NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

February 13, 2023

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

The National Alliance to Impact Social Determinants of Health (NASDOH) thanks you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Contract Year (CY) 2024 Policy and Technical Changes to Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs.

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). Additionally, NASDOH is committed to advancing health equity as a critical component to addressing social needs and SDOH and improving the health of individuals and communities.

NASDOH is greatly appreciative of CMS's vision for Medicare putting the person at the center of care and its commitment to embedding health equity in its work. We are particularly grateful to see many provisions in this Proposed Rule which demonstrate CMS' continued commitment to support and advance health equity. We are encouraged to see that CMS is considering the concrete actions and changes which should be taken to modify and update its own programs to ensure health inequities are identified and meaningfully addressed. NASDOH recommends the following in response to the proposed rule:

Solicitation of Public Comments

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

CMS proposes further clarification of a current requirement for MA plans to provide culturally competent care by expanding the list of populations that MA organizations must provide services to in a culturally competent manner. This includes people: (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minority groups; (3) with disabilities; (4) who identify as lesbian, gay, bisexual,

or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality.

NASDOH supports CMS' proposal to rename the equitable access provisions in the proposed rule from "Cultural Considerations" to "Ensuring Equitable Access to Medicare Advantage (MA) Services." NASDOH agrees with CMS assertion that the existing heading, "Cultural Considerations," may be interpreted to mean that protections apply only to some populations and not others. The revised language offers a broader description which clarifies that the provisions apply to all enrollees and reflects the inclusive nature of the protections.

As CMS has cited in past proposed rules, studies show that belonging to underserved populations such as a racial or ethnic minority group or being a member of the LGBTQ+ community is often associated with receiving lower quality of care, having a worse experience of care, and having worse health outcomes. Due to systemic and institutionalized racism and discrimination, these groups are also more likely to experience adverse SDOH which influence health risks and health outcomes. Additionally, each of these groups face unique health needs. We understand that accommodating each underserved group with unique needs will entail more work from MA plans; however, we strongly urge CMS to institute these changes because without this foundation of equity, we may continue to see health disparities within and across these groups. Thus, NASDOH supports CMS' proposal to add paragraphs listing the examples of underserved populations to whom an MA organization must ensure that services are provided in a culturally competent manner and promote equitable access to services. NASDOH encourages CMS to be explicit in its language that the groups highlighted are not necessarily all underserved populations, but an illustrative example of some of those populations.

CMS proposes updating the required provider directory data elements by mirroring the Medicaid provider directory and codifying two additional best practices to requirements: encouraging organizations to identify non-English languages spoken by each provider and provider/location accessibility for people with physical disabilities.

Underscoring that access to care can be prohibited by both language and physical barriers, NASDOH encourages CMS to make the changes proposed here to ensure that provider best practices in accommodating speakers of non-English languages and individuals with disabilities receive the accommodations they need to access the care and services made possible for other enrollees. NASDOH agrees with CMS' inference that this regulatory change would enhance the quality and usability of provider directories. It will be particularly useful for non-English speaking enrollees searching for providers who speak their preferred language, for limited English proficient individuals, and for those enrollees seeking providers who use ASL themselves or have an ASL interpreter available in their office. Furthermore, adding explicit language on accessibility for people with physical disabilities will make it clear which providers and practices have physical spaces that can accommodate those with physical disabilities and promote access. Each of these improvements will further advance CMS' commitment to health equity and address additional social determinants of health which have a highly impactful role on the ability to access care even if the care exists and is available.

CMS proposes requiring MA organizations to develop and maintain procedures to offer digital health education to enrollees to improve access to medically necessary covered telehealth benefits.

