Healthcare Advisory Committee

Working Group Framing Questions

Six Working Groups support the Committee's charge to advise the US Department of Health & Human Services (HHS) and Centers for Medicare & Medicare Services (CMS) on strategies for improving the operations and outcomes of federally administered healthcare insurance and payment programs.

CMS subject matter experts developed key framing questions to help Working Groups understand CMS's greatest challenges within each group's scope as they generate ideas and develop presentations for the Healthcare Advisory Committee meetings.

Framing Questions by Working Group

MAHA by Improving Wellness & Preventing Chronic Disease Working Group

Framing Questions

1. What are the core benefits of improvements in primary prevention behaviors around physical activity and nutrition (e.g., brain health, longevity, healthcare affordability)?
2. What are the highest impact approaches to change "consumer" behavior for primary prevention (e.g., physical activity, nutrition)? What are effective and appropriate ways the Centers for Medicare & Medicaid Services (CMS) can engage beneficiaries to adopt healthy lifestyle choices?
3. Beyond primary prevention of physical activity and evidence-based nutrition, what are the top 4-5 chronic conditions CMS should prioritize its MAHA efforts around (e.g., by prevalence or condition burden on society)?
4. What are the most important policy and communications "levers" CMS has to promote MAHA (e.g., emphasizing quality measures that reward measurable improvements in health outcomes)?
    a. What 5-7 policy initiatives should CMS prioritize to advance MAHA goals (that do not require new statutory authority)?
5. Are there levers CMS can use to address the loneliness epidemic and social isolation? What is the appropriate balance between CMS levers vs. non-government solutions?

Reducing Administrative Burden Working Group

Framing Questions

1. What specific regulatory, data, and payment requirements create the greatest administrative burden today—and what would a simplified, modernized framework look like if we redesigned it from scratch?
2. What criteria should CMS consider in modernizing regulations? For example, regulations that are outdated, duplicative, processes vs outcomes?
3. What types of regulations cause the highest regulatory burden with minimal effect on health outcomes (e.g., facility surveys, reporting, outdated or duplicative regulations)?
4. What types of regulations stifle innovation? What kind of clarity from CMS (or other United States Department of Health and Human Services [HHS] Operating Divisions) would spark innovation?
5. How can CMS help with streamlining or speeding up the regulatory process, and integrate stakeholder feedback better?
6. What quality measures could be consolidated, eliminated or changed to reduce administrative burden? What quality measures focus on activity / compliance vs health outcomes?
7. What sub-regulatory guidance should be addressed?
8. Where does CMS need to collaborate with other HHS Operating Divisions to create a simpler stakeholder experience?

Deploying Real-time Data Working Group

Framing Questions

1. How can CMS better align incentives and data-sharing requirements across payors and providers to improve payment accuracy, reduce administrative burden, and encourage participation in trusted data-sharing networks that support patient access, claims processing, and operational workflows? Additionally, what issues are noted with Revenue Cycle, Case Management, Utilization Management and other teams that CMS can address with tactical solutions?
2. How can CMS leverage technology, artificial intelligence (AI), and automation to modernize claims processing, enable more real-time decision-making, and reduce improper payments while lowering administrative costs for providers and the program? Notably, is AI (both Generative AI and statistical AI tools) being utilized appropriately or are there other ways it can be aligned with providers and payers to achieve success?
3. How should CMS redesign its fraud, waste, and abuse and audit strategy to be more predictive, less burdensome for compliant providers, and better focused on high-risk actors? Please, identify specific strategies that could prevent adversaries from being granted a National Provider Identifier (NPI), Provider Transaction Access Number (PTAN) or other identifiers required to bill Medicare or Medicaid or that can preemptively prevent authorization to bill.
4. What payment and data reforms can CMS implement to better align the broader healthcare ecosystem around value, price and quality transparency, and accountability while supporting interoperable data exchange and reducing administrative complexity? Specifically, are there tools or policies that CMS could address that would be deflationary to healthcare costs, increase participation in accountable care organizations, expand the capacity of providers, incentivize patient ownership over their own health, as well as acceleration of outcomes-based payments that could preserve the vitality of our healthcare system?
5. What investments in data infrastructure and interoperability are needed to give CMS, states, and law enforcement real-time access to claims, enrollment, and clinical data to support fraud, waste, and abuse (FWA) detection and program integrity? What data should CMS be sharing with providers (and how) to help them build better compliance tools to prevent FWA?

