



March 4, 2022

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2022-0021
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

Dear Sir/Madam,

The Center for Consumer Engagement in Health Innovation at Community Catalyst respectfully submits the following comments on the 2023 Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

[Community Catalyst](#) is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill.

[The Center for Consumer Engagement in Health Innovation](#) at Community Catalyst focuses on health system transformation and bringing the community experience to the forefront of health. The Center works directly with advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate individuals' experience into the design of their systems of care. We also work with state and federal policymakers to spur change that makes the health system more responsive to people, particularly those who are most vulnerable.

The focus of our comments are on the health equity sections of Potential New Measure Concepts and Methodological Enhancements for Future Years.

Driving Equity – Overarching Comments

In order to achieve health equity, we believe that everyone deserves a fair opportunity to achieve health regardless of race, ethnicity, income, age, gender identity, sexual orientation, disability or

health status, language, or zip code. For too long, structural forms of discrimination and oppression have created and perpetuated health inequities in the United States. These powerful forces are present within our health care system and disproportionately impact Black people, Indigenous people, and other people of color (BIPOC). We are encouraged to see health equity in this Advance Notice and CMS's commitment to centering equity in its policies and programs.

Stratified Reporting (Part C and D)

We extend our gratitude to CMS, in efforts to report differences in contract performance on additional Star Ratings measure for subgroups of beneficiaries with social risk factors (SRF). Allowing stratified reporting on SRF for BIPOC communities is a meaningful step in the right direction, which would allow for better improvements in equity and quality of care, for communities that are often underserved by the healthcare system. However, we first encourage CMS to consider additional demographic variables, which is impactful for persons' health (e.g., sexual orientation and gender inclusion and rurality). Per the [Centers for Disease Control and Prevention](#), without the ability to collect structured SO/GI data, LGBT patients and their specific health care needs cannot be identified, the health disparities they experience cannot be addressed, and important health care services may not be delivered. Additionally, HHS' Office of the National Coordinator for Health Information Technology (ONC) recently released the updated USCDI, to include interoperability standards to support the electronic exchange of sexual orientation, gender inclusion, and social determinants of health. Stratified SOGI data would be an invaluable tool in allowing providers to address disparities within this group.

We fully acknowledge that there are providers with hesitations on ascertaining SOGI data from beneficiaries, as identified in the [EQUALITY Study](#). However, the main takeaway was that implementation of a standardized, patient-centered approach for routine collection of sexual orientation data is required on a national scale to help to identify and address health disparities among lesbian, gay, and bisexual populations. We are prepared to fully support CMS' efforts to work with providers in communities, by providing education and trainings to improve their self-efficacy to this regard. To not pursue tools that could improve the health of underserved populations, because of comfortability in the healthcare system, is a structural inequity that could exacerbate systematic disadvantage.

Importantly, we also encourage CMS to explore ways to also stratify with an intersectional lens. Intersectionality spotlights how inequity develops when various intersecting variables including age, sex, gender, health status, geographic location, disability, migration status, race/ethnicity, and socioeconomic status, and how these can be multiplied and exacerbated in contexts marked by systematic inequalities. There are implications for underreported data – continued inequities for underserved communities. If CMS is not at a point where it is able to do so, we highly encourage CMS to make disaggregated and raw data publicly available.

Health Equity Index (Part C and D)

The Center would also like to express our support for CMS Office of Minority Health's work on developing the Health Equity Summary Score (HESS) and CMS' willingness to consider a health equity index for Part C and D. OMH demonstrated the efficacy of the HESS in identifying

MA plans that provide excellent care to large numbers of beneficiaries with SRFs, particularly plans with more diverse enrollees. However, when developing the Health Equity Index, we urge CMS to incorporate a community-based participatory research framework in the design of the index. We are prepared to support CMS in strategizing the best ways to incorporate voices from the community in the design and testing of the instrument – including cross-cultural validation. Building partnerships with patient advocacy organizations, communities, and beneficiaries would offer greater reliability of the instrument, especially for BIPOC and underserved communities, who are oftentimes only considered during utilization phases. We are also persuaded that a more inclusive and participatory approach would allow us to meaningfully partner with CMS in operationalizing its [strategic pillar](#) of engaging partners and communities throughout the policymaking and implementation process.

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

We would like to extend our appreciation of CMS for funding the Accountable Health Communities Model and leveraging the ongoing lessons-learned to drive the imperative to address social risk factors in healthcare. We also support the notion of CMS developing a performance measure to determine if a contractor’s enrollee had their needs assessed with a screening tool, as the screener used in the AHC Model. First, we believe that plans that are currently using their own assessment tools, should be allowed to continue using these tools, and allow them to work towards a set of agreed upon standards. All SRF screenings should include minimal standards, to ensure quality and equity. Secondly, CMS should promote that plans prioritize an existing instrument or work towards developing or adapting an instrument that is validated, particularly with the demographics served by the plan. CMS should also provide funding to community organizations to partner with plans to develop, test, and validate assessments, to ensure that the language resonates with and is inclusive of diverse communities. This will also ensure that the SRF’s addressed in the assessments are the ones identified and prioritized by enrollees, so that plans are not aligning resources to address the wrong problems.

Screening and Referral to Services for Social Needs (Part C)

We support measure development that screens for social needs and referrals to the right interventions. Understanding which interventions were recommended and ultimately implemented would further shed light on types of interventions that actually work for the beneficiary, this type of information is narrative, and an important part of person-centered measurement. Community Catalyst’s publication [Screening for Social Needs](#) provides detailed insights on effective design and implementation of social needs assessments. Building upon lessons learned from the AHC Model, we feel that although screening for SRF’s is important, it is also necessary that enrollees receive culturally-competent navigation services to address any identified needs. For this reason, CMS should partner with community organizations to explore channels that would allow for equitable funding to those providing supply to this increase in demand (e.g., the development of a SRF fund by CMS, Department of Housing and Urban Development, Department of Energy, Department of Education, or the Department of Agriculture). Exploring ventures with other federal partners could allow for a more robust

response to address SRF domains that may typically fall within other federal agencies. CMS could consider allowing braided or blended funding, in order to fulfill this gap.

Beneficiary Access and Performance Problems (Part C and D)

Reintroducing BAPP in Star Ratings is a step in the right direction however, we urge CMS to not assume a one size fits all in capturing beneficiaries' experiences. Problem reports should 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.

We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues in the future.

Sincerely,

DocuSigned by:
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