ltqa
LONG-TERM
QUALITY ALLIANCE

ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

August 31, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4203-NC
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure:

Long-Term Quality Alliance (LTQA) and ATI Advisory ("ATI") appreciate the opportunity to provide input on CMS' Request for Information (RFI) on the Medicare Advantage (MA) program, published in the Federal Register on August 1, 2022.[1]

- LTQA is a 501(c)3 membership organization aimed at improving outcomes and quality of life for persons with functional limitations, and their families.[2] LTQA advances person- and family-centered, integrated long-term services and supports (LTSS) through research, education, and advocacy.
- ATI is a research and consulting firm that works to transform healthcare delivery systems, aligning financial incentives with care models that deliver flexible, individualized care to populations with complex needs. We provide insight backed by original research and deliver practical solutions for our clients and the families they serve. We work across diverse sectors and stakeholders to identify and foster partnerships, create shared solutions, and move ideas into action. ATI is backed by a team of nationally recognized experts and experienced analysts.

Beginning in 2019, with funding support from The SCAN Foundation, LTQA and ATI Advisory have conducted a multi-year study tracking the industry's progress over time on the implementation of non-medical supplemental benefits in Medicare Advantage (MA), including both non-medical benefits under the expanded definition of "primarily health-related benefits" (PHRB)[3] as well as Special Supplemental

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[1] Medicare Program; Request for Information on Medicare. 87 Fed. Reg. 46918. August 1, 2022. Available at: https://www.govinfo.gov/content/pkg/FR-2022-08-01/pdf/2022-16463.pdf

[2] See full list of LTQA members on our website.

[3] In 2018, CMS expanded the definition of what was considered "primarily health-related" to include services that diagnose, prevent, or treat an illness or injury; compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare

Benefits for the Chronically Ill (SSBCI). Over the past several years, LTQA and ATI Advisory have analyzed MA Plan Benefit Package (PBP) data annually and interviewed over 30 organizations, including MA plans, providers, consumer advocacy groups, policy experts, researchers, and other stakeholder groups, culminating in multiple reports and data briefs on the progress of plans and providers in implementing these benefits over time.[4] Based on these findings, ATI and LTQA put together a roadmap for plans and providers to guide the delivery of non-medical benefits, followed by a progress report on the state of implementation of the benefits across the field.[5]

In addition to our reports describing the landscape of non-medical benefits in MA, LTQA and ATI Advisory have also developed several reports with policy recommendations to advance the uptake and utilization of these benefits. Based on our research in the Fall of 2020 (the second year of availability for expanded PHRB and first year for SSBCI), we released a report with considerations and opportunities for policymakers. This was followed by a set of policy recommendations for CMS in Fall 2021, and a set of recommendations for Congress in Spring 2022, based on our updated field research one year later.

LTQA and ATI appreciate CMS' efforts to explore how to better support MA beneficiaries with serious, chronic conditions and functional needs and advance equity through this RFI. LTQA and ATI's comments on this RFI draw from our extensive research on non-medical supplemental benefits as well as our engagements with a working group comprised of national experts on MA and LTSS, which provides ongoing guidance on our research.[6]

As MA enrollment approaches half of the Medicare beneficiary population, and MA continues to be the locus of innovation within Medicare, this RFI represents a tremendous opportunity to set a path forward for the Medicare program that promotes health equity and person-centered care. Now is a critical time to set this path given the increasing number of Americans eligible for Medicare, the increasing enrollment in MA, and the growing prevalence of complex care needs as the baby boomer generation enters their eighties this decade.

