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August 15, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Submitted via electronic submission

Re: Request for Information on Medicare

ACAP is a national association of 74 not-for profit health plans. ACAP health plans provide coverage to over 23 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. Twenty-five of our plans are D-SNPs, 10 are MMP plans, and 24 are MLTSS plans. Collectively, ACAP plans enroll over one-third of the total MMP enrollment nationwide. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicare and managed long-term care services and supports.

ACAP appreciates this opportunity to respond to CMS' RFI soliciting feedback on ways to strengthen Medicare Advantage (MA) in ways that align with the Vision for Medicare and the [CMS Strategic Pillars](#). Specifically, we would like to:

- Provide CMS with examples of initiatives from ACAP plans that have advanced health equity by delivering better, more affordable care and improving health outcomes;
- Reiterate the importance of policies we have developed to improve the ability of D-SNPs to meet their enrollees' SDOH needs, such as our [SDOH Adjustment for Integrated D-SNPs](#), which is one of two prongs in the proposed legislation, The Incentivizing Dual-Eligible Alignment Act ([IDEAL Act](#));
- Discuss ways that CMS can make improvements to Star Ratings, expand eligibility for the frailty adjuster, and advocate for Medicaid continuous eligibility to advance health equity; and
- Highlight a legislative policy related to Medicaid continuous eligibility that would benefit dually eligible individuals.

ACAP Plans Advance Health Equity for Dually Eligibles

ACAP stands firmly against all forms of discrimination in health care. This year was the launch of the ACAP Center for SDOH Innovation, which provides a rich portfolio of shared services to facilitate and demonstrate the leadership of ACAP-member Safety Net Health Plans in the field of social determinants of health. The Center provides for a wide array of services for health plans in nurturing and disseminating best practices in the field of SDOH;



it will develop tools and resources for policymakers, thought leaders and others in the health care space.

In our 2022 report, [ACAP Pathway to Improve Health Equity](#), we discuss in detail how ACAP’s Medicaid and Medicare member plans have forged efforts to end discrimination and close gaps in coverage and care for people who live with disabilities, for people of color, for people whose primary language is not English, and for LGBTQI+ individuals. They have engaged in advocacy, implemented programming, and adopted enterprise-level policies to address barriers to health care, increase training for providers, and ultimately, decrease disparities in care for LGBTQI+ individuals.¹

ACAP recognizes that working to reduce health disparities and to make progress toward health equity is embedded in its member Safety Net Health Plans’ commitment to serve their members appropriately and effectively.² ACAP has also documented our D-SNP members’ work to advance health equity by improving the SDOH needs of their dually eligible enrollees. In our 2020 report, [Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development](#), we detail how our plans assess, prioritize, and address SDOH needs by identify gaps and implementing interventions:

- *Assess* – Our plans use some combination of assessment tools, such as Health Risk Assessments (HRAs), data analytics or other information technologies, and care managers or referral coordinators to assess need.
- *Prioritize* – With information gathered through assessment tools, information technologies, and care management platforms, plans take time to comprehensively understand members’ SDOH needs. Through active engagement, they understand how members prioritize their own SDOH needs and what SDOH-related interventions will have the greatest effect on those needs and the members’ clinical outcomes.
- *Identified Gaps in Meeting Member SDOH Needs* – D-SNP plans cite challenges in coordinating SDOH-related services for dually eligible beneficiaries receiving their services through Medicaid, and in offering more permanent solutions to those with housing, social isolation, or transportation needs when they lack resources and funding.
- *Interventions to Address SDOH Needs* – Some ACAP D-SNPs use vendor-developed web applications or their own databases of community services and supports within their care management models to help address SDOH needs. Plans also leverage

¹ Association for Community Affiliated Plans, “[Safety Net Health Plan Initiatives to Improve LGBTQI+ Health Equity](#),” 2021.

² Association for Community Affiliated Plans, “[ACAP Pathway to Improve Health Equity](#),” 2022.



external partners and community-based organizations to help to address members' needs.³

ACAP's D-SNP members also rapidly [ramped up efforts](#) in innovative ways to address their enrollees' SDOH needs that were exacerbated during the COVID-19 pandemic. To assess unmet needs, all ACAP plans that responded to CHCS' [Gap Analysis Survey](#) cited conducting enrollee outreach, often prioritizing high-risk enrollees. Unmet needs were also identified through enrollee interactions with care management staff or through referrals from community-based organizations and social service agencies.⁴

