March 2, 2022

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

Re: CMS-4192-P, CY 2023 Medicare Advantage and Part D Proposed Rule

Dear Ms. Brooks-LaSure,

On behalf of the National Alliance to Impact Social Determinants of Health (NASDOH), we thank you for the opportunity to provide comments on the contract year (CY) 2023 Medicare Advantage (MA) and Part D proposed rule. NASDOH is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. NASDOH brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining efforts to address social determinants of health (SDOH).

NASDOH continues to be extremely appreciative of CMS's commitment to ensuring that social risks are being identified and considered for Medicare enrollees given the impact unmet social needs can have on individual's health overall. Similarly, we support CMS efforts to ensure that dual-eligible special needs plans (D-SNPs) have mechanisms to solicit enrollee input in plan operations and focus on health equity. NASDOH recommends the following in response to the request for comments in the CY 2023 MA and Part D proposed rule:

<u>Social Determinants of Health and Special Needs Plan Health Risk Assessments</u>
CMS is proposing that all SNPs (chronic condition special needs plans, D–SNPs, and institutional special needs plans) include one or more standardized questions on the topics of housing stability, food security, and access to transportation as part of their Health Risk Assessments (HRAs).

Given the impact that social risks can have on health outcomes, we applaud CMS' efforts to encourage SNP plans to take into account enrollees social risks when developing individualized care plans. Identification of individual's social risks and needs will better enable SNPs to provide social care and deliver effective health care. We offer the following input on CMS's specific questions with regard to this proposal.

- CMS asked whether more or fewer questions on additional topics related to social risk factors should be required. NASDOH believes the three topics identified in the proposal – food and housing insecurity, and transportation – are sufficient. These three risks have demonstrated impacts on health outcomes and are issues that SNPs are well-positioned to address. We do not believe additional questions are necessary because soliciting information on these three factors

provides a sufficient signal to plans that an individual may have social risks which can impact their well-being, and that social care should be incorporated into the visualized care plan.

- CMS included three potential questions in the proposed rule – a transportation question from the post-acute care patient/ resident instruments and the housing and food insecurity questions from the Accountable Health Communities (AHC) Model Health Related Social Needs Screening (HRSN) Tool – and asked for comment on different example questions that could be required in HRAs. CMS also noted it was considering whether it is sufficient for the proposal to require domains be addressed without CMS specifying questions in sub-regulatory guidance. NASDOH does not have a preference to which questions are specified (i.e., from which standardized screening tool they are extracted).
    - We strongly encourage CMS to include standardized questions for HRAs in sub-regulatory guidance, and we recommend that CMS coordinate with other HHS Agencies to require the same set of standardized questions. We also request that CMS coordinate with states, who are often requiring their own HRA assessments to identify social risk and needs, to reduce burden. NASDOH members note that plans and providers, who are responsible for collecting this information, are managing multiple and often competing requirements. This burden can be disruptive to effective and efficient operations. Importantly, this can also impact enrollees, who are then asked to share their social risks and needs multiple times to meet programmatic requirements. Finalizing these questions would also allow the data elements to be made available for understanding social risk across plans and enrollees.
    - However, we note that it is important that there continues to be flexibility for providers to pursue more in-depth screening in the clinical setting as they deem appropriate. There are clinical reasons for tailoring questions or conducting more in-depth screening; for example, screening that is tailored to a pediatric or adult population, and the ability to conduct a more in-depth screening once need is identified to inform interventions or care plans.
- CMS noted that it would consider whether the new questions should only be applied to certain enrollees because some questions may be irrelevant to some enrollees. NASDOH believes that all enrollees should be screened and that a universal screening approach is likely to be more straightforward to implement and to identify and meet enrollee needs. In fact, we urge CMS to consider how it can encourage all MA plans to screen beneficiaries for social risk, not just SNP enrollees. While SNP enrollees are more likely to be affected by multiple social risks, NASDOH members observe social needs to be prevalent among a much larger group of older adults than just those who are enrolled in SNPs. The impacts of these factors on individual health outcomes and overall well-being are not limited to dual eligible individuals.
- CMS asked whether the 2024 contract year was too soon to enforce this requirement. We believe that this is ample time to develop and implement HRA tools and implement models of care; therefore, we support the requirement going into effect in the CY 2024 year.
- Finally, CMS noted that incorporating these questions into HRAs would not require SNPs to provide social care. However, we urge CMS to consider how it can further encourage and support plans to use this data in meaningful ways to address enrollees' unmet social needs, and what guidance and resources it can provide plans on assisting enrollees in meeting social needs in line with the enrollee's preference. Information about an individual's social risk and needs has been shown to be sensitive information, and individuals are hesitant to disclose this information for fear of bias or discrimination. Asking enrollees to disclose this information without also offering them services and supports is disrespectful and may lead to distrust.

Enrollee Input on D-SNP Operations

CMS is proposing that any MA organization offering one or more D– SNPs in a State must establish and maintain one or more enrollee advisory committees to solicit direct input on enrollee experiences.

We applaud CMS's effort to create more mechanisms for enrollee input in plan operations and to consult enrollees on issues related to health equity. NASDOH agrees that plans' ability to meet enrollee needs and improve health equity are strengthened when enrollees are engaged and can provide input on plan policy and operational issues.

However, NASDOH believes that requiring each SNP to establish and maintain a separate advisory committee could be redundant and duplicative to existing efforts. For example, in many regions, coalitions or community groups already exist that are well positioned and skilled to provide essential input on enrollee needs. CMS has noted it would not propose requirements on frequency, location, format, participant recruiting, and training parameters. Given this, NASDOH believes that in some cases, existing coalitions or groups are already prepared to inform plans effectively and meaningfully about the communities they serve and the challenges that impact their enrollees. Instead of requiring a separate enrollee advisory committee in every instance, we recommend that CMS require all SNPs to have a mechanism to obtain diverse and representative enrollee input on plan policy and operations, and to provide guidance on the topics which should be addressed. Where community groups do not already exist, plans could then establish their own enrollee advisory committees.

Greater Transparency in Medical Loss Ratio (MLR) Reporting

CMS is proposing to reinstate MLR reporting requirements that were in effect for contract years 2014 – 2017. The proposal would require that MA organizations report the amounts they spend on various types of supplemental benefits not available under original Medicare (e.g., dental, vision, hearing, transportation).

NASDOH does not have comments about the proposal to reinstate the MLR reporting requirements. However, should it be finalized, we do support the inclusion of social care services, like meals, transportation, remote access, and SSBCI in the list of categorical benefits to be included. Access to Information, if it can be reported at this granular level by a plan, can help us understand the uptake of important social care services and needs among MA beneficiaries.

Thank you for the opportunity to provide comments on the CY 2023 MA and Part D proposed Rule. We appreciate your focus health equity and the importance of addressing social needs as part of overall strategy to address enrollee health. We welcome any opportunity to discuss our comments with you further.

Sincerely,

Sara Singleton

Sara Singleton
Principal, Leavitt Partners and Advisor to NASDOH

For more information on NASDOH and our members, please visit our website at www.nasdoh.org or contact Sara Singleton at Sara.Singleton@leavittpartners.com.