

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 4, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via <https://www.regulations.gov>

Re: Docket No. CMS-2022-0021; Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Justice in Aging appreciates the opportunity to comment on the above referenced advanced notice of proposed rulemaking (ANPRM). We are in strong support of the Centers for Medicare & Medicaid Services' (CMS's) commitment to advancing health equity pursuant to [Executive Order 13985](#).

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

Our comments focus on CMS's proposals to advance equity, particularly for older adults of color, LGBTQ older adults, and people with limited English proficiency, including Star Ratings measures, the Health Equity Index, health risk assessments, and CAHPS surveys.

I. Stratified Reporting (Part C and D) in additional Star Ratings Measures

a. Improve data collection and transparency for specific and intersecting populations

Universally, a major barrier in achieving health equity is lack of sufficient data around health care access and experience for marginalized populations.¹ Not having this information perpetuates structural racism in Medicare because CMS and plan administrators are unable to accurately identify gaps in services and tailor solutions. We support CMS's efforts to report additional Star Ratings measures for subgroups of beneficiaries with social risk factors (SRF) in addition to the existing factors, such as disability, low-income subsidy (LIS), and dual eligible (DE) status. We encourage CMS to ensure that other factors—specifically sexual orientation and gender identity (SOGI), age, limited English proficiency, and primary language—are uniformly collected and reported as part of the Star Ratings measures.

LGBTQ individuals have more barriers to health care and experience poorer outcomes due to discrimination and uninformed care providers. Thus, collecting SOGI information is vital to understanding and remedying systemic health disparities.² Similarly, individuals with limited English proficiency experience barriers to quality health care. By collecting information on individuals with limited English proficiency and their primary languages, CMS and MA plans can understand which translations, interpretation and other language-access tools are required, and identify gaps in services.

¹ KFF, [Advancing Health Equity Requires More and Better Data](#) (Oct. 2021).

² SAGE, [Disrupting Disparities: Solutions for LGBTQ New Yorkers Age 50+, 38-40](#), at 38-40 (2021).



Stratified data by age is also necessary to understand gaps and successes in health care for various age groups, particularly older adults whose health needs may differ from younger adults with disabilities.

Most importantly, intersectional data for all demographics should be reported. We appreciate that CMS has reported some stratified data by race and gender. We urge the agency to also report data intersecting by other configurations (e.g., race and age; disability, race and gender; LGBTQ status, age and race etc.). Individuals with intersecting identities are more likely to experience confounded or different forms of inequities, and enhanced reporting of intersectional data will reveal those for specific populations where the single-demographic data does not.

We are especially thankful for CMS's continued commitment to better understanding and addressing racial disparities among people enrolled in MA plans. While some race data may be insufficient to include in analyses or trend reports (e.g., data on American Indian and Alaskan Native (AI/AN) and multi-racial populations in [Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018](#)), it should be public nonetheless in some format. Researchers, advocates and plans will still benefit from viewing this limited information because there are few or no other sources. We also urge CMS to clarify its current reporting on race and ethnicity. For example, "Hispanic" is often being reported alongside race and not as an ethnicity in addition to race. While we support recommendations and best practices around combining race and ethnicity questions when collecting data, it would be helpful for CMS to clearly report race by ethnicity.

b. Make available disaggregated data at the plan and local levels and raw demographic data.

Both lack of data collection and lack of transparency in collected data are forms of structural racism, as they prevent agencies, researchers and advocates from identifying specific populations and localities with the greatest needs. Contract level data should be disaggregated where possible to provide a clearer picture in regards to plan-level and county- or local-level trends.

Additionally, CMS should make raw data—particularly around demographic and local trends—available publicly. Stratified reports accompanied by graphs and analyses are hugely useful to consumer advocates, policy makers, community-based organizations and direct service providers and we encourage CMS to publish and expand/update easy to understand data dashboards whenever possible. However, access to the raw data is equally as important. It allows researchers to work with the information themselves and perform the analyses that CMS may not have capacity to conduct (e.g., intersectional reports).

While we understand that data stratification and reporting may not be appropriate for evaluating plan operations, as discussed below in the context of BAPP and CAHPS, we encourage CMS to learn and share the experiences of specific communities of consumers when interacting with the plan and have some metrics to capture that experience.

