• ACHP recommends CMS require social determinant screening with template recommended questions. • ACHP encourages CMS to consider incorporating health plan incentives for the use of care management teams that ensure the personalization of at-home assessments and follow-up based on consumers' individual circumstances and needs. • ACHP recommends CMS issue guidance on best practices for social determinant of health data governance to help organizations develop internal policies on how to identify the "original" or "most-reliable" source of data when they encounter conflicting information. • ACHP urges CMS to expand this network adequacy telehealth credit by county designation, with a focus on rural and frontier areas. • ACHP recommends CMS develop incentives for behavioral health providers to contract with health plans. CMS should collect and share these examples and establish value-based payment templates to encourage further contracting innovation. • ACHP looks forward to working with CMS to reduce regulatory burden for care coordination efforts, particularly for health plans that obtain high Star Ratings. • ACHP strongly recommend CMS conduct a full review of marketing practices, requirements and financing for third party marketing organizations (TPMOs). • ACHP encourages CMS to regulate private equity's participation in MA, using the bid process, similar to what is required for related party due diligence or DIR reporting. • ACHP encourages CMS to implement equal incentives and investments for both payers and providers in any new transparency measures.

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			• ACHP recommends CMS implement additional financial incentives and provider requirements to collect and exchange data. • ACHP recommends CMS implement provider requirements in future rulemaking for Advanced Explanation of Benefits and electronic prior authorization programs. • ACHP recommends CMS target resources and leverage external stakeholders to identify methods of evaluating experience of care in real-time, digital formats that are less burdensome for both the surveyor and the survey-taker. • ACHP has repeatedly called for the transition to encounter data and elimination of the across-the-board coding intensity adjustment which unfairly creates winners and losers based on coding practices. • ACHP supports processes that automate aspects of prior authorization and reduce provider burden, such as document lookup services and document repositories.
	AHIP	SDOH, encounter data, network adequacy, value-based care, MA vs FFS payment parity, REL data collection	• AHIP recommends CMS to expand benefit flexibility through regulation and demonstrations, and promote better data collection. • AHIP recommends CMS to update its network requirements to leverage new and innovative delivery and payment models as well as promote innovation and lower costs for people with end-stage renal disease (ESRD). • AHIP notes that CMS should consider a comprehensive set of suggestions for improving access to mental health care and substance use disorder treatment (SUD). • AHIP recommends that CMS should consider targeted improvements to the payment and quality components of the MA program to build on the cost-effectiveness and higher quality care of MA. • AHIP makes concrete recommendations for how CMS can promote policies that standardize data, reduce burdens for providers, and preserve plan flexibilities to respond to different enrollee needs. • AHIP emphasizes the importance that CMS take steps to enhance engagement, increase predictability, and ensure adequate time for implementation.
	Better Medicare Alliance (BMA)	SDOH risk adjustment, telehealth, value-based care, employer group waiver plans (EGWPs), prior authorization, in-	• BMA recommends CMS to advance health equity through public policies that help better identify and address social needs and risk factors to reduce gaps in care, such as establishing a health equity index. • BMA recommends CMS to improve access to telehealth and virtual care in Medicare and MA by extending or making permanent flexibilities tied to the public health emergency (PHE). • BMA recommends CMS to expand and permanently authorize the MA-VBID model so Medicare Advantage can continue to offer tailored and innovative benefits that meet the whole health care needs of Medicare beneficiaries.

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		home health risk assessments	• BMA supports bipartisan policies to strengthen Medicare Advantage, including increasing flexibility for plans to address social determinants of health and reforms to streamline and improve prior authorization. • BMA supports codifying the 2016 best practices proposed in the CY 2016 Rate Announcement and Final Call Letter for in-home health risk assessments, which are critical in identifying and addressing unmet medical and social needs among beneficiaries.

	National Association of Health Underwriters (NAHU)	MA marketing practices	• NAHU provides comments on the Medicare Program: Contract Year 2023 Policy and Technical Changes to Medicare Advantage and Medicare Prescription Drug Benefit Programs.
			  ○ NAHU requests that the definition of third-party marketing organizations (TPMOs) be altered to merely apply to lead-generation entities and exclude licensed professional health insurance producers appointed to sell MA plans with licensed insurance issuers.
			  ○ NAHU requests a one-year delay of the implementation of this rule for CMS to meet with stakeholders to draft a rule that truly reflects the goals of protecting Medicare beneficiaries from deceiving marketing practices.
			• NAHU is concerned that the implementation timeline (less than a year) will not be feasible for Medicare Advantage and Part D plan sponsors that would need to update all contracts and oversight processes.

