Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI)

Covered California Responses Submitted November 4, 2022

Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs

Summary of the Request for Information

CMS is seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE). RFI is part of the Biden-Harris Administration's ongoing work to advance health equity and reduce health disparities.

CMS will use the comments received in response to this RFI to build solutions that will help close the gap in healthcare quality, access, and outcomes to ensure that all those served by CMS programs have a fair and just opportunity to attain their optimal level of health.

Covered California Responses

Summary of Covered California Responses

Covered California responses to this RFI focus on supporting the CMS Framework for Health Equity that identifies the need for CMS to be a leader on the advancement of health equity. To see this through and to make necessary advancements on health equity, CMS needs to unify and standardize the identification and collection of data so that measurable data can be collected on determinants of health (DOH) and social determinants of health (SDOH), and the accommodation of individuals with disabilities. Covered California also voices support for CMS's efforts to mitigate the potential harm caused by valuable clinical algorithmic tools, machine learning, or other similar developing technology as well as how CMS' payment policies can positively impact mental and behavioral health. Lastly, Covered California urges CMS to provide Exchanges with flexibility when obtaining updated consumer tax information during the annual eligibility redetermination process.

CMS Prompt: Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and implementing policies that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs, and strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

CMS Sub-Prompt

Better understand individual and community-level burdens, health-related social needs (such as individual-level food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address structural social determinants of health and burdens impairing access to comprehensive quality care.

Covered California Response

Public health and economic research overwhelmingly indicate the importance of measuring and addressing social determinants of health (SDOH), which the World Health Organization defines as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" as well as associated individual-level health-related social needs, also referred to as drivers of health (DOH). Individuals and agencies invested in reducing health disparities know from decades of research – including CMS's own social needs screening data – that racial and ethnic minorities more often face experience challenging drivers of health. Given this demonstrated inequity, Covered California encourages CMS to unify and standardize the currently fragmented data collection process as there has never been a unified approach to identify and standardize SDOH and drivers of health data measures. By creating a unified and standardized approach, the healthcare industry will be better positioned to understand and address community-level burdens, health-related social needs, and health inequities.

Specifically, Covered California encourages CMS to adopt the "Screening for Social Drivers of Health" measure in the quality performance category measure set for the Merit-Based Incentive Payment System (MIPS) as well as the "Screen Positive Rate for Social Drivers of Health" measure, which was recently adopted for the Hospital Inpatient Quality Reporting Program. Adopting these measures will ensure alignment across hospital and provider payment programs. Additionally, Covered California encourages CMS to include both the "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" measures into the APM Performance Pathway measure set so they can be incorporated into the Medicare Shared Savings Program (MSSP). Adding these two measures will allow for the screening and identification of unmet needs such as housing instability, lack of transportation, utility difficulties, food insecurity, and interpersonal safety. Importantly, while universal screening will enable intervention at the individual level as well as potential risk adjustment for payment, the screen positive rate is necessary for organizations to better prioritize efforts and resources for population-level interventions and provides important data to begin addressing community-level SDOH. Standardizing and collecting this data will allow physicians enrolled in MIPS and Accountable Care Organizations in MSSP to better serve patients by addressing and monitoring what are often key contributors to poor physical and mental health outcomes. Taking these steps will create a standard set of

measures to collect patient-level DOH and SDOH data in federal quality and payment programs.

While Covered California has taken steps in an attempt to fill this void, we know that this initiative requires the leadership of CMS. By not addressing this lack of data identification and collection, providers, carriers, and purchasers will not know how to effectively redistribute resources or adjust payments to best meet the needs of patients. This is why Covered California is encouraging CMS to require the use of the U.S. Core Data Set for Interoperability (USCDI) version 2, to better understand individual and community-level burdens. Requiring the use of USCDI version 2 will allow for data collection in a uniform manner across the U.S.

CMS Sub-Prompt

How can CMS better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences

Covered California Response

Entities like Covered California are limited with the information allowed to be collected from applicants, including specific questions about disability status. Covered California urges CMS to work with HHS to address this gap in data collection which prevents the identification of and accommodation for individuals with disabilities. Another shortcoming is the lack of standardized definitions of disability leading to disjointed data, at best. Covered California recommends that CMS provide clarifying guidance on the Accountable Healthy Communities Health-Related Social Needs Screening Tool that will allow the healthcare industry to better collect data on individuals' disability status which will likely result in more useful data.

CMS Sub-Prompt

Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias.

Covered California Response

Covered California supports CMS's efforts to mitigate the potential harm caused by valuable clinical algorithmic tools, machine learning, or other similar developing technology. Awareness of the potential and actual discriminatory harms caused by clinical algorithms has grown in recent years, and Covered California urges CMS to continue to pursue meaningful protections despite the challenge of building and maintaining the technical knowledge required to implement and maintain these guardrails. Covered California has recently begun to assess QHP issuers' approaches to monitoring algorithms used in health care, including clinical algorithms, for potential bias. Importantly, we note protections against discrimination should be applied beyond

clinical algorithms to include all related automated or augmented decision-making tools such as artificial learning or artificial intelligence.

While the prohibition against discrimination is foundational, effective federal action to mitigate discriminatory outcomes will need to be specific and include guidance for covered entities on how to appropriately assess algorithms for bias. Augmented decision-making tools are being increasingly adopted by a variety of healthcare entities ranging from individual clinicians to hospital systems to issuers, many who may not have the resources or technical knowledge to assess whether their tools are driving discriminatory outcomes. In other words, the issue at hand is not discriminatory intent; it is discriminatory impact. Therefore, any action must go beyond intentional discrimination while providing workable solutions.