II. Health Equity Index (Part C and D)

We support CMS's effort to implement a health equity index coupled with methods to reduce health disparities for historically marginalized individuals. Addressing inequities and reducing health disparities is integral to providing quality health care. We support the proposal to include additional "social risk factors" for the Health Equity Index, but race and ethnicity data should explicitly be included as well.³ It is critical that CMS ensure this index and any other measures be designed and implemented to reduce

³ See JAMA Network, [Association of Medicare Advantage Star Ratings With Racial, Ethnic, and Socioeconomic Disparities in Quality of Care](#) (June 2021) (finding that "simulated star ratings for persons with lower SES and Black and Hispanic enrollees were substantially lower than ratings for those with higher SES and White enrollees in the same contract" and concluding that "Measures of equity in MA plans' quality of care may be needed.").

disparities on an ongoing basis. Sometimes we see incentives given to health plans to report on equity measures but no real enforcement to ensure they are improving on those measures and reducing disparities.

Incorporating the Area Deprivation Index (ADI) into the Health Equity Index or any other equity measure will allow CMS and plans to target communities with the greatest need in terms of access to plan support and delivery of services. Several states have used ADIs to promote equitable access to COVID prevention and treatment resources for communities who are highest risk. For example, a study in Louisiana found that a composite ADI can be a useful tool in “assessing the role of the neighborhood on COVID-19 disease.”⁴ However, we caution CMS against relying solely on ADI as a measure of equity as it is not fully representative of systemic disparities for historically marginalized communities. For example, an ADI may identify a rural community as needing greater support, but without specific measures around race and ethnicity, plans may ultimately focus support on white individuals living in rural counties and not address the needs of Black, Latino, AAPI, and AI/AN populations living in those same or other rural counties.

While we support efforts to implement and enhance health equity measures, we have questions about the utility of having two separate measures: The Health Equity Index and the Health Equity Summary Score (HESS). The HESS metric focuses on plan performance for patients with social risk factors, but to our understanding it only uses race and ethnicity data as part of the measure and is for the purpose of incentivizing plans. The proposed Health Equity Index currently has data readily available regarding disability, low-income-subsidy (LIS) eligibility, and dual-eligibility (DE), but is for the purpose of comparing plan performance. We question the efficacy of creating two plan-performance measures with different metrics but related purposes, specifically since race data is not currently available for the Health Equity Index for Star Ratings and there may be unintended consequences for using race/ethnicity based measures only for plan incentives. For example, to receive bonus payments, plans could design their benefit structures to make them less attractive to individuals with certain health conditions or higher needs. This could in effect discriminate against people of color who are more likely to have those conditions. While some people of color may still enroll in their plan and have good health outcomes leading to the plan’s receipt of bonus payments for not having racially disparate outcomes among their enrollees, this metric would not actually be addressing health disparities for Medicare enrollees of color as a whole.

Creating two different measures of plan-performance may also lead to unreliable information about the experiences of historically marginalized populations, so we suggest using one metric that contains a broad range of demographic measures for both purposes. Regardless of the purpose of the metric, incentivization or analysis, both the HESS and Health Equity Index should at least use the same demographic measures—i.e., race, ethnicity, disability, LIS and DE. Additionally, we recommend that the Health Equity Index, as well as the HESS or any other measures of plan performance, include other demographic factors such as age, sexual orientation and gender identity (SOGI), and primary language. These combined with the existing factors will allow CMS to have a full understanding of plan performance with regard to health inequities among patients, and will allow for analysis of intersecting identities.

III. Measure of Contracts’ Assessment of Beneficiary Needs (Part C)

We support CMS’s initiative to encourage plans to evaluate their assessment process for their enrollees health-related social needs and agree that consistency in these assessments is necessary to understand

⁴ Madhav K.C. et al., *The effect of deprivation on COVID-19 risk in Louisiana*, PLOS ONE 15(2) (2020), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0243028>.

plan performance overall. We discourage CMS from focusing solely on completion rates of screen tools, and instead urge the agency to incorporate the quality of the plans ability to identify patients' social needs using the tool—i.e., Were the correct SRFs assessed? Did the plan connect the patient with culturally-competent services? Did the plan follow up with the patient to ensure services were in place?

