NATIONAL HEALTH COUNCIL

February 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-4201-P Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

On behalf of the National Health Council (NHC), I am pleased to provide comments on the proposed rule on Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicare cost plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations.

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, sustainable health care. Made up of more than 150 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The growth of Medicare Advantage (MA) over the last several years means that this proposed rule is particularly timely. Forty eight percent of Medicare beneficiaries are enrolled in Advantage plans, up from 31 percent in 2016, according to data from the Kaiser Family Foundation. For people with chronic diseases and disabilities, the decisions made when selecting between traditional Medicare and MA, choosing between specific plans, and when navigating their Medicare or MA plan to access care are particularly important. In addition, Part D is a critical resource for people with chronic conditions and disabilities that rely on its coverage for access to needed therapies, and it is poised to provide even greater benefit in the near future with upcoming changes to create a limit on out-of-pocket expenses. The following is our response to specific proposals in the rule.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186)

The NHC shares the Administration's commitment to advancing equity throughout the health care system and supports your efforts to provide beneficiaries transparent, clear information about the quality of health insurance plans, including their health equity efforts. The proposed creation of a health equity index (HEI) reward for the 2027 Star Ratings and the risk adjustment based on sociodemographic status characteristics could help drive more care to underserved individuals and areas. By incentivizing plans to proactively seek to serve additional marginalized

individuals, it will increase health equity. However, we urge CMS to assure that this adjustment is not used to conceal overall quality shortcomings. Implementation of this adjustment must be carefully monitored. We also support including screenings for social drivers of health in future measures development.

Medication Therapy Management (MTM) Program (§ 423.153)

The NHC appreciates the CMS proposals to enhance the MTM program and increase the number of beneficiaries receiving these services. The NHC shares CMS' goals to increase availability of MTM services to better help people with chronic diseases and disabilities manage their conditions and improve their health outcomes.

Strengthening Translation and Accessible Format Requirements for Medicare Advantage, Part D, and D-SNP Enrollee Marketing and Communication Materials (§§ 422.2267 and 423.2267)

The prosed rule requires MA organizations, cost plans, and Part D sponsors to provide materials to enrollees on a *standing basis* in any non-English language that is the primary language of at least five percent of the individuals in a plan benefit package service area. It also requires information in an accessible format using auxiliary aids and services upon receiving a request for the materials or otherwise learning of the enrollee's preferred language and/or need for an accessible format using auxiliary aids and services.

The NHC appreciates the focus on language access. This is an important part of making sure that people receive understandable and usable health care information. The NHC particularly appreciates that disability communication access is also a part of all efforts to address language and cultural barriers to care. The standardization of language access requirements will help patients reliably expect what their language access to health information will be.

Health Equity in Medicare Advantage (MA) (§§ 422.111 and 422.112)

This rule would require organizations to include providers' cultural and linguistic capabilities (including American Sign Language, ASL) in their provider directories. The NHC strongly urged the inclusion of this in our response[1] to the recent request for information on a National Directory of Healthcare Providers & Services (NDH). While some of these elements may not matter to all patients, for the ones who do need this information, it is paramount. Including such information will help prospective patients not only find accessible care, but also find a provider more likely to provide them with high-quality care.

In addition, the NHC supports requiring MA organizations to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing telehealth benefits. The benefits of telehealth and the increased access it can provide are clear. Making sure that Medicare recipients have the tools they need to participate in this type of care is critical.

Finally, requiring plans to include activities to address health disparities in the Quality Improvement (QI) program will help drive more action addressing the needs of marginalized populations. We recommend that CMS engage with plans and patient groups to regularly review and analyze the outcomes of these activities to assure that the activities being reported and credited to the plans are the most effective choices.

