VIA ELECTRONIC SUBMISSION

March 7, 2022

Re: [CMS-4192-P] RIN 0938-AU30: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P, P.O. Box 8013,
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure:

The Community Living Policy Center (CLPC) at the Lurie Institute for Disability Policy at Brandeis University appreciates the opportunity to respond to the above-referenced Notice of Proposed Rulemaking (NPRM). The CLPC, a multi-partner center, works to improve policies and practices that keep people with disabilities in the community. We conduct research on the provision and quality of home- and community-based service programs for people with disabilities in the United States.

We applaud the actions CMS and the current administration are taking to reverse recent deregulation efforts and oversight of the MA program. We appreciate that the agency has sought to strengthen and clarify various requirements and has placed enrollee needs and experiences at the center of these efforts. In light of how rapidly D-SNPs are growing, we urge CMS to act quickly to adopt regulations that reflect advocacy stakeholder recommendations.

We support the comments submitted by our colleagues at Justice in Aging. We would specifically like to direct CMS’s attention to their concerns regarding disruption in behavioral health care for individuals in the 24 FIDE-SNPs that do not now incorporate behavioral health in their contracts. We share these concerns. Our additional comments add to theirs by focusing on several opportunities to improve D-SNP performance and address several entrenched and longstanding barriers to care MA enrollees with chronic health conditions, significant functional limitations, and disabilities have experienced. These barriers, now understood to be among many social determinants of health
(SDOH), contribute to health and health care disparities and inequities, limit opportunities for community integration and participation, and affect the quality and length of their lives.

1. **Enrollee Participation in Plan Governance**

We support the principle of requiring MA enrollee advisory committees that reasonably represent D-SNP dual eligible enrollees. However, we strongly recommend that CMS restructure the advisory committee requirements in two ways. First, CMS proposes permitting MA organization offering one or more D–SNPs in a state to choose how many advisory committees will be established regardless of the number of D-SNPs it operates. There are distinct regional, geographic, demographic, and provider network capacity differences in communities that D-SNPs serve. Therefore, we think that each D-SNP should be required to convene a committee to ensure that enrollees, their advocates, and other knowledgeable representatives provide input based on their experience of the operational characteristics of the plan as well as the community it serves rather than allowing MAs to decide whether or not each D-SNP will be required to establish a committee. Second, using the Massachusetts experience as an example, we strongly recommend that CMS also require states to establish an implementation council, as described in the proposed rule. We discuss our reasoning for these recommendations below.

- **Prescriptive requirements—Advisory Committees**

We agree that enrollee participation in governance can improve MA organization awareness of barriers to care that some enrollees experience. Included are people with multiple identities based on race, ethnicity, LGBTQ+ status, chronic conditions, significant functional limitations, and disabilities who experience health and health care inequities. Such committees can spur procedural changes that improve access to health care services, devices, and long-term services and supports (LTSS) and recommend actions that reduce disparities that often stem from SDOH. This group could be particularly helpful in developing the plan’s design and use of the proposed health risk assessment, which we support (§ 422.101). We see the proposed requirement as an essential opportunity to operationally integrate the experiences of such enrollees and others. However, we think that CMS should adopt more prescriptive requirements to ensure that the advisory committee composition fairly represents the diversity of enrollees in any given D-SNP and facilitates informed feedback and participation. Specifically, CMS should require that each D-SNP convene an enrollee advisory committee, establish requirements that guide D-SNP selection and training of
participants, and at a minimum, task the committee with specific topics to consider. Given the option, we are concerned that plan sponsors will elect to do the minimum the regulation requires even as this strategy might not meet beneficiary needs. California exemplifies why each D-SNP should have its own committee. The state is geographically large and racially diverse with big urban centers such as Los Angeles, rural farming communities, and less populated mountainous areas. The state has proposed using D-SNPs to provide care for most dually eligible beneficiaries. The potential impact of having a single advisory committee representing these diverse communities assures that the impact will be blunted and the issues that each unique area and demographic population presents will not be recognized or addressed.

Consequently, we recommend that CMS prescribe that D-SNP advisory committees be composed of a majority of participants based on the proportional representation of enrollees with lived experiences and demographic identities, including disability. Specifically, participants should include people of color with diverse functional limitations in hearing, vision, communication, and mobility. People with intellectual and developmental disabilities, behavioral health diagnoses, autism, and older adults with functional limitations should also be included. It is also vital to include individuals who use LTSS and home and community-based services (HCBS). Many D-SNP enrollees belong to these distinct marginalized groups so it is especially important to deliberately and fully include them in the advisory committee structure.