Supplemental benefits are a key differentiator between Traditional FFS and MA and an important tool for plans to address the whole-person needs of their beneficiaries. These benefits are an opportunity for plans to leverage limited rebate dollars to design tailored benefits that will attract/retain members, improve their care experience, and provide non-medical supports to maintain or improve the overall health and well-being of their members. Given our collaborative focus on non-medical benefits over the last several years, our responses here are focused on those benefits and how CMS can increase beneficiary understanding of and access to these promising benefits, while also developing a framework and structure for tracking and evaluating these benefits. To that end, we recommend that CMS:

- Provide guidance that clarifies eligibility for non-medical benefits under SSBCI authority, specifically for those individuals with functional need;

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utilization. This authority allowed plans to offer a broader set of supplemental benefits, starting in Plan Year 2019, as "primarily health-related," including services like In-Home Support Services and Caregiver Supports.

[4] See our project website for our research and resources for plans, providers, and policymakers to advance the availability and implementation of non-medical supplemental benefits in Medicare Advantage.

[5] The roadmap and progress report outline key considerations related to the offering and delivery of non-medical benefits.

[6] See full list of working group participants here.

- Launch a robust evaluation of non-medical benefits, beginning with the collection of utilization data for these benefits, to investigate who receives these benefits and the impact of these benefits;
- Improve the information on non-medical benefits available to beneficiaries and those who support them (ranging from caregivers to State Health Insurance Assistance Programs) for improved understanding and plan navigation experiences; and
- Ensure flexibility for plans and states to work together to allow for streamlined delivery of non-medical benefits, particularly for the dually eligible population.

Our specific responses are outlined below.

A. Advance Health Equity

A.1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- ***Enrollees from racial and ethnic minority groups.***
- ***Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.***
- ***Enrollees who identify as transgender, nonbinary, or another gender identity.***
- ***Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.***
- ***Enrollees with diverse cultural or religious beliefs and practices.***
- ***Enrollees of disadvantaged socioeconomic status.***
- ***Enrollees with limited English proficiency or other communication needs.***
- ***Enrollees who live in rural or other underserved communities***

Non-medical supplemental benefits provide Medicare Advantage (MA) plans with unprecedented flexibility to address the broader social and economic needs that impact the health and well-being of Medicare beneficiaries with complex needs. Given the type of services and supports that can be covered and the ability to target them based on individual need, non-medical supplemental benefits are a critical tool for advancing health equity, if CMS is intentional about building upon this promising framework. Through our research, LTQA and ATI have identified the following opportunities for CMS to improve the ability of plans to leverage non-medical supplemental benefits to advance health equity for the sub-populations identified:

1. Provide guidance clarifying that beneficiaries with functional need meet the eligibility criteria for SSBCI.
2. Provide additional flexibilities to give plans the ability to address the social needs for which standardized data collection will be required, starting in 2024.

These two opportunities are described in further detail in our Spring 2022 Policy Report to Congress as well as below.

1. Provide guidance clarifying that beneficiaries with functional need meet the eligibility criteria for SSBCI.

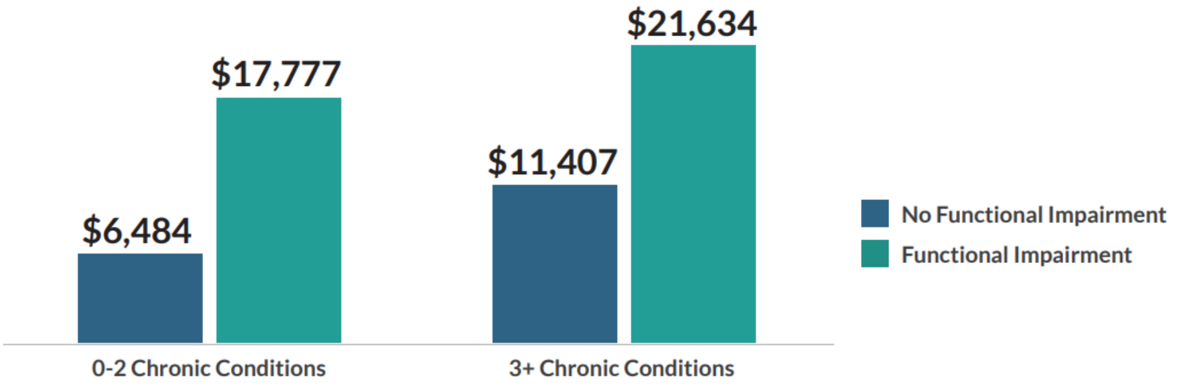
With respect to SSBCI, the *CHRONIC Care Act* defined a chronically ill Medicare beneficiary as someone who:

> 1) Has one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit overall health or function;
>
> 2) Has a high risk of hospitalization or other adverse health outcomes; and
>
> 3) Requires intensive care coordination.