[1] NHC Comments on Provider Directory RFI - National Health Council

Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, 422.138, and 422.202)

The rule proposes to increase the transparency of MA plans' utilization management and prior authorization policies. The NHC supports these efforts to ensure that MA enrollees receive access to medically necessary care. While utilization management protocols may be grounded in sound clinical decision making, such as prior authorization to limit drug-to-drug interactions or to prevent overprescribing of potentially addictive medication, the development of such protocols is typically done without much or any patient input, and the rationale for such decisions is not typically made public. As a result, the chronic disease and disability community has become greatly frustrated by the additional burden placed on patients, families, and health care providers. We support oversight and transparency of such practices to inform the patient community as to how decisions are made that have such a direct impact on patients. We appreciate that the rule would do the following:

- Require that the physician or other health care professional used by the MA plan have expertise in the field of medicine that is appropriate for the service be involved before the MA plan can deny coverage.
- Streamline prior authorization requirements, including adding continuity of care requirements in ongoing care for beneficiaries.
- Require all MA plans establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines.

These changes are aligned with NHC priorities shared in our response to the RFI on the experience of individuals navigating the Medicare and MA program[2].

Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

The NHC appreciates that the proposed rule enhances the information that patients are provided when selecting or switching plans. In particular, we are pleased that the rule requires that agents explain the effect of an enrollee's enrollment choice on their current coverage whenever the enrollee makes an enrollment decision. This additional information will help increase health literacy and help patients make informed decisions.

Behavioral Health in Medicare Advantage (MA) (§§ 422.112 and 422.116)

Numerous studies have shown that the provider networks for mental health and substance use disorder specialists are less robust than other specialties. This can leave people with mental health conditions with no other option than to seek care that is out-of-network, often making mental health care unaffordable. Some people will pay overwhelming out-of-pocket costs or take on medical debt, while others will forgo medically necessary mental health treatment. The NHC appreciates that CMS has reaffirmed that MA organizations have responsibilities to provide behavioral health services in ways that assure access. Specifically, we appreciate that CMS proposes:

- Adding new provider types (clinical social workers, psychologists, and opioid use disorder prescribers) in provider networks and subject to network adequacy standards. We encourage CMS to work with plans and providers to develop a reasonable timetable and necessary supports to implement this provision.

[2] Medicare-Advantage-RFI-Letter-Final.pdf (nationalhealthcouncil.org)

- Clarifying that behavioral health services can qualify as emergency services, so they are not subject to prior authorization.
- Extending current requirements to coordinate between community services and behavioral health to close equity gaps.

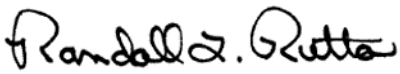
Expanding Eligibility for Low-Income Subsidies (LIS) Under Part D of the Medicare Program (§§ 423.773 and 423.780)

People who live in poverty tend to have higher disease burden. Across the U.S., poverty at the county level was associated with mortality for certain chronic conditions such as heart disease, liver disease, and kidney disease[3][4][5]. Other studies have also shown a relationship between low income and dental complications across all ages[6]. During the COVID-19 pandemic, poverty became a stronger predictor of infection risk, negative health outcomes, and mortality. The implementation of the expanded access to the Low-Income Subsidies in the Inflation Reduction Act will help more individuals access needed care.

Conclusion

The NHC thanks CMS for the opportunity to provide input on these important issues. Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these comments in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,



Randall L. Rutta

Chief Executive Officer

[3] Ahmad K, Chen EW, Nazir U, Cotts W, AndradeA, Trivedi AN, Erqou S, Wu WC. Regional Variation in the Association of Poverty and Heart Failure mortality in the 3135 Counties of the United States. J Am Heart Assoc. 2019;8(18). org/10.1161/JAHA.119.012422 (pov & heart failure)

[4] Goldberg D, Ross-Driscoll K, Lynch R. County Differences in Liver Mortality in the United States: Impact of Sociodemographics, Disease Risk Factors, and Access to Care. Gastroenterology. 2021;160(4):1140-1150.e1. doi:10.1053/j.gastro.2020.11.016

[5] Norris KC, Beech BM. Social Determinants of Kidney Health: Focus on Poverty. Clin J Am Soc Nephrol. 2021;16(5):809-811. doi:10.2215/CJN.12710820

[6] Foley M, Akers HF. Does poverty cause dental caries? Australian Dental Journal. 2018;64(1):96-102. doi.org/10.1111/adj.12666