CHLPI CENTER for HEALTH LAW and POLICY INNOVATION
HARVARD LAW SCHOOL

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Meena Seshamani, M.D, Ph.D.
Director, Center for Medicare
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building 200 Independence Ave SW Washington, DC 20201
Attn: CMS-2022-0021

Dear Director Seshamani,

The Center for Health Law and Policy Innovation of Harvard Law School (**CHLPI**) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (**CMS**) Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (**MA**) Capitation Rates and Part C and Part D Payment Policies (the "**2023 Proposal**").

CHLPI advocates for reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. We have an active portfolio dedicated to nurturing the integration of social determinants of health (**SDOH**) interventions into health care delivery and financing. For a number of years, CHLPI has worked with stakeholders including health systems, private and public health plans, community-based organizations (**CBOs**), and government officials across the country to address the damaging impact of food insecurity on health outcomes and advance Food is Medicine interventions (such as medically tailored meals and produce prescriptions).

Although it is now widely acknowledged that SDOH have a significant impact on health outcomes,[1] there has been slow progress integrating related services and supports into health insurance coverage. In particular, there is a need for more proactive approaches to addressing food insecurity, which affects an unacceptably high number of U.S households,[2] and a particularly high number of Medicare beneficiaries. This situation worsened during the COVID-19 pandemic, which exacerbated pre-existing racial and ethnic disparities in food security,[3] and challenges for older adults and persons with disabilities (i.e. Medicare beneficiaries) consistently accessing enough nutritious food.[4] Indeed, recent studies show that approximately one third of Medicare/Medicaid dual enrollees reported experiencing food insecurity during the pandemic.[5] Food insecurity plays a critical role in driving negative health outcomes and increasing health care costs, especially for Medicare beneficiaries. For example, data demonstrates that food-insecure older adults are 57 percent more likely to

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[1] *See, e.g.*, WHO, SOCIAL DETERMINANTS OF HEALTH, HTTPS://PERMA.CC/5EZ2-5VLW (last visited Mar. 2, 2022).

[2] *See* Heather Hartline-Grafton, *The Impact of Poverty, Food Insecurity and Poor Nutrition on Health and Well-Being*, FOOD RSCH. & ACTION CTR. 1, 3 (2017), https://perma.cc/E4P9-GV8J.

[3] *See* A.M. Lacko & G. Henchy, *Hunger, Poverty, and Health Disparities During COVID-19 and the Federal Nutrition Programs' Role in an Equitable Recovery*, FOOD RSCH. & ACTION CTR. 1, 9 (2021), https://perma.cc/M63D-W5MP.

[4] *See* Carli Friedman, *Food insecurity of people with disabilities who were Medicare Beneficiaries During the COVID-19 Pandemic*, 14(4) DISABILITY & HEALTH J. 1, 1 (2021), https://perma.cc/E4X3-NBEZ.

[5] Jeanne M. Madden et al., *Risk Factors Associated with Food Insecurity in the Medicare Population*, 180 JAMA INTERNAL MED. 144, 144-47 (2020).

report congestive heart failure, almost 90 percent more likely to report asthma, and more than 65 percent more likely to have had a heart attack.[6] Additionally, food insecurity can exacerbate existing health conditions, including, for example, poor glycemic control for people with diabetes.[7]

We therefore commend CMS on the proposed development of Star Ratings measures relating to health-related social needs (**HRSN**), including food insecurity. As detailed herein, we believe the Star Ratings program is a useful lever in driving plan and member behavior, and so integrating these measures will help motivate plans to address food insecurity. The proposal will also help to educate MA plans and other stakeholders about HRSN. However, in order to have a real impact on the health outcomes of beneficiaries, it is crucial to integrate screening, referral, and payment for services that respond to SDOH. Accordingly, we recommend the following:

1. CMS should adopt Star Ratings measures for HRSN screening and referral to address unmet needs.

2. Moving forward, we urge CMS to ensure that changes to the Star Ratings program are part of a broader coordinated strategy to promote screening, referral, and payment for services that respond to HRSN in the Medicare program—and clearly articulate the same to stakeholders.

1. CMS should adopt Star Ratings measures for HRSN screening and referral to address unmet needs.

A. The Star Ratings program is a useful tool that motivates plan behavior, influences beneficiary decision-making, and creates data insights for policy reform.

