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AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

March 6, 2022

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P
PO Box 8013
Baltimore, MD 21244-8013
Submitted: https://www.regulations.gov

RE: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments on Medicare Advantage and Medicare pharmacy benefits as they impact persons with disabilities, and in these proposed rules, particularly persons dually eligible for Medicare and Medicaid.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

AAHD was actively engaged as part of the comments drafting team for the Consortium for Citizens with Disabilities (CCD). We also joined the comments of the Coalition To Preserve Rehabilitation (CPR) and the Medicare Access for Patients Rx (MAPRx) Coalition. Our comments here are the three AAHD-Lakeshore issues that we initially authored for CCD.

Standardizing Housing Stability, Food Insecurity, and Transportation Questions in the Enrollee Health Risk Assessments (§ 422.101)

We support the enhancement of details and frequency of the all-SNPs health risk assessment of the individual's physical, psychosocial, and functional needs. We agree that certain social risk factors can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status.

We support the CMS proposal to require all SNPs include standardized questions on housing stability, food security, and access to transportation as part of their health risk assessments. This would result in SNPs having a more complete picture of the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence. Such assessments would also be an incentive for SNPs to connect and partner with community-based social services, disability, and aging organizations. Standardizing these assessments will enhance both SNP's and CMS' ability to collect, analyze, and publicly report disparity and equity-related data.

These CMS proposals are consistent with the February 1, 2022 National Quality Forum (NQF) Measure Applications Partnership (MAP) recommendations to CMS (MUC 21-134 and MUC 21-136) for screening for social drivers of health and public data on those screening positive for social drivers of health. The NQF MAP recommendation is for Medicare beneficiaries aged 18 and over screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. Ultimately, the Medicare Advantage (MA), including SNPs, and all Medicare provider social determinants of health (SDOH) screening elements should be identical.

Redefining Definitions for Fully-Integrated and Highly Integrated D-SNPs; and, Additional Opportunities for Integration Between D-SNPs and State Medicaid Managed Care Plans (§ 422.2 and § 422.107)

There are 12.2 million individuals enrolled in both Medicare and Medicaid (dually eligible persons); 4.6 million are people with disabilities under age 65.[1] Many dually eligible persons have complex care needs, including chronic illness, physical disabilities, behavioral health

[1] MACPAC, Data book: Beneficiaries dually eligible for Medicare and Medicaid — February 2022, www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf.

issues, and cognitive impairments; frequently these are co-occurring conditions. These persons, on average, use more services and have higher per capita costs than those beneficiaries enrolled in Medicare or Medicaid alone. Many live with major social risk factors. Although Congress created multiple authorities to integrate their care, in 2019 only about 10% of the dual-eligible population are enrolled in integrated care programs, such as the Medicare-Medicaid financial alignment initiative, PACE, dual eligible special needs plans (D-SNPs), and Medicaid Managed FFS programs.[2] The division of coverage between Medicare and Medicaid results in fragmented care and cost shifting. A recent RAND study, commissioned by CMS, documented dually eligible persons in MA programs had much greater clinical care quality disparities (using HEDIS measures) than non-dually eligible persons. Additional recent studies on the dually eligible population have been published by MACPAC, Bipartisan Policy Center, Health Management Associates, and the Alliance for Health Policy.

As advocates for persons with disabilities including those dually eligible for Medicare and Medicaid, we believe that Congress and the Administration should expand existing models and design and pilot further programs to more effectively integrate all aspects of services and supports for persons dually eligible for Medicare and Medicaid. This is especially important given the recent rapid growth of D-SNPs. As of 2021, almost three million dually eligible individuals are enrolled in D-SNPs, accounting for nearly 25% of the dual eligible population.[3] We support the CMS objective of enhanced pathways for sharing information and partnering between Medicare Advantage including D-SNP plans and State Medicaid agencies. Thus, we are fully supportive of these modest, incremental, and helpful CMS proposals regarding D-SNPs.

We support the CMS proposal that Fully-Integrated Dual Eligible (FIDE) D-SNPs would have to offer Medicaid home health, durable medical equipment, behavioral health, and long-term services and supports (LTSS) through capitated contracts with state Medicaid agencies. FIDE D-SNPs would be required to cover Medicare cost-sharing for acute and primary care. Highly-Integrated Dual Eligible (HIDE) SNPs would be required to cover the vast majority of Medicaid behavioral health or the vast majority of Medicaid LTSS. Ideally, the goal is full Medicare D-SNP and Medicaid integration, including behavioral health and long-term services and supports within each state.

We support the improved CMS and State Medicaid agency coordination of monitoring and oversight of D-SNPs. CMS would give state Medicaid agencies access to D-SNP information systems. It is vitally important to have strong oversight by both the state and CMS, improved data exchange, and transparency. We also recommend CMS require states to have separate contracts with the plan sponsor for each D-SNP to facilitate a more complete picture of plan performance and network adequacy specifically for the dually-eligible population. State Medicaid agencies would be given new authority to require D-SNPs to integrate materials and notices for enrollees. We support integrated member materials for all exclusively aligned D-SNPs and urge CMS to include a provision that translation requirements for integrated member materials to follow the standard (federal or state) that is most favorable to the enrollees.

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[2] https://www.cms.gov/files/document/mmco-report-congress.pdf

[3] MACPAC, Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans, p. 203 (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf.

Network Adequacy in Medicare Advantage Plans (§ 422.116)

We support the modest CMS-proposed revisions to the timeline for reviewing network adequacy submissions, including the emphasis on network adequacy review as part of the MA application process for new and expanding service areas. We encourage CMS to also reinstate and strengthen overall MA network adequacy requirements that were weakened in recent years (for example, reinstate the minimum percentage of enrollees that must reside within the maximum time and distance standards in non-urban counties back to 90 percent rather than 85 percent). Such actions would improve access to care for those enrolled in MA plans.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,

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National Quality Forum (NQF) Member, NQF Measure Applications Partnership (MAP) Coordinating Committee (July 2021-present); NQF Medicare Hospital Star Ratings Technical Expert Panel (June-November 2019 and September-October 2020); workgroup on Medicaid adult measures (appointed 2016 and 2017); Medicaid-CHIP Scorecard Committee (appointed October 2018); and Measure Sets and Measurement Systems TEP (June 2019-August 2020). Member, National Quality Forum (NQF) workgroup on persons dually eligible for Medicare and Medicaid (July 2012-July 2017) and NQF population health task force (2013-2014) http://www.qualityforum.org/) and NQF representative of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports (http://www.c-c-d.org/). 2016-2017 NQF duals workgroup liaison to the NQF clinician workgroup. 2015-2016 and 2014-2015 NQF duals workgroup liaison to the NQF PAC/LTC workgroup. AAHD Representative to the CMS-AHIP-NQF Core Quality Measures Collaborative (CQMC) (2019-present).

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