Research has shown that people with disabilities, particularly those with overlapping racial, ethnic, LGBTQ+, language, and age identities, experience significant health and healthcare disparities and inequities. These disparities are rooted in historic, marginalizing policies and practices, limited access to health care, and the impacts of other social determinants of health.¹ Health care policies and practices can sometimes impose barriers to obtaining care, services, devices, and disability accommodations in health care settings.² Another common concern involves the experience of dually eligible beneficiaries who have mobility limitations when they attempt to get a medically necessary motorized wheelchair or scooter. Frequent barriers to receiving equipment that is essential for all aspects of independent home and community living are well known to advocates but might not reach either the D-SNP advisory committee or the state Implementation council unless a participant is aware of the problem. When advisory committee members can share these lived experiences with D-SNP and state health care services administrators, practical solutions can be crafted that affect all similarly situated enrollees.
We also recommend that D-SNP advisory committee members receive an honorarium as compensation for their time and contribution, accessible transportation if meetings are held in person, and any required accommodations including those needed to improve online meeting participation. Other accommodations include Sign Language interpreters, materials in accessible formats, access to internet hot spots and other digital hardware, software, and devices.

- **Training for the D-SNP advisory committees**

We appreciate the emphasis on soliciting input from the advisory committee on improving access to covered services, coordination of services, and health equity among underserved populations. We recommend that CMS specifically include a requirement that the advisory committee receives training on key health and health care disparity concerns that affect the population served by the D-SNP and a robust module be provided on disability inclusion in health care, emphasizing intersectional identities. For nearly two decades research has identified barriers to care for people with disabilities, yet very little has changed in that time, thus the need for this module.² It should include an overview of typical barriers to care, for instance, physical access barriers, lack of clinical accommodations such as accessible medical and diagnostic equipment, lack of communication access such as extended exam time and Sign Language interpreters, and provider misperceptions and stereotypes about people with disabilities.³ The CMS Office of Minority Health Disparities Impact Statement is a starting point. This module will help all committee members understand the barriers to care that many enrollees encounter and possible actions to reduce them. We also recommend that D-SNPs provide the committee an orientation to the organizational structure of the D-SNP, basic information about the right to request reasonable accommodations and policy modifications, an overview of the D-SNPs' transparency and accountability mechanisms, and local and state agencies and commissions with overlapping responsibilities and interests.

- **The responsibilities of the D-SNP advisory committees, and additional topics for enrollee input**

The advisory committee structure as CMS envisions it also opens opportunities to liaison and collaborate with other similar health services and LTSS/HCBS county and state-level committees. These collaborations can leverage the work of the D-SNP committee for greater impact and potentially reduce the 'silo' effect. We recommend that the committees should communicate their findings, recommendations, and actions as appropriate, with the implementation council, which in turn coordinates with state bodies
such as the Olmstead strategic plan committee, Money Follows the Person advisory committee and the Medicaid advisory committee. The D-SNP advisory committees should also include in their ambit the issues identified in the state’s Olmstead Strategic Plan. Typically, there is overlap between the actions in the plan and the purpose and mission of D-SNPs, for instance, reducing institutionalization and increasing HCBS. There are also opportunities for collaboration with county programs especially where health care programs, provider networks, and LTSS/HCBS overlap and interact.

We also recommend that CMS require that the D-SNP advisory committees provide input on two specific topics: D-SNP collection of self-identified functional limitation data and addition of self-identified functional limitation data fields to their electronic patient records. Advocates have long called for collecting such data as part of the patient health care record just as such demographic data is collected for race, ethnicity, LGBTQ+, gender identity, and age status. Self-identified functional limitation data is needed for the same reasons it is collected for other marginalized groups. For instance, it is required to determine if people are receiving appropriate treatments, devices and services, including LTSS and HCBS and to evaluate the effectiveness and outcomes of clinical care decisions and recommendations. The data is also needed for public health and emergency planning, population research, and to plan for physical or programmatic accommodations in advance of clinical visits. The Covid-19 pandemic shone a bright light on the need for such data, which was missing from EHRs, public health surveillance reports, reported Covid infection rates, vaccination rates, and death records. Had the data been available, lives could have been saved. Yet such data is not routinely collected. The D-SNP advisory committees should explore how plans can individually or collectively begin adding self-identified functional limitation questions to their records. Long-standing disability census questions provide a template for committees to consider.5 Other field and cognitively tested question sets include those created by the Washington Group on Disability Statistics and those recommended by advocates to the Office of the National Coordinator for Health Information Technology.6, 7

- **Prescriptive requirements--Implementation Council**

Using the Massachusetts experience as an example, we strongly recommend that CMS also require states to establish an implementation council, as described in the proposed rule. Notably, the council should play more than an advisory role. For instance, it should provide support and advise the state health care agency on issues brought to it by the D-SNP advisory committees, which should serve as conduits when trends or systemic issues and concerns arise. It should also monitor access to health care and compliance with the Americans with Disabilities Act (ADA), track quality of services, assist in
shaping quality metrics, review issues raised through the grievances and appeals process and Ombudsperson reports, assist in the development and fielding of the health risk assessment, and promote accountability and transparency.