	America's Physician Groups (APG)	Health equity, adjustments to Star Ratings, network adequacy, telehealth, prior authorization, reducing physician burden, risk adjustment	• APG believes the goal of having all Medicare beneficiaries in accountable care relationships by 2030 should apply across the entire program, including MA • APG encourages CMS to adopt policies that reward plans for shifting more risk to providers, such as amending the Star ratings to encourage and reward more accountable partnerships • APG urges CMS to allow providers more leeway to tailor benefits to meet the needs of marginalized patients and create consistency in the health equity measures that are applied across the Medicare program. • APG recommends CMS reward providers and plans for engaging beneficiaries in careful decision-making in plan selection, such as the Star ratings, and crack down on deceptive practices that spark churn in MA enrollment. • APG encourages CMS to allow the use of telehealth in appropriate circumstances for the purposes of fulfilling network adequacy requirements. • APG recommends CMS ensure that MA plans have adequate provider networks for mental/behavioral health care and drive more integration of behavioral and primary health care. • APG supports efforts to move toward "smart" electronic prior authorization and other means to lessen the burden on physicians who routinely provide high-value care.

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Provider Trades/Groups			• APG believes CMS should require plans to be more transparent about their attribution methodology and require all states to have functional health information exchange networks in place by January 2023. • APG urges more improvements to HEDIS measures and Star ratings to emphasize outcomes as opposed to processes • APG urges CMS and other government agencies to use the tools they have to pursue instances of fraud and abuse in risk adjustment even more aggressively if they suspect these issues are widespread. • APG urges CMS to collect more granular information about conditions across MA markets, including on total costs of care in markets where plans or providers have high degrees of market power.
	American Academy of Family Physicians (AAFP) *(Note: Joint letter from the Regulatory Relief Coalition)*	Prior authorization	• AAFP believes that it is critical for CMS to establish a maintain a robust system for continual oversight of MA plans' use of PA processes to ensure that Medicare beneficiaries enrolled in MA plans have the same access to covered services as those covered under Medicare Fee-for-Service (FFS), as required by the Medicare Act. • AAFP urges CMS to implement the recommendations included in the April 22, 2022 OIG Report references, which recommended (and the U.S. Department of Health and Human Services agreed) that CMS should take a closer look at the appropriateness of clinical criteria used by MA plans in making coverage determinations and issue instructions clarifying MA plans authority to adopt PA clinical guidelines that are narrower than those used under Medicare Fee-for-Service. • AAFP urges CMS to expand the scope of the requirements included in the e-PA Proposed Rule to MA plans and to publish the expanded e-PA Final Rule as soon as practicable. • AAFP strongly urges CMS to establish closer oversight over MA plans use of PA more generally.
	American Dental Association (ADA)	SDOH data collection, MA marketing practices, telehealth, network adequacy	• The ADA believes CMS should collect and analyze data on supplemental benefits for lower income enrollees. The ADA believes that it is critical that CMS analyze data on supplemental benefits in the MA program, including who is enrolled by ages and income, what is covered, and what benefits are being utilized. • The ADA requests CMS to collect the data to quantify how many enrollees are getting the different types of dental benefits. • The ADA recommends that Part C plans that offer dental as a supplemental benefit publicly report some standardized quality measures. • The ADA believes teledentistry has the capability of expanding the reach of a dental home to provide needed dental care to populations experiencing distance barriers. • The ADA recommend that CMS require MA plans to report on the following metrics representing various aspects of dental providers' experiences with and participation in the plans:

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			○ Provider participation ○ Network Adequacy ○ Credentialing ○ Claims Administration ○ Provider Satisfaction • The ADA agrees with CMS that it would be helpful to understand what factors MA plans use when deciding whether to offer supplemental dental benefits, including which dental services are covered under the benefit. • The ADA urges CMS to require MA plan administrators to notify beneficiaries in writing by U.S. mail – upon enrollment and annually thereafter if plan changes occur– of all service areas and specific services for which they are eligible, directions on how to get more specific information on the terms of their plan, and directions on finding and making appointments with health care providers in the network. • The ADA urges CMS to work with the ADA Dental Quality Alliance in the identification and endorsement of standardized tools for measuring beneficiary experience, such as the CAHPS Dental Plan Survey3 (measuring beneficiary satisfaction with service delivery among those who successfully access services) and the Oral Health Impact Profile4 (OHIP-5, a validated instrument for assessing oral health-related quality of life). • The ADA suggests that CMS institute a Dental Loss Ratio (DLR) reporting requirement for the dental component of any MA plan. • The ADA is eager to collaborate with CMS and MA plan administrators to promote the oral health of the public.
	LeadingAge	Value-based care, network adequacy, prior authorization, home health value-based care	• LeadingAge recommends the HHS Secretary to establish a rate floor that plans must pay unless the plan can negotiate a pay-for-performance or other value-based arrangement (VBA) with the provider. • LeadingAge recommends CMS to limit plans from removing or excluding providers just because of size. • LeadingAge recommends amending section 422.204 or 422.205 to require plans to ensure access to 1 or more providers with 3 stars or higher for nursing homes and home health. • LeadingAge recommends CMS to: ○ Develop guidance or templates that establish a roadmap with VBA parameters. ○ Establish goals for the percentage of contracts that should be VBA by provider types. ○ Encourage VBAs between providers and MA plans serving specific or high-need populations. ○ Invest in health information exchange. • LeadingAge recommends CMs to

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			○ Establish limits on the number of claims and prior authorizations that plans can audit each year. ○ Establish timely prior authorization timelines for plans or require plans to staff their PA process 24/7/365 with qualified personnel who can make a PA decision in 24-48 hours. ○ Establish penalties for plans that fail to meet the established PA timeline requirements. ○ Require CMS to establish a dedicated provider complaints line to report instances where an MAO is wrongly and consistently denying claims or missing prompt payment or PA decisions. ○ Add measures to the MA star rating system that track payment/claim denials, appeals and rate of overturned. MAOs could receive higher ratings for improving their denial to overturned rate, which might require them to ensure their systems are adjudicating claims properly. • LeadingAge supports a home health VBID.
	Primary Care Collaborative (PCC)	Value-based care, MA vs. FFS data, primary care payment reform, SDOH, MSSP	• PCC recommends CMS to measure primary care spending and its impact on Medicare Advantage beneficiary outcomes. • PCC recommends CMS to improve CMS capacity to collect, standardize, report, and where practicable and effective, stratify data to facilitate comparisons across all parts of Medicare (traditional fee-for-service, ACOs/MSSP, and Medicare Advantage). • PCC recommends CMS to use plan design and payment reform to encourage proactive care and to remove cost and other barriers to beneficiaries accessing preventive care, integrated behavioral health care and chronic care. • PCC believes CMS should encourage MA plans to use primary care payment reform and investment to drive practice level innovation, support comprehensive primary care, and reduce administrative burden, as recommended in the 2021 National Academies of Science, Engineering, and Medicine (NASEM) report, Implementing High-Quality Primary Care. • PCC believes CMS should use a small, robust, valid set of quality measures and incentives that reflect the contribution of primary care.
	American Medical Group Association (AMGA)	Supplemental benefits, telehealth, risk adjustment, prior authorization, coding adjustment	• AMGA recommends that CMS enable MA health plans to provide more flexible, supplemental benefits designed to address social determinants of health • AMGA recommends video and audio-only visits satisfy the face-to-face requirement for the purpose of gathering diagnosis information for risk adjustment and care coordination purposes • AMGA believes the issues surrounding prior authorization can best be solved by eliminating it when possible • AMGA recommends that CMS continue the statutory minimum coding adjustment factor for MA