Before the pandemic, plans already faced difficulties in finding the right community vehicles to increase engagement with disengaged populations. These difficulties were worsened with the arrival of COVID-19, particularly as congregate and other in-home supports were no longer available or offered limited access. The pandemic also hindered access to safe transportation options, which are critically important to dually eligible individuals' ability to get to work, grocery stores, or other daily activities in addition to medical appointments.⁵ According to the Gap Analysis Survey, prior to the pandemic, plans report that their enrollees' greatest social risk factors were housing instability, food insecurity, and a lack of transportation. During the pandemic, food and social isolation were the areas of greatest need, followed by housing, basic supplies, and personal protective equipment.⁶

Plans stepped up quickly to address these needs and protect dually eligible beneficiaries. To combat food insecurity, plans described many initiatives, such as the development or expansion of emergency meal programs; the coordination and delivery of food/personal supplies from local food banks; the expansion of a [Fresh Food Farmacy](#) program; the creation of food pickup events; and the identification of community resources for food assistance.⁷

To advance the health equity of dually eligible individuals, ACAP plans also stepped up contracting efforts with CBOs to provide services to their enrollees and began using innovative platforms, such as [Unite Us](#) to create and track referrals. Another plan expanded connections to organizations such as United Way and its 2-1-1 program to help enrollees access support for emergency basic needs. Other plans signed new contracts with providers for

³ Association for Community Affiliated Plans, "[Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development](#)," 2020.

⁴ Center for Health Care Strategies, "[Addressing Social Needs Amid the COVID-19 Pandemic: A Survey of Dual Eligible Special Needs Plans](#)," 2021.

⁵ Association for Community Affiliated Plans, "[Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development](#)," 2020.

⁶ Center for Health Care Strategies, "[Addressing Social Needs Amid the COVID-19 Pandemic: A Survey of Dual Eligible Special Needs Plans](#)," 2021.

⁷ Center for Health Care Strategies, "[Addressing Social Needs Amid the COVID-19 Pandemic: A Survey of Dual Eligible Special Needs Plans](#)," 2021.



emergency meal service coordination and to help combat social isolation. Plans also cited delivering PPE and basic supplies to enrollees' homes and increasing outreach efforts to combat social isolation.⁸

During the pandemic, plans cited an inability to bear the sole responsibility of funding interventions that targeted member SDOH needs, so they identified ways to combine funding with other organizations. One plan invested in a community housing partner that can directly fund housing services, paying the organization a per-member-per-month fee to support plan members who met criteria for an unstable housing situation. Through this initiative, the plan improved the quality of life for their members, as evidenced by housing indicators (decreasing the length of time individuals were homeless, the time it takes to receive a housing voucher, etc.) and health-related outcomes (significant decreases in unplanned care, etc.).⁹

Other ACAP plans utilized alternative funding options in addition to the SSBCI pathway. They reported focusing on specific quality improvement activities, which are counted as medical or clinical expenses, to address SDOH needs exacerbated by the pandemic, or using administrative funds for individuals needing social supports. Administrative dollars can pay for care management and disease management activities that are not part of covered services.¹⁰

The SDOH Adjustment for Integrated D-SNPs

CMS is seeking feedback on how it can provide affordable quality health care for MA beneficiaries. We encourage CMS to consider adopting the [SDOH Adjustment](#) for Integrated D-SNPs as a pilot or demonstration program. The SDOH Adjustment is one of two proposed policy actions in ACAP's Incentivizing Dual-Eligible Alignment Act ([IDEAL Act](#)). Building upon Congress and CMS' foundational work, an adjustment factor for FIDE and HIDE SNPs would provide additional funds to be used to offer more SDOH services as supplemental benefits – non-medical food and nutrition benefits, housing supports, and programs to combat social isolation.

The SDOH Adjustment is:

- *Targeted* – Only fully integrated D-SNPs would be eligible (i.e., FIDE SNPs and HIDE SNPs)

⁸ Center for Health Care Strategies, "[Addressing Social Needs Amid the COVID-19 Pandemic: A Survey of Dual Eligible Special Needs Plans](#)," 2021.

⁹ Association for Community Affiliated Plans, "[Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development](#)," 2020.

¹⁰ Association for Community Affiliated Plans, "[Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development](#)," 2020.