The state-level implementation council should be required to coordinate with each state’s Medical Care Advisory Committee, which includes provider, consumer, and government representatives and participates in policy development and program administration. We also strongly recommend that CMS release guidance to states on using the Medical Care Advisory Committee to monitor beneficiary experiences in FIDE-SNPs. The Implementation council mechanism also presents new opportunities to coordinate insights and learnings with other such committees operating in the Medicaid space such as Money Follows the Person. It also could play an important role in the event of a public health emergency, such as COVID-19 presented, to ensure that civil rights continue to be recognized. The council should also crosswalk high level outcomes with state level advisory committees concerned with related topics such as improving equity in public health programs, disaster planning, and community integration (e.g., Olmstead committees). The council should be made up of members with diverse perspectives, with the majority of representatives being MA members with disabilities and their family members and guardians. The Council should also include community-based and advocacy organizations, unions, and providers.

We also appreciate that CMS proposes to update audit protocols to request documentation of enrollee advisory committee meetings as a method to verify that the committees are operating as intended and to increase transparency. We recommend that CMS extend this requirement to the implementation council.

2. Network adequacy standards

We appreciate that CMS proposes that MAs demonstrate rather than attest that they meet the network adequacy standards for the pending service area as part of the MA application process for new and expanding service areas. We know that when providers simply attest to meeting certain standards often their facilities do not actually meet accessibility requirements and accessible medical and diagnostic equipment is not present. We hope CMS’s new provision will increase access to providers, therefore making it easier to obtain care for some enrollees. However, we are concerned that Medicare provider network adequacy standards MAs are required to use are not congruent with Medicaid standards in several important ways that directly affect dual eligible enrollees. For instance, the Medicaid standards require states to develop and enforce network adequacy standards that consider, at a minimum, “The ability of
network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities." They must also consider the geographic location of network providers and Medicaid enrollees, considering not only distance and travel time but also "...the means of transportation ordinarily used by Medicaid enrollees." These Medicaid network adequacy provisions respond to the fact that twenty-eight percent of dually eligible enrollees have three or more functional limitations. Many of them require specific accessibility features and accommodations and policy modifications in clinical settings in order to receive equitable and effective care. Many of them also experience transportation barriers. The absence of these elements can mean that enrollees might forgo routine and preventive care and experience health and health care inequities and poor health outcomes. Years of research has shown that Medicaid primary care practices, which overlap with D-SNP network providers, are ill-equipped to provide equitable care to enrollees with specific disabilities. For instance, these studies have found that only between 10-20% of practices have height-adjustable exam tables and 1-3% have accessible scales. Without this equipment, enrollees with various functional limitations cannot be weighed or receive certain preventative and other examinations that have to be carried out lying in the supine position.

At a minimum, we recommend that CMS require that these provisions apply specifically to D-SNPs either by amending the Medicare standards to include them, requiring that D-SNPs apply these Medicaid standards to their networks, or applying the provisions independently. We also recommend that D-SNPs be required to report to states how they determine the extent to which their networks meet these standards and what steps they will take to ensure the network is adequate if a sufficient number of providers do not meet them. CMS provided guidance for collecting this information for the Medicare/Medicaid financial alignment demonstration in their three-way contracts. These contracts contain certain uniform provisions that reflect the influence of the federal readiness review process required of states and MCOs that participated in the demonstration. For instance, the readiness review required MCOs to carry out an on-site accessibility survey of health care provider facilities and medical equipment and their capacity to accommodate people with disabilities. It also required disability awareness and competency training for both plan and provider staff. Implementation of these contract provisions remains a challenge, but some states and MCOs have made progress. For instance, California has adopted an access and equipment survey that is included in facility site reviews MCOs administer with primary care providers when new practices join plans and every three years thereafter. This survey could serve as a model.
Currently, there appears to be no standardized data collection, reporting, or oversight mechanism and CMS does not require either Medicaid managed care plans or MAAs to demonstrate how compliance with the network adequacy standards is considered or evaluated. States also should be required to conduct regular audits or monitoring of D-SNP network adequacy compliance.