Standardized screening tools, like any automated or algorithm-based tool, are also prone to bias and have the risk of perpetuating health inequities. Algorithmic-bias refers to “the application of an algorithm that compounds existing inequities in socioeconomic status, race, ethnic background, religion, gender, disability, or sexual orientation and amplifies inequities in health systems.”⁵ Any screening tool at its core is an algorithm: a set of steps to reach a result. Bias can seep into any step of the screening and compound with each step; purely engineering-based solutions (e.g., removing race from the data) will not resolve these problems.⁶ Racial and other systemic oppression from even before CMS or any health plan was established permeate current health equity efforts because historical data is used to create screening tools and studies. Essentially, “if bias is present in the world it will be present in the data.”⁷ Meaning that groups who have not had equal access to traditional or managed care, had poorer health outcomes, or whose data was not collected are not adequately represented in the data used to create screening tools, and such tools are likely to incorrectly identify or apply to members of such groups. For example, a study found that because Black patients had lower entry to care management programs, the gap between care needed and care received for Black patients was larger than for white patients. There the “neutral” factor of previous health care spending was actually found to be a racially biased factor.⁸ As another example, the Framingham Heart Study was found to work well for white patients because 80% of the collected data used to create the Study came from white patients; and so, the Study is less applicable and accurate for non-white patients.⁹

For these reasons, we urge CMS to mitigate the risk and effect of bias in health-related social needs screenings. Some bias-mitigation techniques that CMS can require health plans to pursue are (1) implement a human-in-the-loop approach, where any screening tool decision is passed to a human decisionmaker; (2) ensure adequate diversity in the teams that develop and implement screening tools; and (3) require transparency in the development of the screening tools, including the ability to explain to stakeholders what information is being used in the screenings and why.¹⁰ We also encourage CMS to actively engage with a diverse group of stakeholders, including data scientists and researchers, advocates and self-advocates from various affinity groups, health care professionals, social services professionals, and developers of similar tools that have been vetted for equitable results. We support the use of evidence from various needs-specific assessments in the development of CMS's Accountable Health Communities Health-Related Social Needs (AHC-HSRN) screening tool,¹¹ and we encourage CMS

⁵ Harvard TH Chan School of Public Health, [Algorithmic Bias in Health Care Exacerbates Social Inequities — How to Prevent It](#) (Mar 12, 2021).

⁶ As the examples point out, much of the bias injected into health-care tools a result of the non-inclusive data pools and power dynamics that contribute to “who gets a chance to build algorithms and for what purpose.” *Id.*

⁷ Trishan Panch et al., *Artificial intelligence and algorithmic bias: implications for health systems*, 9 J. Global Health (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6875681/>.

⁸ See Ziad Obermeyer et al., *Dissecting racial bias in an algorithm used to manage the health of populations* (2019), Reviewed by Penny Sun, Race, Research, & Pol’y Portal, <https://rrapp.hks.harvard.edu/algorithms-can-replicate-or-remedy-racial-biases-in-healthcare-resource-allocation/>.

⁹ *Id.*

¹⁰ See Panch, *supra* note 10.

¹¹ [A Practical Approach to Screening for Social Determinants of Health](#), *Fam Pract Manag.* 2018 May-June;25(3):7-12 (noting that the AHC-HSRN drew from several food insecurity, housing instability, interpersonal safety, and utility needs assessments).

to pursue a similar effort in the creation of any new tool and regular re-evaluation of the AHC-HSRN and other screening tools for equitable outcomes.

It is also important to note that a screening tool that is equitable in its development is incomplete without culturally-competent administration. Plans should be required to identify social services providers that understand the needs of individual members and with which the member feels comfortable and safe to use—for example by identifying community based organizations and other local affinity or faith-based groups that provide housing or nutrition assistance.¹² Plans should also incorporate principals of cultural competence in their administration of screenings, especially considering racial and other traumas that exist for many patients in health care settings.¹³

IV. Screening and Referral for Services for Social Needs (Part C)

We are also supportive of the development of the NCQA measure to assess screening for unmet food, housing and transportation needs, and referral to intervention for those who screened positive. This is particularly important as transportation and food needs have risen among communities of color during the COVID-19 pandemic. Much like the screening tools and other contracts' assessments of beneficiaries' needs, the NCQA screening and referral for services for social needs should not simply capture a completion rate of screenings and referrals, but also the quality of both the screenings and the referrals themselves (i.e., cultural competency of screenings, going beyond simply providing a phone number as a referral, post-referral follow-up, was the referral successful?). This measure does seem appropriate to incorporate into Star Ratings or other overall quality measures.