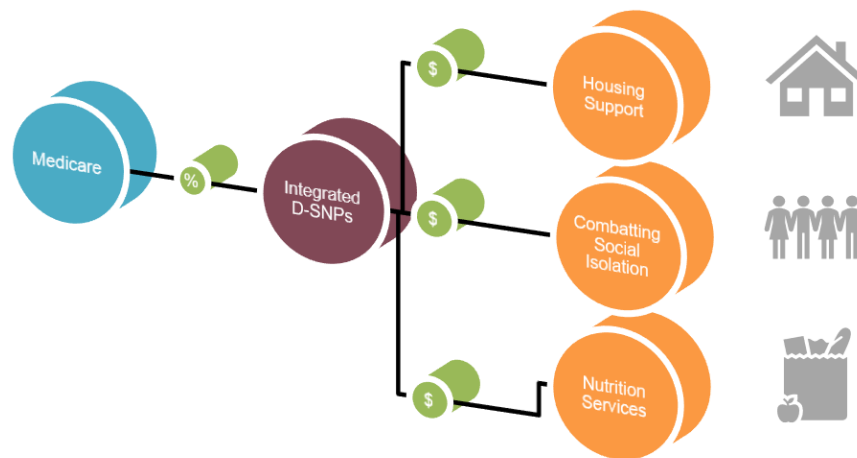


- *Predictable* – Gives integrated D-SNPs a predictable funding source for SDOH supplemental benefits through an SDOH adjustment to their rebate percentage
- *Direct* – The SDOH funds can only be used to fund SDOH supplemental benefits for dually eligible beneficiaries

Providing a Medicare SDOH adjustment for integrated D-SNPs that serve our most vulnerable dually eligible Medicare-Medicaid beneficiaries would provide direct support to these beneficiaries to improve their social determinant of health needs, improve their health security, and promote equitable, effective care.

ACAP estimates that a 5-percentage-point SDOH adjustment to the rebate would give integrated D-SNPs an additional \$10 per member per month (with an estimated cost of approximately \$190 million a year based on ACAP analysis)⁵ to use to fund SDOH supplemental benefits (as Special Supplemental Benefits for the Chronically Ill or non-primarily health-related supplemental benefits). Only a small percentage (less than 9 percent) of specialized MA plans that enroll dually eligible beneficiaries would receive this adjustment, as it targets HIDE- and FIDE-SNP plans.

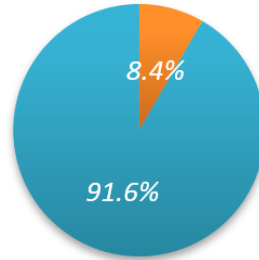
An SDOH Adjustment for integrated D-SNPs addresses CMS’ goals to advance health equity and expand access to care and should be piloted. With the finalization of the 2023 MA-PD proposed rule, plans will have to report spending on supplemental benefits to CMS in their MLR filings. However, piloting the SDOH Adjustment provides an even greater opportunity for a more thorough data collection and evaluation of the role of SDOH-related supplemental benefits on dual-eligible beneficiaries’ SDOH needs and health equity.¹¹



¹¹ Association for Community Affiliated Plans, “[ACAP’s Incentivizing Dual-Eligible Alignment \(IDEAL\) Act](#),” 2022.



The SDOH Adjustment targets a small percentage of specialized MA plans that only enroll dually eligible beneficiaries (HIDE- or FIDE-SNPs).



Only 8.4% of Medicare Advantage plans are HIDE- or FIDE-SNPs

Allowing HIDE SNPs to be Eligible for the Frailty Adjuster

To support the sustainability of HIDE SNPs and to promote expanded access to integrated care, ACAP suggests that CMS allow HIDE SNPs, in addition to FIDE SNPs, to be eligible for the frailty adjuster. According to regulations proposed in the 2023 MA-PD Proposed Rule, the difference between FIDE SNPs and HIDE SNPs will be predicated on which Medicaid benefits are carved in and on exclusively aligned enrollment, but not on underlying differences in enrollee demographics, dual eligible status, or levels of frailty. Payment accuracy should be a consistent principle across all integrated plans, and not a principle that only applies to PACE providers and FIDE SNPs. As such, CMS should allow HIDE SNPs to also be eligible for the frailty adjuster.

Star Ratings

ACAP is strongly supportive of CMS' exploration of stratifying Star Ratings measures by dual eligible status, LIS, and disability status, and the public reporting of this data. We agree with CMS that this policy will improve integration for FIDE SNPs and this policy is consistent with our long-standing ask for CMS to require MA plans to separately report Star Ratings for D-SNPs. We understand that the intent of this policy is to improve integration, rather than to address the impact of dual status on plans' Star Ratings. However, as CMS continues to evaluate the impact of D-SNPs having separate contracts, we encourage CMS to explore whether it is feasible to require plans to report Star Ratings measures at the PBP level. We also reiterate ACAP's long-standing ask that CMS modify the Star Ratings to adjust for between-contract differences between D-SNPs and non-SNP MA plans that are due to underlying population differences rather than actual differences in the quality of care provided by plans. Adjustment for between-contract differences is a way for CMS to address sustainability and access.