The COVID-19 pandemic has shed light on the important role that telehealth can serve for individuals to access the care and services they need. Moreover, evidence suggests that telehealth can be used as a platform to minimize the social barriers to care, such as transportation, childcare, and lost wages from time off work, that prevent some people from accessing care.[1]

That said, certain individuals and populations continue to face barriers to accessing telehealth services, which can exacerbate health inequities. CMS outlines several of those barriers, including lack of video sharing technology (for example, a smartphone, tablet, or computer), spotty or no internet access, lack of housing or private space to participate in virtual visits, few local providers who offer telehealth practices, language barriers (including oral, written, and signed language), the inability to incorporate third party auxiliary aids and services such as live captioners, telehealth software, apps, and websites that are accessible and usable by people with disabilities, and lack of adaptive equipment for people with disabilities along with incompatibility with external assistive technologies used by people with disabilities. This demonstrates that individuals that have social needs and have particularly impactful social determinants of health are the very individuals who may be most impacted by barriers to accessing telehealth.

Recognizing that poor digital health literacy can prevent an individual from accessing care via telehealth, NASDOH supports CMS' proposed requirements for MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy. NASDOH supports CMS' proposal to add a provision around digital health education to the continuity of care requirement for MA organizations which applies to MA organizations offering coordinated care plans. Moreover, NASDOH encourages CMS to apply this requirement not only to MA organizations offering coordinated care plans, but to all MA organizations. In a health care system that is increasingly offering telehealth, we believe that this will maximize enrollees' ability to access care and advance CMS' commitment to health equity.

CMS makes several proposals for behavioral health services, including to require MA organizations to establish care coordination programs, including coordination of community, social, and behavioral health services to help move towards parity between behavioral health and physical health services and advance whole person care.

NASDOH is committed to advancing policies which address the whole person, and particularly policies which address an individual's physical, mental, and social health. Many of NASDOH's members have firsthand experience to support care management and address not only individuals' immediate physical needs, but also their behavioral health needs, social needs, and systemic drivers of health. We encourage CMS to make the changes it proposes to add new provider specialty types to MA plans specifically for mental health, including the proposed categories of clinical psychology, clinical social work, and prescribers of medication for opioid use disorder. NASDOH also supports CMS' proposal to amend the list of health care providers in the existing access to service standards to include that the network must also

[1] Improving Access to Care: Telemedicine Across Medical Domains; William Barbosa, Kina Zhou, Emma Waddell, Taylor Myers, E. Ray Dorsey; Annual Review of Public Health 2021 42:1, 463-481; https://www.annualreviews.org/doi/10.1146/annurev-publhealth-090519-093711

include providers that specialize in behavioral health services. Making changes to the MA program that promote whole-person care further demonstrates CMS' commitment to health equity. In addition to the changes and additions proposed for coverage of increased behavioral health specialties, NASDOH also supports CMS' proposals to improve access to behavioral health specialties.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

CMS proposes a health equity index (HEI) reward, beginning with the 2027 Star Ratings using measure data from the 2024 and 2025 measurement years, to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors (dual eligibility, low-income subsidies, and disability).

NASDOH supports CMS' proposal to add a health equity index (HEI) reward beginning with the 2027 Star Ratings using measure data from the 2024 and 2025 measurement years, to encourage MA and Part D plans to address disparities in health and improve care for enrollees with certain specified social risk factors (SRFs). NASDOH believes that embedding the HEI in the Star Ratings measure is an important step towards making health equity part of the fabric of quality programs. NASDOH is supportive of CMS' existing requirements of adjusting for the average within-contract disparities in performance through Categorical Adjustment Index (CAI); however, we believe this proposal of incorporating the HEI will incentivize contracts not only to focus on improving performance, but also to focus on reducing disparities. Therefore, we support CMS' proposal to complement the existing CAI with the HEI so that plans can better identify and address disparities in care provided to members with particularly SRFs. NASDOH thanks CMS for its consideration of diverse measure sets within the HEI, including the Area Deprivation Index (ADI) which measures socioeconomic neighborhood deprivation. We urge CMS to consider adding this and/or other measure sets which effectively capture SRFs in the HEI in the future.

NASDOH appreciates the opportunity to comment on this proposed rule. 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.

Sincerely,

Sara Singleton

Sara Singleton
Principal, Leavitt Partners and Advisor to NASDOH