AMERICAN ACADEMY *of* ACTUARIES

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August 30, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4203–NC
P.O. Box 8013
Baltimore, MD 21244–8013

Re: CMS–4203–NC, CMS Request for Information on the Medicare Advantage Program

Dear Administrator Brooks-LaSure:

The Health Equity Committee (Committee) of the American Academy of Actuaries (Academy)[1] offers the following comments and considerations related to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) on the Medicare Advantage (MA) program.[2] Although the Committee's comments focus specifically on the health equity aspects of the questions posed, the Committee would welcome the opportunity to support CMS further on other actuarial aspects of the questions.

The Academy's Health Equity Committee is comprised of actuaries with a focus on and interest in health equity challenges in all types of health insurance products. To respond to these questions, the Committee has leveraged the research and work performed over the past two years with specific consideration to the Medicare Advantage product design and enrolled population.

What are examples of policies, programs, and innovations that can advance health equity in Medicare Advantage (MA)?

Some examples of policies, programs, and innovations that can advance health equity in MA include:

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[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

[2] https://www.govinfo.gov/content/pkg/FR-2022-08-01/pdf/2022-16463.pdf.

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- An assessment of the Quality Bonus Program's impact on health equity and a program restructure, as needed, to ensure that financial incentives align with quality of care and health equity goals. Such a restructure could entail the inclusion of specific health equity measures and/or adjustment of existing measures for social risk. This process could incorporate the concept of a health equity index that measures how well MA plans serve at-risk beneficiaries.
- Exploration as to whether and how to incorporate social risk considerations into the risk adjustment model. (A more detailed discussion is available in the recently released issue brief [attached], *Health Risk Assessment and Risk Adjustment in the Context of Health Equity*.)
- Expansion of data collection initiatives in the enrollment process to include socioeconomic level and geographic classification (e.g., rural, urban, suburban, frontier), in addition to the planned collection of race, ethnicity, language, gender identity, sexual orientation, disability status, and social determinants of health (SDOH) as enumerated in the CMS Framework for Health Equity.[3] Improved data collection may help MA plans identify subpopulations that have unmet needs and develop initiatives that positively impact beneficiary health.
- Exploration of the differences in utilization levels of medical services by historically marginalized groups and implementation of initiatives to address disparities.
- Implementation of policies related to supplemental benefits that could advance health equity include:
    - Promoting year-over-year stability in the offering of supplemental benefits. Because supplemental benefits are tied to MA rebate dollars, which can vary significantly from one year to the next, the availability of supplemental benefits could vary by year.
    - Presenting supplemental benefit offerings in places like the Medicare Plan Finder and the Plan Benefit Package (PBP) in a uniform way to make it easier for beneficiaries to compare plan designs. Improving the way information is presented in the PBP may also improve research into topics such as trends in supplemental benefit uptake.
    - Providing technical assistance on operationalizing the offering of supplemental benefits. For example, some MA plans may have the intention of aligning benefits with the SDOH-related needs of beneficiaries but may have limited experience on operational aspects such as identifying the beneficiaries most suited to the benefits as well as pricing such benefits.

[3] https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

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?

The Committee cannot comment directly on the socioeconomic data that plans use to better understand beneficiary needs. However, the Committee can highlight some of the limitations associated with the collection of socioeconomic data. Several challenges exist in obtaining, using, and sharing socioeconomic data, including:

- A lack of standards and uniformity for the collection of certain data may make it difficult to create a coherent and accurate profile of a beneficiary.
- Coordinating and reconciling data that have been collected from different sources present technical challenges. It can be difficult to use disparate sources of data to create a profile of a single beneficiary due to differences in the methodology used and the timing of the collection of different data elements as well as differences in the accuracy of elements collected from different sources. Understanding the data collection and processing methodologies used for each data source would be important to the appropriate aggregation of disparate data sources.
- Lags between when the data is collected and the event that the data is meant to capture, for example, a beneficiary may have moved to a different ZIP code than the one recorded on a plan's most recent enrollment dataset.
- Issues with privacy may arise when a beneficiary may be uncomfortable sharing certain information about themselves.
- Closely related to the issue of privacy is that of stigma. There may be some social stigma associated with certain benefits, which can also lead to data gaps.
- There may also be regulatory constraints that make it difficult to collect certain data. An example of this can occur when there is a perceived risk that the data could be used to harm the beneficiary or when it is unclear how the collection of the data will benefit the beneficiary.
- Lack of the necessary operational capacity (e.g., personnel and tools) to collect, aggregate and use the data while protecting privacy concerns.

What role could risk adjustment play in driving health equity and addressing SDOH?

Risk assessment and risk adjustment are valuable tools that are used for a variety of purposes in health care and health insurance systems. They are used to adjust premium payments to health insurance plans so that plans are not over- or under-paid relative to the health of their enrollees. They are also used in programs that reward or penalize health care providers based on health care outcomes so they are not unfairly rewarded or penalized for factors outside of their control. In both of these instances, the use of risk adjustment is critical to helping ensure access to health insurance coverage and health care services among people who are at higher risk of using health care services or who have more complex health care needs. These tools can also be used to help identify individuals who would benefit from care management programs.

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As with many aspects of the health care ecosystem, risk assessment and risk adjustment are being reexamined to better understand their effects on health equity. For instance, do these tools exacerbate or mitigate health care disparities? Would incorporating factors that better reflect social determinants of health or social risk improve health equity? If so, how should these factors be incorporated? Answering these questions can facilitate an improvement in health equity and lead to a more efficient use of health care dollars.

The Academy recently released issue brief *Health Risk Assessment and Risk Adjustment in the Context of Health Equity* explores these questions and is included as an attachment.

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We appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services Request for Information on Medicare Advantage plans. We welcome the opportunity to speak with you to provide more detail and answer any questions you might have regarding these comments or on other issues. If you have any questions or would like to discuss further, please contact Matthew Williams, the American Academy of Actuaries senior health policy analyst, at williams@actuary.org.

Sincerely,

Annette V. James, MAAA, FSA, FCA
Chairperson, Health Equity Committee
American Academy of Actuaries