Firstly, Star Ratings influence the behavior of MA plans because they incentivize plans to achieve higher ratings. The amount of government funds that a plan receives is contingent on how well a plan is rated.[8] Star Ratings also influence the composition of the market because the ratings affect when plans are able to accept new beneficiaries.[9] Further, Star Ratings influence consumer choice and enrollment decisions as they give beneficiaries information regarding the quality and cost of plans, which help beneficiaries in determining which plans might be best for them.[10] Indeed, research demonstrates that a one-star higher rating was associated with a 9.5 percent increase in beneficiaries' likelihood of enrolling.[11]

Additionally, the adoption of screening and referral measures will create valuable data sets to inform policy development. This information will help CMS, plans, and other stakeholders

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[6] Craig Gunderson & James P. Ziliak, *The Health Consequences of Senior Hunger in the United States: Evidence from the 2019-2014 NHANES, Feeding America*, FEEDING AMERICA & THE NAT'L FOUND. TO END SENIOR HUNGER, 3, 7 (2017), https://perma.cc/JN9H-ZASM.

[7] Victoria L. Mayer et al. *Food Insecurity, Coping Strategies and Glucose Control in Low-Income Patients with Diabetes*, 19(6) PUB. HEALTH NUTRITION 1103, 1105 (2015), https://perma.cc/SF99-P9SV.

[8] BETTER MEDICARE ALLIANCE, *Medicare Advantage Payment Structure Fact Sheet*, (Jan. 2021), https://perma.cc/69TW-PFRG.

[9] *Medicare Part C&D Star Ratings: Update for 2019*, CMS 1, 5 (2018), https://perma.cc/BSY4-VQCT.

[10] MEDICARE, https://perma.cc/FF54-PSKY (last visited Mar. 3, 2022).

[11] Richard O. Reid et al., *Association between Medicare Advantage Plan Star Ratings and Enrollment*, 309(3) JAMA INTERNAL MED. 267, 270 (2013), https://perma.cc/K24X-JQ7B.

understand beneficiary needs and prevent them from 'flying blind' when developing interventions to address HRSN.

    B. <u>The proposal will fill an important gap in the current Star Ratings measures, which do not directly encourage plans to respond to key HRSN such as food insecurity.</u>

There are, arguably, some incentives for plans to evaluate and respond to HRSN within existing Star Ratings measures. For example, identifying food insecure members and facilitating access to nutritious food for such members through produce prescriptions, could result in a higher score in 'C05- Improving or Maintaining Physical Health' and 'C15-Diabetes Care – Blood Sugar Controlled'.[12] However, the connection is attenuated and thus the existing measures do not sufficiently motivate plans to proactively engage with member HRSN. We therefore strongly support the addition of measures that more directly incentivize proactive action with respect to HRSN, such as screening and referrals to services.

2. Moving forward, we urge CMS to ensure that changes to the Star Ratings program are part of a broader coordinated strategy to promote screening, referral, and payment for services that respond HRSN in the Medicare program—and clearly articulate the same to stakeholders.

    A. <u>CMS should promote a coordinated strategy to promote screening, referral, and payment for services that respond to HRSN via Star Ratings and other policy levers.</u>

Meaningfully addressing HRSN involves a continuum of interventions that includes screening, referral, and access to services and supports. Accordingly, it is essential that there is greater strategic coordination across current policies (e.g., pathways for plans to offer non-primarily health related services and supports), Star Ratings, and other aspects of the 2023 Proposal (e.g., the Health Equity Index (HEI), and whether enhancements can be made to the CMS-HCC risk adjustment model to address the impacts of SDOH on beneficiary health status).

Consider, for example, the clear limits to the Star Ratings proposal. If a plan screens a member for HRSN and engagement ends there, the screening has largely been in vain. Even if a plan focuses on screening and referral, a member referred to services may not be able to afford them. Community organizations that provide such services for free or at a discounted cost may not have the capacity to accept all plan members. In other words, improving screening and referral through a Star Ratings measure does not necessarily translate into improved access to supports for HRSN and, ultimately, improved outcomes.

