MEDICARE RIGHTS CENTER
Getting Medicare right

266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

June 28, 2021

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

RE: CMS-1752-P: RIN 0938-AU4

Dear Administrator Brooks-LaSure:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

While we address only a small percentage of the proposed rule, we are encouraged by the focus on equity and closing gaps in care and coverage. We are especially pleased at the proposal to ease access to compensation for providers who treat those who are dually enrolled in Medicare and Medicaid.

IX.B: Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information

Washington, DC Office:
1444 I Street NW, Suite 1105
Washington, DC 20005
202.637.0961

www.medicarerights.org www.medicareinteractive.org

The Medicare Rights Center strongly supports addressing health equity gaps, reducing disparities, and better serving all Medicare beneficiaries. To that end, we support efforts to stratify quality measures by race and ethnicity to better identify where those pernicious gaps remain and learn how interventions may, or may not, be working to close them.

In the absence of high-quality self-reported sociodemographic data, CMS proposes to develop an algorithm to indirectly estimate race and ethnicity to enable the stratification of quality measures until more accurate data sets become available. We have grave concerns with this proposal. Overlaying the sensitive and complex topics of race and ethnicity with algorithms that cannot, by their very nature, capture how people self-identify, may encode and exacerbate existing disparities rather than reveal them and allow them to be remedied. All algorithms are built on the assumptions of those doing the designing, making decisions based solely on algorithms suspect. While timely response to inequity and disparities is important, it cannot be at the expense of accuracy.

We also encourage CMS to include other demographic information that addresses heterogeneity within race and ethnicity including sub-groups for Asian, American Indian and Alaska Native, and Native Hawaiian and Other Pacific Islander beneficiaries, and beneficiaries who identify as two or more races. Additionally, in its efforts to achieve health equity, including LGBTQ identification, social, nutritional, and financial need, and mental health challenges.

X.A. Medicaid Enrollment of Medicare Providers and Suppliers for Purposes of Processing Claims for Cost-Sharing for Services Furnished to Dually Eligible Beneficiaries—Proposed Policy Changes

On our national helpline, we often hear from Medicare beneficiaries whose chosen providers encounter barriers when they seek compensation for the care or services they have delivered. This can result in confusion, improper billing of dually eligible beneficiaries, or even providers choosing to stop working with such beneficiaries at all, stranding people without access to their providers of choice or even the care they need.

CMS proposes to require, for purposes of determining Medicare cost-sharing obligations, all state Medicaid programs to accept enrollment of all Medicare-enrolled providers and suppliers who meet the federal Medicaid enrollment requirements and to process claims from such providers to determine the state's cost-sharing liability. This includes providers or suppliers of a type not currently recognized as eligible to enroll in state Medicaid programs. We strongly support this change and hope it will result in increased access to care and affordability for the dually eligible population.

We further appreciate CMS's encouragement for states to consider simplified enrollment forms for these providers. 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 and may lead both to less willingness to treat dually eligible individuals or improper and illegal attempts to get payment from the QMB individual.

We also urge CMS to work with Congress to eliminate the "lesser of" payment policy which leads to disparities in access to care by exacting a financial penalty every time providers serve dually eligible individuals.

CMS is also considering a policy that states must process claims for Medicare cost sharing without requiring that the claim meet the Medicaid State plan coverage and payment rules for that service. We would likely support such a policy to better reduce barriers to care for dually eligible beneficiaries.

Conclusion

Thank you again for this opportunity to provide comment. For further information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi
President
Medicare Rights Center