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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

[CMS-4203-NC]

RIN 0938-AV01

Medicare Program; Request for Information on Medicare

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human (HHS)

ACTION: Request for information.

SUMMARY: This request for information seeks input from the public regarding various aspects of the Medicare Advantage program. Responses to this request for information may be used to inform potential future rulemaking or other policy development.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by **[**Insert date 30 days after date of publication in the **Federal Register].**

ADDRESSES: In commenting, refer to file code CMS-4203-NC.

Comments, including mass comment submissions, must be submitted in *one* of the following three ways (please choose only ***one*** of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-4203-NC,

P.O. Box 8013,

Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-4203-NC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT: Andrew Siske (410) 786-4263.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

The Vision for Medicare (https://www.cms.gov/blog/building-cms-strategic-vision-working-together-stronger-medicare) puts the person at the center of care and drives towards a future where people with Medicare receive more equitable, high quality, and whole-person care that is affordable and sustainable. Through this Request for Information (RFI), the Centers for

Medicare & Medicaid Services (CMS) is seeking feedback on ways to strengthen Medicare Advantage (MA) in ways that align with the Vision for Medicare and the CMS Strategic Pillars (https://www.cms.gov/cms-strategic-plan). An additional goal of this RFI is to create more opportunities for stakeholders to engage with CMS, in line with the agency's Strategic Pillars that prioritize increased engagement with our partners and the communities we serve throughout the policy development and implementation process. We encourage input from a wide variety of voices on the questions below, including beneficiary advocates, plans, providers, community-based organizations, researchers, employers and unions, and all other stakeholders.

II. Solicitation of Public Comments

A. Advance Health Equity

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes" (https://www.cms.gov/pillar/health-equity). The CMS Framework for Health Equity (https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity) lays out how CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. We seek feedback regarding how we can enhance health equity for all enrollees through MA.

1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- Enrollees from racial and ethnic minority groups.
- Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.

- Enrollees who identify as transgender, nonbinary, or another gender identity.
- Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.
- Enrollees with diverse cultural or religious beliefs and practices.
- Enrollees of disadvantaged socioeconomic status.
- Enrollees with limited English proficiency or other communication needs.
- Enrollees who live in rural or other underserved communities.[1]

2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)?[2] Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

4. What have been the most successful methods for MA plans to ensure access to language services for enrollees in different health care settings? Where is improvement needed?

5. What socioeconomic data do MA plans leverage to better understand their enrollees and to inform care delivery? What are the sources of this data? What challenges exist in obtaining, leveraging, or sharing such data?

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[1] CMS defines "underserved communities" as "populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life." CMS derives this definition from that of the same term in Executive Order 13895 (United States, Executive Office of the President [Joseph Biden]. "Executive Order 13985 of January 20, 2021, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," 86 FR 7009 (January 25, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

[2] CMS defines social determinants of health (SDOH) as "the conditions in the environments where people are born, live learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, https://health.gov/healthypeople/priority-areas/social-determinants-health.

6. For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.

7. What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically-tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.

8. What physical activity-related supplemental benefits do MA plans provide today? At what rate do enrollees use these benefits? How do these benefits improve enrollees' health? What physical activity-related policy changes within the scope of applicable law could lead to improved health for MA enrollees?

9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPSs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

10. How have MA plans and providers used algorithms to identify enrollees that need additional services or supports, such as care management or care coordination? Please describe

prediction targets used by the algorithms to achieve this, such as expected future cost and/or utilization, whether such algorithms have been tested different kinds of differential treatments, impacts, or inequities, including racial bias, and if bias is identified, any steps taken to mitigate unjustified differential outcomes. For MA plans and providers that do test for differential outcomes in their algorithms, please provide information on how such tests function, how their validity is established, whether there is independent evaluation, and what kind of reporting is generated.

11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

B. Expand Access: Coverage and Care

CMS is committed to providing affordable quality health care for all people with Medicare. We seek feedback regarding how we can continue to strengthen beneficiary access to health services to support this goal in MA.

1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

4. How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what

steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

7. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?

8. How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?

9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)?

10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and

services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

C. Drive Innovation to Promote Person-Centered Care

We strive to deliver better, more affordable care and improved health outcomes. Key to this mission are care innovations that empower the beneficiary to engage with their health care and other service providers. We seek feedback regarding how to promote innovation in payment and care delivery, and accountable, coordinated care responsive to the specific needs of each person enrolled in MA.

1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?

2. What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?

3. What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?

4. How are providers and MA plans incorporating and measuring outcomes for the provision of behavioral health services in value-based care arrangements?

5. What is the experience for providers who wish to simultaneously contract with MA plans or participate in an MA network and participate in an Accountable Care Organization (ACO)? How could MA plans and ACOs align their quality measures, data exchange requirements, attribution methods and other features to reduce provider burden and promote delivery of high-quality, equitable care?

6. Do certain value-based arrangements serve as a "starting point" for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost?

7. What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreement[3] to support improved health information exchange for use cases relevant to MA plans and providers?

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[3] For more information, *see* U.S. Department of Health and Human Services, Office of the National Coordinator, "Trusted Exchange Framework and Common Agreement (TEFCA)," https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement-tefca.

8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity?

11. What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID Model? What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?

12. What issues specific to Employer Group Waiver Plans (EGWPs) should CMS consider?

D. Support Affordability and Sustainability

We are committed to ensuring that Medicare beneficiaries have access to affordable, high value options. We request feedback on how we can improve the MA market and support effective competition.

1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

4. Are there additional considerations specific to payments to MA plans in Puerto Rico or other localities that CMS should consider?

5. What are notable barriers to entry or other obstacles to competition within the MA market generally, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program?

6. Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?

7. How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks?

8. What new approaches have MA plans employed to combat fraud, waste, and abuse, and how could CMS further assist and augment those efforts?

E. Engage Partners

The goals of Medicare can only be achieved through partnerships and an ongoing dialogue between the program and enrollees and other key stakeholders. We request feedback regarding how we can better engage our valued partners and other stakeholders to continuously improve MA.

1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA?

More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?

2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

3. What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

4. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

III. Collection of Information Requirements

Please note, this is a request for information (RFI) only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This RFI does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party’s expense. In addition, this RFI does not commit the Government to any policy decision and CMS will follow established methods for proposing

future policy changes, including the MA Advance Notice and Rate Announcement process. We note that not responding to this RFI does not preclude participation in any future procurement or rulemaking, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this RFI.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 26, 2022.

Dated: July 27, 2022.

Xavier Becerra,

Secretary,

Department of Health and Human Services.

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