

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

June 28, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1752-P
Baltimore, MD 21244-1850

Submitted electronically via [regulations.gov](https://www.regulations.gov)

Re: CMS-1752-P Medicare Program; Hospital Inpatient Prospective Payment Systems and for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and other policies

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency.

Our comments focus on Sections IX and X of the proposal.

IX. Closing the health equity gap in CMS hospital quality programs

Justice in Aging strongly supports efforts to collect more and better data on race and ethnicity as an important step in developing solutions to the huge inequities in our current health care system. We support efforts in the NPRM to stratify quality measures by race and ethnicity for Part A providers.

Use of indirect estimates for race and ethnicity: The data coming out of the Covid-19 pandemic have made it clear that systemic inequities and disparities in health outcomes constitute their own public health emergency meriting the immediate attention of the entire health care community.¹ The need for more and better data to monitor current performance and help

¹ See, e.g., Medicare COVID-19 Data Snapshot, available at www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf

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identify effective solutions is urgent. Of particular importance is data collection supporting intersectional analysis to create a more nuanced picture to inform solutions.

As part of this effort, Justice in Aging supports moving forward quickly with enhanced data collection to support the stratification of quality measures. We have serious concerns, however, with the proposal in the NPRM to develop an algorithm to indirectly estimate race and ethnicity. Algorithms cannot, by their very nature, capture how people self-identify, and may add bias and exacerbate existing disparities rather than contribute to remedies. While timely response to inequity and disparities is important, it cannot be at the expense of accuracy. We ask that, instead of employing algorithms of questionable accuracy, CMS intensify its efforts to train provider organizations in best practices for getting better self-reported data from individuals, including culturally competent approaches, and set clear expectations for improvements in the quantity and quality of data collection by provider entities.

Collection of data other than race and ethnicity: The NPRM indicates that CMS expects to expand data collection to other categories. We believe the need to do so is urgent and CMS should undertake this effort as soon as possible. Categories beyond race and ethnicity that we believe are essential to intersectional analysis include sex, gender identity, sexual orientation, , disability status, and primary language. All of this data should be collected in a way that allows CMS to examine the intersections of these categories with age, race and ethnicity, as well as geographic location of the hospital (urban/rural).

Transparency: Justice in Aging fully supports the development of a Hospital Equity Score, but we caution that a score must be based on full and accurate data. Hospitals are not yet uniformly collecting comprehensive, disaggregated sociodemographic data or accurately stratifying quality and outcome measures by social determinants of health. Collecting good data must be the first step, but we also encourage CMS to continue with developing the design of a Health Equity Score.

More broadly, we urge CMS to take necessary steps to make available to the public all the equity data it collects and the analysis it creates. The crisis in health equity demands the efforts of everyone. If critical data and the agency's comparative analysis of that data are only shared on a confidential basis with hospital management, the many other players, including the communities experiencing the disparities, who can contribute to a solution are sidelined.

Hospitals are in many ways public utilities, particularly in smaller communities where only one hospital is available. Further, with the ongoing consolidation of hospital ownership, consumer choice is increasingly limited even in larger communities. Hospital operations are financed in significant part by public payers, including notably Medicare and Medicaid as well as other state and local entities. Given these realities, it is particularly important that communities, state and local regulators, all hospital employees (not just management), health care researchers, the press and other stakeholders all are able to look behind the curtain with respect to hospital quality and be partners in improving performance. Most importantly, Medicare enrollees most especially have a right to the information needed to inform their choice. It is particularly

disempowering to withhold from members of groups that experience disparate treatment the very information they need to give them more control over their own health outcomes.

X. Medicaid enrollment of Medicare providers and suppliers for purposes of processing claims for cost-sharing for services furnished to dually eligible beneficiaries.

Justice in Aging appreciates that CMS has focused attention on issues that some Medicare providers face in enrolling in Medicaid for the limited purpose of Medicare co-insurance claims. We support proposed 42 C.F.R. § 455.410, which would spell out with more specificity the long-standing obligation of states to offer a Medicaid enrollment path for providers of any Medicare service so Qualified Medicare Beneficiary (QMB) claims can be processed. As the NPRM notes, the current inadequacies in enrollment systems in many states frustrate providers and disincentivize them from serving dually eligible individuals and QMBs, thus affecting access to health care for these individuals. It also is our experience that any added complexity or dead ends in getting claims processed also can increase the likelihood that providers may attempt to improperly bill QMBs.

We further appreciate that CMS is encouraging states to consider shortened and simplified enrollment forms for the limited purpose of processing Medicare co-insurance. Some states have already adopted such simplified forms leading to administrative efficiency. By easing the paperwork burden, simplified forms encourage more Medicare providers to serve QMBs. Though the issue affects all Medicare providers, one category of providers experiencing frustration is out-of-state providers who have served a dually eligible individual, usually in an emergency situation while the individual was traveling or temporarily visiting family. Filling out a many-page form for what may well be a single interaction with a Medicaid agency of a state on the other side of the country just to get a Remittance Advice with zero payment is an onerous burden. We have heard of several cases where that burden on an out-of-state provider has translated into an improper and illegal attempt to get payment from the QMB individual. We ask CMS to consider whether the agency could require, rather than suggest, that states use a uniform short form so that this barrier to efficient operation of the QMB program can be removed across the board.

The NPRM also asks about stakeholder experiences with Medicaid programs denying crossover Medicare claims for QMBs because specific Medicaid conditions were not met. We have heard from advocates about such denials or, at least, about delays while beneficiaries and providers got conflicting answers from state Medicaid offices or, more likely, from Medicaid MCOs about what is necessary.

It is our experience that, in a state with many Medicaid MCOs, there simply are more opportunities for errors in applying what should be uniform rules. We urge CMS to consider a regulation or at least a State Medicaid Director letter, that would clarify state and Medicaid MCO obligations in this area.

Although beyond the scope of this NPRM, we also urge CMS to work with the Congress to address head-on the bigger issue that severely limits the effectiveness of QMB protections, that

is, the need to abolish the “lesser of” payment policy. In the absence of legislative change, we ask that CMS consider using its demonstration authority to test a program to address the “lesser of” policy.²

In Section IX of the NPRM, CMS discusses at length the agency’s commitment to address the glaring disparities in access to care and in health outcomes in this country. The hard reality, however, is that the “lesser of” policy works at cross purposes with CMS’s policy goals. It sends precisely the wrong signal to providers, exacting a financial penalty every time they serve the very communities that suffer most from health care inequities. While we appreciate and fully support CMS’s efforts in this rulemaking to eliminate some of the underbrush affecting provider participation in QMB programs, the most effective way to assure equitable treatment of all Medicare enrollees is to also equitably pay providers who serve the most disadvantaged Medicare enrollees.

Conclusion

Justice in Aging looks forward to working with CMS on concrete steps, including better data collection, to address the serious inequities low-income Medicare enrollees face. We also support the proposed regulatory changes to improve administration of the QMB program and improve provider access for QMB enrollees. If any questions arise concerning this submission, please contact Georgia Burke, Directing Attorney, at gburke@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Deputy Director

² Note that the Affordable Care Act, at 42 U.S.C. 1396a(a)(13)(c), had authorized a limited program to require Medicaid payment of full Medicare coinsurance for primary care providers, with enhanced federal match. Though the program held promise, it was only authorized for 2013 and 2014 and states were slow to implement its provisions. As a result, there was not enough time for the program to make substantial impact on provider participation or beneficiary access to care.