The current eligibility criteria do not fully capture all determinants that are vital to health, such as functional needs and SDOH needs. The goal of SSBCI eligibility criteria should be to maximize the potential value of the services in a person-centered way. Expanding the aperture of SSBCI eligibility criteria to include a more holistic view of health and function would aid plans in more meaningfully targeting these benefits to advance health equity.

CMS should specify that functional needs meet the eligibility criteria for SSBCI to enhance plans' ability to target meaningful benefits to people who need them. It is our assessment that functional need/frailty and cognitive need represents the largest opportunity for improving care for Medicare beneficiaries, especially with the growing aging population with longer life expectancies. Based on an ATI analysis of Medicare survey and claims data, Medicare beneficiaries with multiple chronic conditions (i.e., limited to clinical diagnoses) and functional impairment are nearly twice as expensive to Medicare than individuals who have multiple chronic conditions but no functional impairment (**Figure 1**).

Figure 1: Per Capita Medicare Spending, 2019



Note: Data are limited to fee-for-service Medicare beneficiaries living in the community. Chronic condition data will be based on self-reported data.
Source: ATI Advisory analysis of 2019 Medicare Current Beneficiary Survey.

Specifying that the definition of chronic condition includes those with functional need/frailty and cognitive need would capture those Medicare beneficiaries with high functional needs and would therefore maximize the potential of these benefits to impact spending for the highest-cost Medicare beneficiaries.

Given that Congress did not define any of the criteria in statute, there is an opportunity for CMS to specify that functional need/frailty and cognitive need are included in the first "chronic condition" criterion. From their inception, SSBCI were intended to improve or maintain Medicare beneficiaries' health or overall function. Specifying that the "chronic condition" criterion for SSBCI eligibility includes functional need / frailty and cognitive need will provide plans with clearer direction around the target population for these benefits.

In the absence of an explicit definition from Congress, CMS initially defined "chronic condition" for purposes of SSBCI eligibility to be consistent with existing CMS policy toward eligibility for Chronic Condition Special Needs Plan (C-SNP) enrollment, which included a set list of 15 qualifying conditions.[7,8] However, in subsequent guidance effective PY 2021, CMS introduced broad flexibility for plans to identify conditions outside of the initial list, acknowledging CMS' intent to allow plans the flexibility to address conditions and needs within their unique plan populations.[9] In the same guidance document, CMS also noted that two of the existing eligibility criteria "refer to the function of the enrollee, so [CMS believes] it is sufficiently clear that this is something that can be considered when determining if an enrollee is a chronically ill enrollee."[10] However, neither the *CHRONIC Care Act* nor CMS guidance clearly specifies that functional need/ frailty and cognitive need are included in the definition of "chronic conditions" for purposes of SSBCI eligibility determination.

For statutory precedent, Congress has previously specified that "chronically ill" individuals include those with functional and cognitive needs. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 defines a chronically ill individual as any individual who has been certified by a licensed healthcare practitioner as one of the following:

1) Being **unable to perform (without substantial assistance from another individual) at least 2 activities of daily living** for a period of at least 90 days due to loss of functional capacity;
2) Having a **level of disability** similar (as determined under regulations prescribed by the Secretary) to the level of disability described in clause 1; or
3) Requiring substantial supervision to protect such individual from threats to health and safety due to **severe cognitive impairment.**[11]

Additionally, the Centers for Disease Control and Prevention (CDC) defines chronic disease as "conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both."[12] Most recently, in the Calendar Year (CY) 2023 Requests for Applications for the Value-Based Insurance Design (VBID) demonstration, CMMI specifies that frailty indicators (e.g., Claims-Based Frailty Index) can be used to identify enrollees with a chronic health condition.[13]

Using these definitions of chronic condition for purposes of SSBCI eligibility would broaden the population of high-risk Medicare beneficiaries who can benefit from SSBCI and enable a more person-centered approach in targeted SSBCI.