We also urge CMS to consider ways to use this measure and the data gathered to ensure that social service providers, especially CBOs, are fairly compensated for being integral to all of these strategies to reduce inequities. As we stated in our comments on the screening tools, no measure nor tool will be complete without culturally competent implementation. Often, that implementation is a referral to another entity that has fewer financial resources than the entity making the referral.

V. Value-based Care (Part C)

The measure of value should be focused on providing quality health care to each enrollee. This necessarily requires addressing inequities and disparities for marginalized populations. Put another way, we urge CMS to view equitable high-quality care as the central and primary goal of the Medicare program, not a side-effect or “bonus” of value-based care. To truly center equity as the goal, we urge CMS to treat progress on health equity measures as a baseline requirement for plans to participate in the program rather than as something to be incentivized through higher payment. We believe that plans will naturally receive financial benefit by reducing disparities (e.g., lower ER use and shorter hospital stays) and so “bonus” based incentives should not be added on. The need to re-center value-based care on equitably meeting the needs of enrollees is highlighted by research showing that MA plans are already overpaid.¹⁴

VI. Kidney Health (Part C)

We support NCQA's endeavor to identify new measures to assess kidney health evaluation and management. The pandemic has had a tremendous impact on end-stage renal disease (ESRD) patients

¹² E.g., The [AMAAD Institute](#) which provides a peer driven recovery support network for Black and Black LGBTQ+ individuals in Los Angeles County.

¹³ For example, SAGE USA's resource on [Disrupting Disparities](#) provides best practices for collecting LGBTQ-identity data in a manner that protects privacy and fosters comfort for older adult patients.

¹⁴ KFF, [Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges](#) (Aug. 2021).

by increasing risk factors for kidney injury¹⁵ and impacting COVID-19 fatality rates due to pre-existing chronic conditions.¹⁶ Black, Hispanic, and American Indian people are at an increased risk for kidney complications¹⁷ due to racial disparities in health care and factors contributing to social determinants of health.¹⁸ Moreover, dialysis treatment centers have been shown to discriminate against Latino and Asian American patients.¹⁹ Enhanced data collection and analysis around racial disparities in kidney disease, management, and treatment through specific measures is a necessary step in fully understanding and addressing the systemic inequities behind kidney health.²⁰

VII. Beneficiary Access and Performance Problems (Part C and D)

Beneficiary Access and Performance Problems (BAPP) are an important factor in Star Ratings measures because they reflect whether plan members are experiencing barriers to receiving services, the seriousness of these problems, and the direct impact to members. While we support re-introducing BAPP in Star Ratings, we urge that attempts to capture members' experiences should not be a one-size-fits all approach. Reports of performance problems should reflect enrollees' self-reported experiences, for example around language access, timely referrals, trauma-informed service delivery, identifying and coordinating health-related culturally appropriate social services, and accessibility of services and programs (e.g., technological accessibility, transportation options etc.). Some examples of consumer experience measures can include wait times at call centers; wait times to receive an interpreter; and whether a consumer was able to work directly with the plan to resolve an issue, or whether the consumer had to receive assistance from a relative or advocate.

We are concerned that if reports of performance problems are overly simplified to fit into categories or if the reports are second-hand (i.e., from a provider or care coordinator), they will not fully capture the nuances and intersecting factors of the problem. People of color and individuals who have been historically marginalized may experience barriers to treatment that are solely the responsibility of the plan or physician, as well as barriers that result from social determinants of health, such as disease stereotyping, clinical nomenclature, untimely or inaccurate diagnosis, untimely referrals or reliance on tools or studies that did not include diverse patients in their development.²¹

Performance problem reports should also reflect the varied experience of all patients, particularly patients of color, LGBTQ patients, older patients, and patients with limited English proficiency. We recommend the BAPP reflect this varied patient experience, either through self-reported barriers from plan members or a combination of self-reports and other measures. Most importantly, CMS should engage with a diverse group of stakeholders, reflective of the demographics listed in this paragraph, to obtain input on reflecting varied experiences in BAPP measures. To do this, plans should be required to gather input regarding BAPP measures through existing consumer advisory councils or convene consumer advisory groups specifically to obtain feedback on BAPP measures.