Improving Care for Vulnerable Populations Working Group

Framing Questions

1. Which health outcomes-focused quality measures are the most well-developed? What should CMS focus on for improvement to encourage improvement in health outcomes?
2. What are the most important measures to prioritize primary prevention, especially encouraging improvement in physical activity and evidence-based nutrition?
3. How can CMS better partner with states to improve results from the rural health transformation program? How about population health outcomes, specifically in underserved rural communities?
4. How should CMS evolve Medicaid quality measurement to better capture whole-person outcomes, including community-based prevention?
5. How should Medicaid redefine the boundary between medical care and social services? What is a reasonable framework for which non-medical services belong in Medicaid (and don't) and how do we evaluate return on investment?
6. With over 70% of Medicaid beneficiaries now enrolled in Managed Care Organizations, what does high-quality managed care accountability look like at scale and what is the role of CMS versus the States?
7. Medicaid generates enormous volumes of claims, enrollment, and clinical data, yet the program's ability to access that data easily to manage quality, detect fraud, and coordinate care remains severely constrained. If you were to redesign data and IT infrastructure that is fit for purpose around these 3 domains in Medicaid, what would it look like and what is the strategic roadmap to get there?
8. Medicaid spends over $200B annually on long-term care (between both home-based care and institutional care), which is ~20% of total computable Medicaid spend. At the same time, this area of Medicaid spend remains the most vulnerable to FWA; how do we build a program integrity framework for Medicaid long-term care that matches the scale of the risk?
9. How can CMS and States transform Medicaid from a health insurance program into a platform that empowers participants in their own health through prevention, lifestyle modification, and provider engagement?
10. How can we achieve genuine integration and whole-person care for dual-eligible beneficiaries (e.g., via Dual Eligible Special Needs Plans [D-SNPs], Program of All-Inclusive Care for the Elderly [PACE]), and how should the federal-state partnership be leveraged to make that possible?

Strengthening Medicare Advantage Working Group

Framing Questions

1. What are additional ways that CMS can focus on accountable care in Medicare to ensure every beneficiary has access to an accountable care relationship?
2. How should CMS refine risk adjustment and quality measurement to ensure long-term MA sustainability and growth while minimizing coding intensity and measure overload?
3. How can CMS support MA plans in improving coordination of primary, specialty, and long-term care services for the aging population?
4. What guardrails can CMS implement to improve transparency and consistency in prior authorization and denials without undermining appropriate utilization management?
5. What pricing and benefit transparency reforms can CMS advance to improve beneficiary trust and market stability in MA?
6. What investments in both Original Medicare and MA should be considered that could reduce the prevalence of chronic disease for our beneficiaries?
7. How can CMS transform MA from a health insurance program into a platform that empowers participants in their own health through prevention, lifestyle modification, and provider engagement?
8. What role will AI play in transforming the traditional functions of insurance and how should CMS partner with insurers to materially improve the insurance value proposition?
9. What are the most significant, non-statutory changes CMS can make to massively manage costs and position Medicare on a long-term sustainable footing?
10. What guardrails should be considered to ensure supplemental benefits in MA meaningfully promote improved health and do not otherwise go toward unintended purposes while not impairing the innovation engine of the program?
11. How can we create a competitive MA market where small and regional plans are viable?

Crushing Fraud, Waste, & Abuse Working Group

Framing Questions

1. How should CMS strengthen its use of existing authorities (e.g., provider enrollment, payment suspension, pre-payment review) to more proactively prevent fraudulent or high-risk actors from entering or remaining in Medicare and Medicaid? What specific policy or operational changes would have the greatest short-term impact?
2. What changes to CMS program integrity processes (e.g., audits, investigations, medical review, contractor operations) would most improve speed, accuracy, and effectiveness in identifying and stopping fraud, waste, and abuse while minimizing burden on compliant providers? How should CMS redesign its fraud, waste, and abuse and audit strategy to be more predictive, less burdensome for compliant providers, and better focused on high-risk actors?
3. What data, analytics, and technology investments (including AI and real-time data approaches) should CMS prioritize to better predict, detect, and prevent fraud, waste, and abuse? Which specific methodologies or data sources are most underutilized today?
4. What emerging fraud schemes or structural vulnerabilities (e.g., ownership opacity, high-risk service categories, or new billing patterns) pose the greatest risk to Medicare and Medicaid, and what targeted policy responses should CMS prioritize?
    a. How should CMS leverage site visits, database checks, and interagency data to strengthen pre-enrollment screening and ongoing monitoring of high-risk provider types?
5. How should CMS better align incentives and accountability across Marketplace, Medicare Advantage plans, and Medicaid (including Managed Care plans) to strengthen program integrity (e.g., payment suspension authority, state incentives, compliance expectations)?
    a. How can CMS improve cross-program data sharing between Medicare, Medicaid, and other federal and state agencies (e.g., Office of the Inspector General, Department of Justice, state Medicaid fraud control units) to improve coordination on FWA investigations?
6. How can CMS improve transparency and communication around fraud, waste, and abuse activities (e.g., enforcement actions, oversight strategies) to build trust with beneficiaries, providers, and stakeholders while maintaining program integrity effectiveness? What role should beneficiary education and reporting mechanisms play in CMS's overall FWA strategy, and how can these be strengthened?
7. Medicaid spends over $200 billion annually on long-term care (between both home-based care and institutional care), which represents approximately 20% of total computable Medicaid spend. This area remains the most vulnerable to FWA. How do we build a program integrity framework for Medicaid long-term care that matches the scale of the risk?

   a. What enhanced monitoring, prior authorization, and audit mechanisms should CMS and states apply specifically to home and community based services (HCBS) to detect and deter FWA in long-term care?
8. How can CMS better align financial incentives for Managed Care Organizations and other payers to prioritize FWA detection and reporting, rather than passing costs through to the program?