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[7] The Centers for Medicare and Medicaid Services Guidance. (April 2019). https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

[8] The Centers for Medicare and Medicaid Services. "Chronic Condition Special Needs Plans (C-SNPs)." https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/C-SNPs

[9] The Centers for Medicare and Medicaid Services 2021 Final Rule. (June 2020). https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

[10] Ibid.

[11] U.S. Code § 7702B - Treatment of qualified long-term care insurance. https://www.law.cornell.edu/uscode/text/26/7702B

[12] The Centers for Disease Control and Prevention. "About Chronic Diseases." https://www.cdc.gov/chronicdisease/about/index.htm

[13] CMS Innovation Center Calendar Year 2023 VBID Request for Applications. (2022). https://innovation.cms.gov/media/document/cy-2023-vbid-rfa

Considerations: Using functional and cognitive need as targeting criteria for SSBCI may be challenging for MA plans to operationalize due to lack of standardized data on functional need for Medicare beneficiaries. Currently, Health Risk Assessments (HRAs) may capture functional data but there are no consistent standards for how these are captured across plans. Additionally, only Special Needs Plans (SNPs) are required to conduct an HRA. In its Updated Policy Roadmap on Caring for Those with Complex Needs (March 2022), the Bipartisan Policy Center recommends that Congress "direct the HHS Secretary to develop a uniform functional assessment tool", which would help to facilitate the collection of standardized data on functional need.

2. **Provide additional flexibilities to give plans the ability to address the social needs for which standardized data collection will be required, starting in 2024.**

Recognizing the important role that HRSNs—such as food insecurity, housing instability, and lack of transportation—play in whole-person health, SSBCI would also benefit individuals with HRSN in the absence of a chronic condition. Current eligibility criteria prohibit social determinants of health (SDOH) from being used as a primary targeting criterion for SSBCI.[14]

On the other hand, under VBID, plans can test different eligibility criteria such as Medicare Part D low-income subsidy (LIS) status or dual-eligibility status for specific supplemental benefits.[15] Notably, there has been substantial growth in the number of MA plans opting to offer supplemental benefits through the VBID demonstration. MAOs noted that VBID is attractive due to its option to target benefits based on qualification of LIS status, which is not possible under expanded PHRB or SSBCI authorities. However, it does not appear that VBID allows plans to target benefits according to functional need.[16]

In its 2023 Medicare Advantage and Part D Final Rule, CMS finalized a provision that, starting in 2024, requires all Special Needs Plans (SNPs) to include in their Health Risk Assessment (HRA) one or more questions on the topics of housing stability, food security, and access to transportation. While SNPs will not be accountable for resolving all risks identified in the assessment questions, SNPs will be required to incorporate the results of the HRAs into individualized care plans and consult with enrollees about their unmet social needs. This may include taking steps to maximize access to supplemental benefits that help address these issues.

LTQA and ATI are pleased to see CMS moving in this direction to capture information on Social Determinants of Health (SDOH) that reflect a more holistic view of a Medicare beneficiary's health and needs. These standardized data will help SNPs to identify members' social needs and connect them to supplemental benefits to address those needs, if the member is deemed eligible. These data also have the potential to inform supplemental benefit design and could be useful for incorporating social risk factors into risk adjustment in the future.