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	Medical Group Management Association (MGMA)	Prior authorization, value-based care	• MGMA urges CMS to implement commonsense policies to reform prior authorization in the MA program, such as increasing oversight of MA plans prior authorization policies, reinstating the prohibition of step therapy for Part B drugs, requiring transparency of payer prior authorization policies, and implementing recent recommendations from HHS OIG. • MGMA believes CMS can support robust participation in value-based payment arrangements in MA by considering how to better support value within the Medicare FFS program which will provide clinicians with a glidepath in value-based care contracts will better prepare them for participation in higher-risk arrangements in MA. • MGMA recommends CMS provide additional support for practices furnishing care to underserved populations to ensure historically underrepresented patient populations are receiving care from organizations engaged in value-based care practices, such as greater technical resources to smaller and rural practices
	National Association of ACOs (NAACOS)	Connections between MA and ACOs, reporting approaches, parity between ACOs and MA, SDOH data, data standardization, risk adjustment	• NAACOS recommends that CMS collect information on the percentage of patients, payments, or providers in other value-based arrangements through value-based insurance design (VBID), Star ratings, rebate dollars, and 402 demonstrations • NAACOS encourages CMS to align approaches within MA with the Quality Payment Program by collecting measure data in a format that could be easily used to for the provider determination of the Advanced APM bonus • NAACOS provides several opportunities for CMS to build parity between ACOs and MA through patient benefits, quality measures, marketing requirements, and risk adjustment • NAACOS urges CMS to define clear standards for collecting sociodemographic and SDOH-related social needs data and collaborate with other payers to ensure comparability across programs and payment mechanisms • NAACOS believes CMS should use positive incentives for providers in MA plans to screen for beneficiaries' SDOH and publish standards and guidelines to help providers choose an appropriate screening tool • NAACOS notes that CMS should work closely with other departments in the federal government, as well as CBOs and social service organizations at the state and local levels, to develop thoughtful solutions to challenges related to SDOH referrals • NAACOS supports efforts to incorporate social risk factors into risk adjustment • CMS should work to create standardized data sets that MA plans share with providers in value-based arrangements to support more comprehensive and standardized information to providers

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	American Hospital Association (AHA)	Advancing health equity, adjustments to Star Ratings Program, data standardization, network adequacy, telehealth, transparency, prior authorization, MA reimbursement	• AHA highlights concerns about the negative effects of Medicare Advantage Organization (MAO) practices and policies including: abuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by Traditional Medicare, requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage in the middle of a contract year • AHA recommends CMS prioritize policies and programs that ensure MAOs are providing enrollees with the necessary tools for health insurance literacy and provide culturally competent resources • AHA recommends that CMS consider weighing disenrollment more heavily in the Star Ratings program • AHA urges CMS to foster consistency and standardization in its approaches to collecting, analyzing and using demographic and social risk data • AHA urges CMS to require MAOs to align medical necessity and coverage criteria with Traditional Medicare rules, especially for the coverage of PAC and behavioral health services, sepsis criteria, emergency services and inpatient admissions in general • AHA recommends CMS develop and adopt proactive network adequacy monitoring strategies in addition to retroactive compliance reviews. For the purposes of defining network adequacy, mental health and substance use disorders should be differentiated and explicitly listed in regulation to ensure appropriate in-network access to providers in each of these uniquely specialized behavioral health concentrations • AHA recommends that capacity standards are applied to telehealth providers in a similar way to in-person providers • AHA recommends that CMS require greater transparency regarding prior authorization and other utilization management restrictions, accessible network information and plan-level information on inappropriate coverage denials and delays in care • AHA recommends CMS take steps to improve the quality and use of MAO data related to the following areas, which should be incorporated into Star ratings: prior authorizations and coverage determinations, appeals, grievances, and member and provider complaints • AHA urges CMS to carefully review capitated MAO reimbursement structures to ensure that the Medicare Trust Fund is being spent judiciously and that MAOs are not being overpaid to cover contracted services • The AHA urges CMS to prohibit plans from submitting for risk adjustment purposes codes for which the payer fails to reimburse providers for the beneficiary's care

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	Center for Medicare Advocacy	MA marketing practices, Star Ratings, network adequacy, prior authorization, encounter data, RADV, health risk assessments	• CMA recommends CMS to provide balanced and neutral information about both the advantages and disadvantages of MA plans.
			• CMA supports expanding federal Medigap guarantee issue rights to make Medicare coverage options between MA and traditional Medicare more equal and truly allow beneficiaries in MA plans to switch back to traditional Medicare.
			• CMA emphasizes CMS to strengthen consumer protections surrounding plan marketing, including further oversight of plan advertising and addressing agent/broker compensation issues.
			• CMA emphasizes CMS
			  ○ Augment oversight of MA networks to address provider availability
			  ○ Rescind the May 2020 network adequacy changes and strengthen requirements
			  ○ Strengthen network adequacy standards by requiring that Long Term Care Hospitals (LTCH) be included among mandatory facility specialty types in a plan network
			  ○ And more
			• CMA recommends CMS to revise guidelines to require a minimum number of days for prior authorization notices.
			• CMA recommends CMS to replace the current Star Ratings system with an MA value incentive program, eliminate double bonuses, and align star ratings and enforcement actions.
			• CMA recommends CMS to achieve payment parity between MA and traditional Medicare.
			• CMA also supports validating encounter data.
			• CMA also supports improving the timeliness of MA audits and appeals to recover improper payments, including through risk adjustment data validation (RADV) audits.
			• CMA also recommends eliminating health risk assessments as a source of diagnosis for risk-adjusted payments.

