



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

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 undersigned members of the CCD Health Task Force and allies appreciate the opportunity to respond to the above referenced proposed rule and requests for information (RFIs). The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance.

Our comments focus on aspects of the proposed rule and RFIs that are especially pertinent to people with disabilities, including those who are dually eligible for Medicare and Medicaid.

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 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 fully support these modest, incremental, and helpful CMS proposals regarding D-SNPs.

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.

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>.

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.

Enrollee Participation in Plan Governance (§ 422.107)

We strongly support the proposal to require D-SNP plan sponsors to have consumer advisory councils. However, we urge CMS to adopt stronger requirements. Currently, the proposed rule would allow plan sponsors to establish a single advisory council for an entire state, which would not work in bigger states. We also recommend requiring advisory councils to meet at least 2 times per year at a minimum. Plan sponsors should also be required to include people with disabilities on the councils and provide accommodations and language access services for members who have limited English proficiency. Finally, we recommend requiring plan accountability regarding implementation of recommendations the advisory council makes.

Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances Procedures (§ 422.561) (§ 422.561)

We support the proposal to expand the universe of D-SNPs that are required to have unified Medicare and Medicaid grievance and appeals processes by revising the definition of an applicable integrated plan. As CMS notes, it is feasible for certain plans that are integrated D-SNPs, but not FIDE-SNPs or HIDE-SNPs, to have a unified grievance and appeals process. We agree that the unified process is simpler for enrollees, improves coordination of coverage, and would extend the protection of continuation of benefits pending appeal and therefore should be extended to integrated plans whenever practicable.

Ombuds Program for Dually Eligible Individuals

We also strongly urge CMS to add a provision establishing an ombuds program for individuals dually eligible for Medicare and Medicaid. Ombuds programs are critical for supporting dually eligible individuals in navigating their coverage, including for D-SNPs and integrated models.

For example, people with disabilities often have to navigate complexities of coverage for durable medical equipment, home- and community-based services, and supplemental benefits under both Medicare and Medicaid. Ombuds should have the responsibility to both assist individuals and to identify and regularly publicly report systemic issues affecting access to care, enrollment, and other barriers beneficiaries encounter.

Limitation on MA Plan Maximum Out-Of-Pocket Limits (§ 422.100 and § 422.101)

We support CMS's proposal to revise the regulations governing the maximum out-of-pocket (MOOP) limits for MA plans to require that all costs for Medicare Parts A and B services accrued under the plan benefit package, including cost-sharing paid by any applicable secondary or supplemental insurance or any cost sharing that remains unpaid, is counted towards the MOOP limit. By limiting state Medicaid programs' liabilities for Medicare cost sharing paid on behalf of Qualified Medicare Beneficiaries (QMBs), this change could also increase QMBs' access to providers. This proposal would also standardize MA plan treatment of MOOP calculations by using plan-adjudicated claims data rather than the enrollee's status as a dually eligible individual, thus treating dually eligible and Medicare-only beneficiaries similarly.

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.

Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§§ 422.2267(e) and 423.2267(e))

We strongly support the proposal to reinstate the requirement for plans to include a multi-language insert in vital documents in the top 15 most common non-English languages in the United States. We also support the proposal to strengthen oversight of third-party marketing organizations (TPMOs), including the requirement of disclaimers informing individuals that such organizations do not sell every plan available in a given area. We also urge CMS to roll back recent changes to marketing guidelines that weakened consumer protections, including blurring the distinction between marketing and educational events.

Pharmacy Price Concessions to Drug Prices at the Point of Sale (§ 423.100)

We support CMS's efforts to address the high cost of prescription drugs at the point of sale and support the proposal to require pass through of pharmacy price concessions to Medicare beneficiaries. When pharmacy DIR fees are applied post point-of-sale, they are not reflected in the negotiated price at the pharmacy counter, which causes many patients to pay more out-of-pocket for their drugs than they should. The reforms proposed by CMS, which would require pharmacy price concessions be assessed at the point-of-sale, are estimated to reduce beneficiaries' out-of-pocket expenses by \$21.3 billion over 10 years.

To help ensure that people obtain maximum savings, CMS should ensure that the savings apply throughout all phases of the Part D program, including the coverage gap. We do not understand why CMS has proposed to exempt the coverage gap from these changes and urge CMS to apply these savings across the benefit.

Finally, while we appreciate these changes, we urge CMS to go further and continue to address the unaffordability of prescription drugs by ensuring that beneficiaries are charged based on the negotiated price, including the price reflecting manufacturer rebates. People who rely on high-cost medications should benefit from all negotiated price concessions at the point of sale.

Request for Information: Prior Authorization for Hospital Transfers to Post-Acute Care Settings during a Public Health Emergency

We thank CMS for its attention to the burdens posed on patients and the providers who serve them by the overuse of prior authorization in the Medicare Advantage program. Particularly in the post-acute care and rehabilitation benefit, prior authorization is frequently required before the approval of services to protect the health and function of individuals with disabilities and chronic conditions. Unfortunately, patients often find that prior authorization serves as a significant barrier to accessing care, delaying or denying medically necessary services that are unlikely to be over-utilized and are often routinely approved after initial denials.

Especially for individuals with disabilities and chronic conditions, delays in accessing post-acute care services can result in significantly worse long-term outcomes. However, many MA plans seem to rely on initial denials of prior authorization as a method to delay care, even for services that are eventually expected to be approved. In fact, a report by the Department of Health and Human Services Office of Inspector General (OIG) found that after appeals by beneficiaries and providers, MA plans overturned their own denials 75% of the time.⁴ This results in an inequitable access to care between traditional Medicare beneficiaries and those subject to prior authorization in Medicare Advantage, which disproportionately harms the patients with the most significant medical needs represented by many of the organizations below.

We recognize that the Medicare program and its private partners in the MA program have a responsibility to protect the financial viability of the program and guard against unnecessary overutilization. However, we urge CMS to address the widespread problems with the use of prior authorization to protect patient access to care – not exclusively during the PHE, but after the end of the emergency declaration as well. We encourage CMS to conduct more oversight of the services subject to prior authorization across plans and the impacts delays and denials have on beneficiaries. Individuals with disabilities, chronic conditions, and other beneficiaries in the MA programs must be able to access the care they need in a timely fashion, including all services that are covered under traditional Medicare.

Conclusion

⁴ U.S. Department of Health and Human Services, Office of Inspector General. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials; Report (OEI-09-16-00410) (Sept. 2018).

Thank you for the opportunity to comment on these important issues. If you have further questions, please contact Cinnamon St. John (cstjohn@medicareadvocacy.org).

Respectfully Submitted,

ALS Association

American Association on Health and Disability

American Music Therapy Association

American Physical Therapy Association

The Arc of the United States

Autistic Self Advocacy Network

Brain Injury Association of America

Caring Across Generations

Center for Medicare Advocacy

Epilepsy Foundation

Justice in Aging

Lakeshore Foundation

National Association of State Head Injury Administrators

National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)

The National Consumer Voice for Quality Long-Term Care

National Health Council

National Health Law Program

National Multiple Sclerosis Society

United Spinal Association