However, when this provision goes into effect, SNPs will collect actionable information on SDOH but lack authority to address the issues that are identified. Under current statutory authority, SDOH cannot be used as primary targeting criteria for SSBCI eligibility, merely as secondary criteria when the three-part eligibility criteria have been met. LTQA and ATI encourage CMS to provide additional flexibilities to give

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[14] The Centers for Medicare and Medicaid Services Guidance. (April 2019). https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

[15] The Centers for Disease Control and Prevention. "About Chronic Diseases." https://www.cdc.gov/chronicdisease/about/index.htm

[16] The Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. "Value-Based Insurance Design Model Request for Applications for Calendar Year 2022." https://innovation.cms.gov/media/document/cy-2022-vbid-rfa-final

plans the ability to address the social needs for which standardized data collection is required in the final rule. **CMS can consider two opportunities to test and expand eligibility criteria to address SDOH needs in VBID before expanding them to SSBCI.**

1) **Short-term:** CMMI could consider using demonstration authority to add to the VBID demonstration new eligibility categories, such as other indicators of SDOH need outside of LIS status. This would allow plans to test and collect evidence on these new targeting criteria before potentially expanding them to SSBCI. Further eligibility expansion for SSBCI may require congressional action.
2) **Long-term:** CMS could consider using evidence from VBID to expand SSBCI eligibility criteria to include LIS eligibility through CMMI authority, if the evidence base is sufficient and the Office of the Chief Actuary approves such a change. As previously mentioned, VBID allows plans to target benefits using LIS status and dual-eligibility status; CMS could consider expanding SSBCI criteria to include these as well. This would allow plans to leverage existing structures for determining need based on income as a proxy for other HRSNs. In particular, there is an opportunity to target partial duals and pre-duals who are near the income threshold for qualifying for Medicaid benefits but do not yet receive services and try to prevent spenddown into Medicaid eligibility

Below are several considerations for CMS with regards to expanding VBID and SSBCI criteria to include HRSNs:

- **HRSNs are broad and far-ranging.** This makes it difficult to define which HRSNs should qualify and how to measure severity of need for purposes of determining a threshold and standardizing eligibility across plans. Stakeholders may disagree on which HRSNs should be addressed using public dollars dedicated for healthcare and whether risk is enough basis for eligibility or whether the need must be present and documented.
- **Plans currently do not capture HRSN data consistently for all MA members.** Some plans are currently collecting these data for their members, but this is not currently required. Without baseline data on a member's HRSNs, plans are unable to determine eligibility consistently and to provide denominators for the population eligible for the benefits. However, some plans have access to predictive modeling based on the information they do have (e.g., zip code) that they can use to estimate probability of social risk until they can conduct a direct member screen. Furthermore, work is underway at CMS to develop standardized survey questions for collecting HRSN information, including through the CMMI Accountable Health Communities Model.

A.2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

In addition to the opportunities to advance health equity via clarification and expansion of eligibility criteria for non-medical supplemental benefits described above, as benefit offerings grow, it is critical for CMS to **facilitate the collection of benefit utilization data from plans in order for policymakers to track progress of implementation and evolve regulations accordingly to address equity issues.** Utilization data are necessary to evaluate the impact of these new supplemental benefits over time, including who is accessing these benefits and how often. Since the new authority to offer SSBCI was introduced, we only have a line of sight into plan offerings, but no quantitative data to demonstrate whether the benefits are actually being delivered to Medicare beneficiaries. Without information on beneficiary uptake of these SSBCI, it is not possible to assess—even on the most basic level—whether these benefits are having the intended impacts on beneficiaries. Additionally, lack of data impedes assessment of whether benefits are being delivered equitably to individuals of diverse backgrounds (e.g., gender, race, ethnicity, language, geography, disability).

As such, LTQA and ATI recommend that CMS develop incentives for plans to submit data on utilization for all supplemental benefits, including key demographic information, to support efforts to measure and ensure equitable access to these benefits.

In our research, we have continually emphasized how the lack of data on utilization of non-medical supplemental benefits impedes the research and policymaking community from understanding who is accessing these benefits and how often – the first step to advancing health equity is to measure existing disparities and identify potential underlying causes. MA plans are not currently required to submit encounter data or any form of utilization data for any supplemental benefits (e.g., dental, vision, hearing, fitness).