	Justice in Aging	REL data, Star Ratings Program, SDOH screening, MSSP, MA marketing practices, network adequacy	• Justice in Aging supports collecting robust data and reporting on the basis of race, ethnicity, sex, sexual orientation, gender identity, age, disability, geographic location, and other factors. • Justice in Aging supports CMS employing a health equity index as a methodological enhancement to the Star Ratings. • Justice in Aging recommends CMS should provide MA plans with screening tools for SDOH that mitigate bias, and require plans to reimburse providers for conducting the screening. • Justice in Aging supports that all Medicare Advantage plans should be required to ask preliminary screening questions for Medicare Savings Program (MSP) eligibility for all members who are not already dual eligible.

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Consumer Groups			• Justice in Aging strongly urges the Center for Medicare to work with the Center for Medicaid and the Department of Agriculture to obtain clarity on the impact of food-related debit cards on income eligibility for these programs and to ensure that eligibility requirements align so that positive actions on the Medicare Advantage side do not cause unintended negative consequences for Medicaid or SNAP benefits. • Justice in Aging appreciates that CMS is looking into the availability and usage of physical activity related supplemental benefits and urges the agency to take a hard look at the usage and value of this benefit, particularly because gym memberships are major selling points for Medicare Advantage plans. • Justice in Aging recommends CMS to significantly strengthen regulation of Medicare Advantage advertising, particularly third-party TV ads. • Justice in Aging urges CMS to at least, track appeals of requests for out-of-network providers with the goal of identifying if plan denials create inequities.
	MACPAC	Integrating care through D-SNPS, requiring states to develop a strategy to integrate care and promote equity	• MACPAC voiced concern that D-SNPs are not required to have important mechanisms to support consumers, including individualized benefit counseling and a dedicated ombudsman program, which are valuable in protecting beneficiaries in two distinct ways: educating them about their coverage and investigating and resolving their complaints. • MACPAC has previously recommended CMS require all states to integrate Medicaid and Medicare coverage for full benefit dually eligible beneficiaries within two years, which should be structured to promote health equity. MACPAC recommends federal support (including additional funding) to assist states in their efforts to develop this strategy, noting that states have indicated the value of CMS technical assistance and suggested that other types of assistance could also be helpful
	American Action Forum	Star Ratings Program	• The American Action Forum supports the MA Star Rating System which gives beneficiaries a method to inform themselves on plan options and creates competition through comparison.
	American Enterprise Institute (AEI)	Transparency of plan options, value-based care, telehealth	• AEI recommends CMS to allow beneficiaries to better compare the costs and value of their total health benefits package options under traditional Medicare and Medicare Advantage and choose the combination of health benefits that work best for them. • AEI supports a newly eligible individuals should be automatically assigned to a Medicare Advantage plan if they have not already selected a Medicare Advantage plan or traditional Medicare. • AEI suggests narrowing the C-SNPs program to diseases in which known interventions driven by insurance design can reduce meaningful morbidity, comorbidity, or costs. • AEI recommends CMS to increase the credit for utilization of telehealth for network access requirements, permit multi-county bidding, allow MA Part D plans additional flexibility for clinical