Importance of Medicaid Continuous Eligibility for Dually Eligible Beneficiaries

Dually eligible beneficiaries are at risk of losing their Medicaid coverage (known as churning) if they do not submit renewal paperwork on time or if they experience a change in eligibility due to a change in income or assets. Most dual-eligible beneficiaries churn because of missed renewal forms or other administrative barriers, causing them to erroneously lose



their Medicaid coverage, and therefore their access to Medicaid benefits and integrated care programs. One study found that 29.1% of *new* dual eligible beneficiaries lost coverage for at least 1 month during their first year of coverage, and 21.1% lost coverage for more than 3 months.¹² Providing continuous Medicaid eligibility for dually eligible beneficiaries for 12 months would allow these individuals to retain Medicaid eligibility for a full year, thus ensuring their access to and continuity of care are stable.

Making dually eligible beneficiaries continuously eligible for Medicaid for 12 months to combat churning is extremely important to their health outcomes. Many dual eligible beneficiaries have complex health and behavioral health needs and may utilize LTSS, but gaps in Medicaid coverage can cause needs to go unmet and can increase health needs down the line.¹³ Gaps in coverage can also create a financial strain for beneficiaries, who are already low-income, because they will incur the cost of Medicaid-covered services and will no longer have Medicaid assisting with their Medicare cost-sharing.¹⁴ Losing Medicaid coverage can disrupt continuity of care and can cause a beneficiary to fall off their integrated care plan (if they are enrolled in one) and lose access to that network.¹⁵

Moreover, continuous Medicaid eligibility can improve the health equity for all dually eligible individuals, including those that are persons of color. Forty-eight percent of dual-eligible beneficiaries are people of color, compared to 21.1% of Medicare-only beneficiaries.¹⁶ Non-White Medicaid beneficiaries are more likely to churn than White beneficiaries: in a 12-month period, 9.4% of Black beneficiaries and 8.4% of Hispanic beneficiaries lost and regained coverage, compared to 8% of White beneficiaries.¹⁷ Additionally, Black, Hispanic, and Indigenous individuals are more likely to live in poverty and to experience income volatility, leading to temporary fluctuations in income that can result in unjust churn.¹⁸ People of color are also more likely to experience unstable housing or employment situations, which can cause one to miss renewal forms or experience other administrative barriers to responding to requests from state Medicaid agencies.¹⁹ Providing continuous eligibility allows dual-eligible beneficiaries of color to have

¹² Jhamirah Howard, "[Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors and Implications](#)," *U.S. Department of Health and Human Services*, 2019.

¹³ Erin Weir Lakhmani, "[When The Public Health Emergency Ends: What Will It Mean For Dually Eligible Individuals?](#)," *Health Affairs*, 2022.

¹⁴ Erin Weir Lakhmani et al., "[Preventing and Addressing Unnecessary Medicaid Eligibility Churn Among Dually Eligible Individuals: Opportunities for States](#)," *Integrated Care Resource Center*, 2022.

¹⁵ Erin Weir Lakhmani, "[When The Public Health Emergency Ends: What Will It Mean For Dually Eligible Individuals?](#)," *Health Affairs*, 2022.

¹⁶ CMS Medicare-Medicaid Coordination Office, "[Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019](#)," 2020.

¹⁷ MACPAC, "[An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP](#)," 2021.

¹⁸ Tricia Brooks and Alexa Gardner, "[Continuous Coverage in Medicaid and CHIP](#)," *Georgetown University Health Policy Institute*, 2021.

¹⁹ Patricia Boozung and Adam Striar, "[The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage](#)," *State Health and Value Strategies*, 2021.



their health needs addressed, which can help reduce health disparities and advance health equity.²⁰ ACAP continues to work with Congress to pass legislation to guarantee 12-month continuous Medicaid eligibility. We will continue to inform CMS of our efforts on this legislative front.

We thank you for your time and attention. If you have any questions regarding the above comments, please do not hesitate to reach out to Christine Aguiar Lynch, Vice President of Medicare and MLTSS Policy (clynch@communityplans.net).

Sincerely,

/s/

Margaret A. Murray
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Association for Community Affiliated Plans

²⁰ Tricia Brooks, Allexa Gardner, "[Medicaid Continuous Eligibility Linked with Better Health, More Efficient Health Care Spending](#)," Georgetown University Health Policy Institute, 2021.