In the CY 2023 MAPD Final Rule, CMS is requiring MA plans to report expenditure data by supplemental benefit category for Medical Loss Ratio (MLR) reporting.[17] The specific list of supplemental benefit categories for which MA plans will be required to report expenditures separately is yet to be finalized in a revised package, which will be updated annually and made available for public comment. Notably, CMS clearly signaled its intent to include "Non-Primarily Health-Related SSBCI" as one of the supplemental benefit categories that require expenditure reporting. This will help CMS assess the impact of its policy change that allowed these services to be included in the MLR numerator as of 2021. In future years, CMS may consider adding individual SSBCI to the list of supplemental benefit categories for which expenditure reporting is required. This new reporting requirement will allow for increased line of sight into how much plans are spending on SSBCI; however, the reporting will not provide information on who is receiving these benefits, which benefits, and at what frequency.

Given the current void in SSBCI utilization data reporting, CMS should develop a mechanism for appropriate reporting of supplemental benefit utilization at the beneficiary-level. Beneficiary-level data will allow CMS and researchers to connect these data on SSBCI utilization to members' demographic data and encounter data for other healthcare services. There are two existing reporting mechanisms for MAOs to submit data on supplemental benefit utilization; however, neither mechanism is required for SSBCI currently. CMS could consider leveraging the existing reporting mechanisms outlined below:

- **Encounter data reporting** – All MA plans are already reporting encounter data for other items and services outside of supplemental benefits. This option aligns with the Medicare Payment Advisory Commission (MedPAC)'s recommendation to ensure the completeness and accuracy of encounter data.[18]
    - *Consideration:* Further work may be needed to establish standardized encounter reporting mechanisms for these new benefits (e.g., diagnosis and procedure codes for SSBCI and related needs). In addition, non-traditional providers, especially smaller providers and community-based organizations, may lack capacity and systems to generate encounter data records at this time.

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[17] The Centers for Medicare and Medicaid Services 2023 Final Rule. (May 2022). https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf

[18] MedPAC March 2022 Report to the Congress. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf

- **VBID demonstration reporting** -- MAOs participating in VBID are required to submit to CMMI quarterly reports with beneficiary-level data on whether an enrollee has been targeted (or is eligible to receive) and whether they received the VBID Flexibility being offered (e.g., reduced cost-sharing, additional supplemental benefits, etc.). Data are reported at the benefit-level or combination package where applicable (e.g., flexible benefit package). This is a promising approach given that MAOs participating in VBID are already collecting these data on supplemental benefit utilization. This approach is less granular and more flexible than encounter data reporting (i.e., does not involve providers to generate a standard encounter data report).

Any reporting requirements should be applied consistently across all supplemental benefits to avoid differential treatment of SSBCI that may cause plans to stop offering these optional benefits. There also should be a clear process and stakeholder input for developing the reporting mechanisms and infrastructure (e.g., developing thoughtful standardized reporting elements). Policymakers should continue to monitor the utility of the data being reported through the existing mechanisms and identify any challenges plans and providers would face in applying a similar reporting framework to SSBCI, including through input from stakeholders.

Furthermore, any changes to reporting requirements should be incremental and coupled with guardrails and incentives to promote plan buy-in. Overall, in addition to not revealing beneficiary-identifiable data, it is critical that any publicly reported data not inadvertently reveal competitive information regarding MA plan benefit design or details about provider contracts and rates. MA plans may be more willing to share data provided appropriate guardrails are put in place and policymakers are clear on how the data will be used and shared. We have identified several potential approaches to increase reporting of data on SSBCI utilization:

- **Impose mandatory reporting –** CMS could require plans to report data as a condition of offering supplemental benefits. Importantly, if implemented, this requirement must be standardized across all supplemental benefits.
- **Provide payment incentives in initial years –** CMS could also consider an incremental approach to data reporting requirements, including potential financial incentives. New reporting requirements will require plans to invest additional resources into staffing and/or system changes. Providing a pay-for-reporting bonus can help to mitigate increased costs and burden in the first several years. If reporting requirements are too burdensome or imposed too quickly without additional payment incentives, it may negatively impact the number of plans offering SSBCI.
- **Create a learning collaborative –** CMS could create a learning collaborative to collect and aggregate SSBCI data from MA plans. No individual MA plan's data would be published, but plans would receive a regular report benchmarking their individual plan's data against the aggregated data of all participating companies. In addition to promoting continuous learning and improvement for plans, this approach would outsource the analysis of data to a central entity rather than requiring plans to develop internal systems for reporting and analysis, but its success would depend on the number of plans participating.

Considerations:

- Reporting utilization data should also be coupled with an understanding of the various factors outside of an MA plan's control that may impact utilization. For example, there may be low uptake of some SSBCI in early years due to challenges associated with early implementation and the COVID-19 pandemic.

- Plans face challenges with collecting demographic data, which would impede their ability to disaggregate utilization data by demographic group. While some plans collect demographic data like age, zip code, and LIS eligibility right now, race and ethnicity data are not collected consistently. Researchers may be able to overcome some of these challenges by linking encounter data to the Medicare Beneficiary Summary File.
- Policymakers should also balance the risk that adding reporting requirements may deter plans from offering these benefits altogether.

A.3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

LTQA and ATI are pleased to see CMS considering scaling approaches to improve screening and documenting SDOH needs that reflect a more holistic view of a Medicare beneficiary's health and needs. However, these approaches must be coupled with the accompanying authorities for MA plans to address the needs that are identified. As mentioned in our response to A.1., under current statutory authority, SDOH cannot be used as primary targeting criteria for SSBCI eligibility, merely as secondary criteria when the three-part eligibility criteria have been met. If CMS moves in the direction of promoting/requiring screening and documentation of SDOH needs, **we urge CMS to provide additional flexibilities to give plans the ability to address the social needs for which standardized data collection will be required through SSBCI.**

That being said, CMS can consider several options for driving innovation and accountability to enable SDOH-informed health care in MA:

1. Build upon the new HRA requirement for SNPs to screen for certain SDOH needs by encouraging all MA plans to use HRAs as an opportunity to collect usable data on SDOH needs, provide information to members with SDOH needs about plan benefits that can help to address identified needs, and target SSBCI.
2. Promote the use of ICD-10 Z-codes among providers (including any member of a person's care team) to identify social needs through additional and broader training efforts, guidance on referrals to social services, and possible financial incentives. Consider leveraging plans to assist with this effort, including encouraging or incentivizing plans to provide incentives to providers for using ICD-10 Z-codes.
3. Convene a workgroup, in collaboration with the U.S. Administration for Community Living (ACL), to develop guidance around braiding of MA plan funding with other sources of funding, such as the *Older Americans Act (OAA)* funds, to address SDOH.

Each of these options are described in further detail below:

1. **Build upon the new HRA requirement for SNPs to screen for certain SDOH needs by encouraging all MA plans to use HRAs as an opportunity to collect usable data on SDOH needs, provide**

information to members with SDOH needs about plan benefits that can help to address identified needs, and target SSBCI.

In its 2023 Medicare Advantage and Part D Final Rule, CMS finalized a provision that, starting in 2024, requires all SNPs to include in their Health Risk Assessment (HRA) one or more questions, selected from a list of CMS-approved questions, on the topics of housing stability, food security, and access to transportation. While SNPs will not be accountable for resolving all risks identified in the assessment questions, SNPs will be required to incorporate the results of the HRAs into individualized care plans and consult with enrollees about their unmet social needs. This may include taking steps to maximize access to supplemental benefits that help address these issues. These data will help SNPs to identify members' social needs and connect them to supplemental benefits to address those needs, if the member is deemed eligible. These data also have the potential to inform supplemental benefit design.