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			outcomes-based contracting, and permit targeted marketing to beneficiaries with the specified qualifying disease(s).
Other	Brookings Institution	Risk adjustment, MA plan accountability, network adequacy, Star Ratings Program,	• Brookings supports improving risk adjustment accuracy to ensure appropriate plan payments. • Brookings supports considering adding ZIP-code-level income as a variable in the risk adjustment model. • Brookings believes CMS could take steps through the MA program to capitalize on better coordinating care for older adults in HUD affordable housing. • Brookings recommends CMS to offer supplemental long-term services and support benefits, which plans have been permitted to offer since 2018. • Brookings believes that CMS should continue to strive to develop measures that reliably capture processes and outcomes for patients with behavioral health care needs. • Brookings recommends CMS to begin collecting more information on financial relationships between MA plans and their related businesses as part of its MLR reviews. • Brookings recommends CMS to examine a wide range of provider types, but we believe that certain categories of related business are particularly ripe for scrutiny, including pharmacy benefit managers (PBMs), behavioral health carve-outs, related medical practices and ambulatory surgery centers, and post-acute facilities. • Brookings recommends CMS to take appropriate steps to strengthen the integrity of the MLR requirements. • Brookings recommends CMS to consider relying more heavily on data that directly reflects enrollees' experiences accessing care, which CMS already routinely collects via CAHPS.

	Healthcare Leadership Council (HLC)	Supplemental benefits, Medicare Plan Finder, SDOH, health equity, data standardization, telehealth, broadband, behavioral health services, hospital-at-home, Star Ratings Program, data	• Supplemental benefits:
			  ○ HLC recommends CMS provide all health plans more flexibility in targeting supplemental benefits to address social risk factors and believes Congress should pass H.R. 4074, the "Addressing Social Determinants in MA Act," to enable health plans to offer certain supplemental benefits to enrollees with low-income or socioeconomic risk factors
			  ○ HLC urges CMS to CMS modify the Medicare Plan Finder (MPF) to show comprehensive summaries of available supplemental benefits
			  ○ HLC recommends CMMI test the expansion of access to supplemental benefits by increasing the rebate percentages for plans offering SSBCI benefits, which would enable health plans to further address health-related social needs, in addition to improved data collection and analysis
			• Improve Data Capture in Support of Health Equity

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		interoperability, value-based care, risk adjustment	○ HLC encourages CMS to focus its efforts on standardizing SDOH data capture and measurement, leveraging resources currently available, and reducing administrative burden ○ HLC recommends CMS work with stakeholders to continue to advance social risk screenings through assessment tools to develop data sharing best practices, while avoiding mandates ○ HLC recommends CMS consider increasing education for providers on the use of existing billing codes for SDOH, evaluate existing ICD-10 Z codes which identify non-medical factors that may influence a patient's health status, and update/promote existing agency recommendations about how these Z codes can be utilized ○ HLC encourages CMS to consider ways to leverage interoperability and health information technology to foster data flow on social risk, ideally available in real-time and at the point of care, not only when a claim is submitted • Telehealth: HLC supports permanent expanded use of telehealth and encourages CMS to work with Congress on further improving access to virtual care ○ HLC recommends CMS permanently allow Hierarchical Condition Category codes to be collected through audio-only telehealth visits for the documentation of diagnosis codes used for the calculation of MA risk scores • HLC encourages CMS to pursue options that increase Medicare beneficiaries' connection to and use of digital tools, such as supporting cellular devices programs and incorporating digital literacy • HLC believes incentives should be created for medical schools to place greater emphasis on behavioral health services, including scholarships, loan forgiveness or tuition reimbursement • CMS should work with Congress to pass H.R. 7053/S. 3792, the "Hospital Inpatient Services Modernization Act," which would extend the current waiver flexibility for two years after the PHE • HLC believes CMS should conduct a study of all Stars measures to determine how each measure should be adjusted to accurately account for social risk factors and coordinate with other measure stewards to improve survey questions and resulting adjustments to better account for health equity • HLC supports proposals to further participation in the Trusted Exchange Framework and Common Exchange (TEFCA) and encourages CMS to continue work with other agencies to support implementation

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			• HLC encourages CMMI to continue to examine how to use value-based payment models to improve overall care and reduce health disparities and incorporate more value-based elements such as utilization metrics into FFS Medicare, but discourages the use of mandatory participation • HLC urges CMS to work with stakeholders to develop a fair, accurate, and predictable Risk Adjustment Data Validation (RADV) methodology and is concerned that current methodology does not account for the different documentation standards between MA and FFS Medicare • HLC recommends CMS ensure end stage renal disease (ESRD) costs are accurately reflected in MA payment and does not will undermine benefits and costs for all MA enrollees