¹⁵ Nat'l Kidney Found., [Dialysis & COVID-19](#); see also Harvard Health Blog, [What's behind racial disparities in kidney disease?](#) (Feb. 3, 2021) (noting that African Americans who develop Covid and carry two copies of the APOL1 gene variant may be at a higher risk if acute kidney injury related to Covid).

¹⁶ Tanawin Nopsosopon *et al.*, *Covid-10 in end-stage renal disease patients with replacement therapies: A systemic review and analysis*, PLOS (2021), <https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0009156>.

¹⁷ NIH, [Race, Ethnicity, & Kidney Disease](#).

¹⁸ Harvard Health Blog, [What's behind racial disparities in kidney disease?](#) (Feb. 3, 2021) (reporting there societal and institutional barriers are the underlying reasons for higher rates of kidney disease for people of color).

¹⁹ HHS OCR complaint, [High-Speed Hemodialysis Has a Disparate Impact on Latino and Asian American Patients](#) (filed Jan. 11, 2022)

²⁰ Harvard Health Blog *supra* note 21 (noting that timely referrals for specialty care and evaluation and enlisting for kidney transplants are two examples of systemic solutions to these inequities).

²¹ KFF, [Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications](#) (Dec. 9, 2021).

VIII. CAHPS (Part C and D)

We appreciate efforts to increase CAHPS response rates. We caution that in doing so, CMS not be overly reliant on web surveys, as it will exclude perspectives from individuals without reliable broadband or technology access. For example, only about half of Native Americans living on tribal lands have access to high-speed Internet²² and nearly 22 million older Americans lack broadband access at home.²³

The process outlined in the ANPRM notes that phone surveys are conducted only after several attempts to gain a web survey response. We recommend that CMS attempt a phone survey more than once for individuals who do not respond to the web survey to ensure that all perspectives are captured. This can be an opportunity to leverage case managers who interact with members one-on-one. Additionally, it is not clear how resources will be divided between web and no-web survey options.

We support CMS adding new topics to the CAHPS survey, particularly language spoken at home and perceived discrimination. If it is not collected through the current plan enrollment process, sexual orientation and gender identity (SOGI) should be collected as part of CAHPS. CMS should ensure that this information is collected using appropriate language and through culturally and trauma-informed practices.

With respect to asking about perceived discrimination, it is vital for CMS to consult with advocates—particularly experts from various affinity groups and direct-services providers—to provide input on asking this question in a culturally competent manner that will not retraumatize individuals who have experienced discrimination. There should be transparency with plan members in how this information will be used and protected.

With respect to CAHPS and all of the proposals in this RFI, we encourage CMS and plans to be intentional about data collection. Low-income communities in particular have been historically over surveilled and monitored by government. Therefore, we urge CMS to (1) avoid collecting data that is not useful in addressing health disparities or may cause a chilling effect on seeking healthcare or related services; (2) limit the number of times the data is collected, for example by sharing de-identified and disaggregated information across the agency and improving data sharing with the Social Security Administration; and (3) ask questions in a way that fosters trust and safety of the person sharing, such as “prefer not to answer” option and not treating race groups as a monolith.

Conclusion

Thank you again for the opportunity to comment. If any questions arise concerning this submission, please contact Natalie Kean at nkean@justiceinaging.org.

Sincerely,



Amber Christ
Directing Attorney

²² Hansi Lo Wang, NPR, [Native Americans On Tribal Land Are 'The Least Connected' To High-Speed Internet](#) (Dec. 6, 2018).

²³ OATS, [22 Million U.S. Seniors Lack Broadband Internet Access; First Time Study Quantifies Digital Isolation of Older Americans as Pandemic Continues to Ravage Nation](#) (Jan. 27, 2021).