Given the wide variation in knowledge and technical expertise in this area, standardizing actions covered entities could take – as well as providing technical assistance and guidance – would accelerate progress and reduce harm in this area.

CMS Sub-Prompt

Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid.

Covered California Response

Comprehensive Primary Care Must be Integrated with Behavioral Health: Integrated behavioral health services with medical services, particularly primary care services, increases access to behavioral health services and improves treatment outcomes. Covered California requires QHP issuers to pay their contracted providers through population-based payment and other alternative payment models (APMs) to support behavioral health integration with primary care. QHP issuers report how they are promoting primary care and behavioral health integration, in particular through the Collaborative Care Model.

To emphasize the importance of behavioral health, Covered California requires QHP issuers to collect and report results for two measures – Depression Screening and Follow-Up for Adolescents and Adults (DSF) and Pharmacotherapy for Opioid Use Disorder (POD) – to supplement the behavioral health measures included in the CMS Quality Rating System measure set. These measures are also included in key Covered California measures sets. Covered California has included these measures as reporting measures in our Quality Transformation Initiative. This initiative places a percent of premium at risk for QHP issuer performance on a small set of measures. Issuers are required to meet national percentile benchmarks for these measures or are subject to sliding scale payments depending on their performance. Covered California will tie performance on the DSF and POD measure to payments once national percentile

benchmarks have been established for these measures. These measures are also included in the Advanced Primary Care (APC) measure set which is used to measure the performance of primary care practices. The APC measure set has been collaboratively defined by the California Quality Collaborative, a program of the Purchaser Business Group on Health, and the Integrated Healthcare Association. Beginning in 2023, QHP issuers will be required to implement the APC measure set to identify primary care practices providing advanced primary care and understand how those practices are distributed throughout Covered California's QHP issuer provider networks.

Covered California recommends that CMS support the adoption of integrated behavioral health models such as the Collaborative Care Model through reimbursing for Collaborative Care Model claims codes, enhancing the use of alternative payment models, and including outcomes-focused behavioral health measures in key measure sets.

Payment to Support Advanced Primary Care Payment Reform Drives Delivery System Innovations: Covered California believes that sufficient payment through shared savings and population-based payment models is necessary for enabling team-based, data-driven, high-quality care. Covered California uses the Health Care Payment Learning & Action Network's (HCP LAN or LAN) payment framework to require all QHP issuers to report the extent to which contracted primary care providers (PCPs) are paid under each LAN category. Covered California also requires QHP issuers to increasingly pay PCPs through APMs such as shared savings and population-based payments. Specifically, Covered California has performance penalties tied to QHP issuer requirements to meet primary care payment targets for alternative payment models built on shared savings and population-based payments. This approach has seen some success, with slow but incremental progress in primary care payment reform in recent years. Specifically, from 2015 to 2021, Covered California saw an increase from 41% to 53% in capitation-based payments to providers and an increase from 8% to 15% in shared savings-based payments. To build on that success, beginning in 2023 Covered California will require QHP issuers to monitor and report on total primary care spend as a percent of their overall budget.

Covered California recommends that CMS require all health plans contracted under CMS programs to increasingly pay PCPs through alternative payment models (HCP LAN categories 2, 3, and 4) that incentivize high-quality, equitable care. CMS could also require all health plans to report on primary care spending. If the evidence shows that rebalancing to increase primary care spend improves quality, reduces disparities, or drives lower total cost of care, CMS could set a target or floor for primary care spend in future requirements.

CMS Prompt: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE to identify areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Covered California Response

Covered California urges CMS to provide Exchanges with the flexibility to obtain updated consumer (qualified individuals) tax information from the federal data services Hub (Hub) to improve the consumer experience and increase enrollment in health insurance. Current federal regulations (45 C.F.R. § 155.335(k)) require Exchanges to obtain active authorization from qualified individuals to obtain updated tax return information for purposes of conducting an annual eligibility redetermination. Additionally, Exchanges may only obtain authorization from qualified individuals to obtain tax information for a maximum of 5 years. To increase enrollment in health insurance and reduce consumer burden, Covered California recommends that Exchanges be allowed to move from an “opt-in” authorization model to an “opt-out” model, allowing Exchanges to automatically obtain updated tax return information from the Hub for purposes of annual eligibility redeterminations. Under this approach, qualified individuals would be able to change their authorization preference at any time, requiring them to actively renew their coverage each year.

Even though Covered California has a robust communication plan for obtaining authorization from qualified individuals to obtain updated tax information, we see a significant number of qualified individuals lose access to Advanced Premium Tax Credits (APTC) during the annual eligibility redetermination process because they fail to provide this authorization. For example, Covered California identified 36,000 qualified individuals who faced losing $19 million in monthly APTC due to the expiration of their authorization for Covered California to obtain updated tax information. After conducting a comprehensive outreach campaign, Covered California was only able to obtain reauthorization from 10,000 qualified individuals. The remaining 26,000 qualified individuals risk losing a collective $11 million in monthly APTC. While grace periods potentially provide qualified individuals with the ability to address this loss of APTC without experiencing a loss of coverage, qualified individuals are often unaware of their loss of APTC, rendering the grace period ineffective.