Other levers to address the HRSN of Medicare beneficiaries (both existing and contemplated) are limited in scope and reach when pursued in a silo. The HEI proposal, for example, aims to incentivize better care for members experiencing social risk factors via Star Ratings stratification. The premise is that plans will work to close the gap between populations with respect to Star Rating metrics. However, the focus seems to be on improving performance across traditional, medical measures as opposed to ameliorating the social risk factors themselves. There is no discussion as to whether HRSN screening and referral measures, if adopted, would be prioritized for the HEI. Yet it is this information that would reveal, most explicitly, how well plans are addressing social risk factors and investing in eliminating the

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[12] Ctr. For Medicare & Medicaid Serv., *Medicare 2021 Part C&D Star Ratings Technical Notes* (Oct. 1, 2020), https://perma.cc/49DA-2DEY.

root causes of disparity. [13] Moreover, while Special Supplemental Benefits for the Chronically Ill (SSBCI) and the Value-Based Insurance Design (VBID) model *do* involve plans directly responding to HRSN with support, these benefits continue to be limited in uptake and reach, impeding impact.[14] (CMS neither requires plans to implement either program, nor does the Agency propose to base Star Ratings or other measurements on SSBCI or VBID coverage and availability.)[15]

These examples highlight that a series of related but disunited policies will not achieve desired outcomes. Policy tools must be thoughtfully integrated and deployed in conjunction with one another. Accordingly, we strongly urge CMS to articulate a coordinated strategy— one that addresses overlap and gaps between the policy tools to advance health equity, connects opportunities to respond to the HRSN of Medicare beneficiaries, and guides stakeholders on how available and proposed tools can better align with one another to amplify impact. We believe that this kind of roadmap will help plans make the most of the opportunities.

> B. <u>CMS should consider what broader steps it can take to support the successful uptake, deployment, and impact of available policy tools and opportunities.</u>

In addition to unifying its policies relating to understanding and supporting the HRSN of Medicare beneficiaries, we encourage CMS to consider what broader steps it can take to maximize the impact of these tools. Achieving improvements through Star Ratings measures, the HEI, SSBCI, VBID, and other opportunities necessitates removing common obstacles across the continuum of interventions such as:

- Plan awareness of available food and nutrition insecurity interventions and how to design benefits;
- Difficulties, on the part of plans and CBOs in creating and navigating partnerships to deliver interventions;[16]
- The steep learning curve for many CBOs that have not previously contracted with health care plans and are newly establishing necessary infrastructure;[17] and
- Lack of awareness, on the part of some case managers and members, that food-related benefits exist, which results in lower engagement.[18]

These issues have a direct impact on the uptake, deployment, and impact of available policy tools. For example, successful referral under the NCQA metric is likely dependent on plan-CBO partnerships and CBO capacity to accept those members. Without awareness of

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[13] CMS can ameliorate this concern by integrating the HRSN screening and referral measures into Star Ratings and having the HEI index incorporate both measures into its calculation.

[14] *See, e.g.*, Meredith Freed, Anthony Damico, Tricia Neuman, *Medicare Advantage 2022 Spotlight: First Look*, KAISER FAMILY FOUNDATION, Nov. 2, 2021, https://perma.cc/ZEJ3-DGLN, noting that vast majorities of the plans do not offer SSBCI, and the ones that do are disproportionately Special Needs Plans (for example: only 6.6% of individual plans offered Food and Produce benefits, compared to 20.5% of SNPs).

[15] In the future, CMS should consider the possibility of creating a Star Ratings metric that addresses access to non-primarily health related services and supports via SSBCI, VBID, or similar pathways.

[16] *See, e.g., Providing Non-Medical Supplemental Benefits in Medicare Advantage: A Roadmap for Plans and Providers*, LONG-TERM QUALITY ALLIANCE & ADVISORY IDEAS TO ACTION IN HEALTHCARE & AGING (2021), https://perma.cc/ZQ3X-DCWG (finding that many plans have trouble creating partnerships necessary to deliver new benefits).

[17] *See Id*. at 20.

[18] *See Id*. at 3.

available food and nutrition insecurity interventions—on the part of plans, case managers, and members—SSBCI and VBID, while theoretically available, will remain underutilized.

Moreover, absent strategic investment on the part of CMS, these issues are likely to create a self-perpetuating cycle that impedes the diffusion of interventions: low uptake of opportunities by plans translates into higher costs for the benefits, [19] a lower likelihood of infrastructure development, and insufficient data to inform benefit design, all of which suppresses the adoption of opportunities by plans.

We therefore urge CMS to pursue additional measures to break the cycle through, for example: (a) providing technical assistance to plans and CBOs on matters such as developing successful partnerships and navigating regulatory barriers; and (b) leveraging data and reporting requirements to amplify how SSBCI and other policy tools impact plan performance and member outcomes in communities across the country.

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We applaud CMS's proposal to create a measure of food insecurity and other HRSN in the Star Ratings program and would be happy to work with CMS to further address any of the comments above. Please contact Kathryn Garfield at kgarfield@law.harvard.edu with any questions.

Sincerely,

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on behalf of

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[19] *See generally Id.*