We also urge CMS to reinstate the time and distance standards that the former administration weakened. States are now permitted significant latitude in making exceptions to the standards that increase enrollee travel distance and time. For example, following a loosening of the federal travel time and distance standards under the Trump Administration, the California Department of Health Care Services (DHCS) approved nearly 10,000 new alternative access standards requests in 2019, and that number rose to 15,000 in 2020. OB/GYN primary care and other specialty providers including ophthalmologists and hematologists experienced the most significant changes in distance requirements under these approvals. Research showed that most approvals increased the required travel distance to all types of providers by more than 20 miles. In the northern part of Los Angeles County, exceptions for travel distances of between 41-60 miles were granted. Limited access to transportation, increases in the time enrollees must travel, and the minimal availability of accessible medical and diagnostic equipment compounds the difficulties enrollees encounter accessing care and dramatically increases the likelihood of inequitable care and poor health outcomes.

3. Standardized Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments (422.101)

We are pleased to see that CMS proposes to include these important questions in all health risk assessments (HRAs). In light of the growing list of known social determinants of health, we encourage CMS to update and standardize additional SDOH’s as evidence supports their inclusion in the HRAs. In addition, we strongly urge CMS to require that specific demographic information also be added to the HRA including on race, ethnicity, LGBTQ+, gender identity, language, and disability status and that the information be recorded and stored so it can be sorted by both individual and overlapping categories. The dearth of demographic information generally, but specifically based on functional limitation and disability status, makes it virtually impossible to understand the impact and outcomes of services, treatments, and aspects of case management on specific populations, including those with multiple, intersectional identities. Therefore, we strongly recommend that CMS require the addition of self-identified functional imitation questions to the standardized HRAs. Without including this important information on disability status, the assessment will be
incomplete and the very disparities the assessment seeks to uncover will be perpetuated. As previously discussed in the context of advisory committees, the American Community Survey’s long-standing use of six functional limitation questions provide one template that could easily be added to standardized HRAs. Other appropriate field and cognitively tested question sets include those created by the Washington Group on Disability Statistics. A third option is to adopt a combination of the two question sets as advocates have recommended to the Office of the National Coordinator for Health Information Technology. The combined questions ensure that individuals with communication and cognitive disabilities are counted.

4. **Scope of Services Covered by FIDE SNPs: Durable Medical Equipment (DME) and Home Health**

Medicare’s rule requiring that DME be medically necessary for use in the home misaligns with Medicaid’s emphasis on promoting community participation and integration. People with disabilities who are dually eligible for Medicare and Medicaid who require durable medical equipment (DME) report significant roadblocks acquiring equipment. Improper denials, months-long waits to determine which program will pay for the equipment, approve orders and delivery, and lengthy waits for repairs are frequently reported. These problems are especially rife when individuals require complex rehabilitation devices such as motorized wheelchairs. In most cases, this equipment enables an enrollee to function to the maximum extent possible in their home and participate and contribute to their communities. Without it, they may be confined to bed or even institutionalized. These problems persist even as CMS issued an Informational Bulletin in 2017 describing the problem and encouraging states to offer a process for suppliers to request prior authorization of more costly DME, prosthetic, orthotics, and supplies. Similarly, home health can ward off serious illness, loss of function, and unwanted institutionalization. For these reasons, DME and home health must be fully integrated in new FIDE-SNPs as they are in current programs. Moreover, because barriers to acquiring certain DME have long been known and documented, we see no reason to delay requiring full integration by FIDE-SNPs. Implementation of the regulation concerning DME and home health integration should go into effect immediately rather than in 2025 as proposed.

5. **Joint State/CMS Oversight: State Input on Provider Network Exceptions**

We are pleased to see that CMS recognizes the extent to which limited provider networks can present arbitrary barriers to care for some enrollees. In particular, many individuals with complex health conditions and functional limitations require care from providers who are trained and equipped to provide equitable and effective care. For
instance, research shows that very few providers have accessible medical and diagnostic equipment and therefore cannot weigh enrollees with certain mobility limitations or conduct thorough physical examinations. Individuals with these specific accessibility requirements must be able to seek care from providers who have the required equipment if none are available within the network or are not within a reasonable travel time and distance from the enrollee’s home. Federal and state collaboration on oversight of D-SNPs concerning approval of reasons for out-of-network referrals is a critical element in the successful, widespread adoption of D-SNPs.

6. Converting MMPs to Integrated D-SNPs

We are very concerned that CMS proposes to end the Financial Alignment Initiatives (FAI) and convert the Medicare-Medicaid Plans to D-SNPs. MMP models have operated effectively in some states and are continuing to innovate. Because they have served as an incubator for D-SNPs, we recommend that CMS create an intentional glide path that supports enrollees whose care could be disrupted if they change providers.

Thank you again for the opportunity to comment.

Sincerely,

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ENDNOTES


Network adequacy standards, 42 C.F.R. § 422.116

Network adequacy standards, 42 C.F.R. § 438.68