While HRAs are a powerful tool for collecting SDOH data, currently, only SNPs are required to conduct an HRA. LTQA and ATI Advisory encourage CMS to consider encouraging all MA plans to use HRAs to collect usable data on their members' SDOH needs. This data collection effort should be accompanied by taking action on the data on identified needs to provide information to members on plan benefits that are available to them to address their needs, as well as to target SSBCI (both under current authority and potentially expanded authority to include certain HRSNs as a primary targeting criterion). A recent study by researchers at Humana Healthcare Research and Harvard University found that roughly half of MA beneficiaries reported at least 1 health-related social need (HRSN), and the majority of MA beneficiaries with HRSNs were neither dually-eligible nor disabled.[19] This underscores the need to identify and address HRSNs in the broader Medicare program, not only among specific groups of high-need patients. Expanding the HRA requirement to all MA plans, and allowing SDOH to qualify as a primary targeting criteria for SSBCI eligibility, would equip plans with the information and authority they need to do this.

2. **Promote the use of ICD-10 Z-codes among providers (including any member of a person's care team) to identify social needs through additional and broader training efforts, guidance on referrals to social services, and possible financial incentives.**

Given that plans that offer non-medical benefits may attract beneficiaries with higher costs, it is important to collect person-level data regarding social needs and functional limitations that are likely associated with these beneficiaries. The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, first implemented in 2015, present an opportunity to capture standardized data on SDOH through Z-codes. Z-codes are a subset of ICD-10-CM codes, used as reason codes to capture "factors that influence health status and contact with health services." However, in 2019, only approximately 1.59% of Medicare FFS beneficiaries had claims with Z-codes due to low provider uptake. Increasing the use of Z-codes can help pave the way to provide standardized data on SDOH for risk adjustment in the future. Other workgroups and efforts are also underway to study incorporating functional limitations and social risk factors into risk adjustment and the impact of Z-codes on risk adjustment.

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[19] Canterberry, M., et al. (July 8, 2022). Association Between Self-reported Health-Related Social Needs and Acute Care Utilization Among Older Adults Enrolled in Medicare Advantage. *JAMA Health Forum, 3*(7), e221874. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2794134

3. **Convene a workgroup, in collaboration with the U.S. Administration for Community Living (ACL), to develop guidance around braiding of MA plan funding with other sources of funding, such as the *Older Americans Act (OAA)* funds, to address SDOH.**

Supports for older adults and people with disabilities are fragmented across federal and state benefit structures and multiple funding streams. There is an opportunity for greater coordination and shared visioning among multiple agencies. CMS should consider partnering with ACL to explore opportunities for braiding of MA plan funding with other sources of funding, such as the *Older Americans Act (OAA)* funds, to address SDOH, and to identify the current perceived and actual barriers to doing so.

Further, there is an opportunity to leverage CBOs to assist with screening, documentation, and delivery of services to help address SDOH needs. CMS should also partner with ACL to develop resources and provide technical assistance for plans to contract with CBOs, possibly through a learning collaborative. *This is discussed in further detail in our response to A.6. below and Section E as relates to CBO contracting and partnership.*

A.6. For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.

According to the Aging and Disability Business Institute's 2021 survey on contracting between CBOs and health care entities, **44%** of responding CBOs were contracting with one or more health care entities. However, only **17%** indicated they had contracts with MA plans, and even fewer are contracting for SSBCI specifically. In general, it may be challenging to identify CBOs contracting for SSBCI because the CBO may not be aware of the specific authority under which they are contracting services, but in our research, LTQA and ATI Advisory also had difficulty identifying CBOs contracting with MA plans to provide SSBCI.

Given that CBOs understand how to serve complex beneficiaries and their non-medical needs, LTQA and ATI Advisory fully recognize the value CBOs bring to this space and support more partnerships between CBOs and MA plans in delivering these new benefits. Many CBOs have a proven track record of delivering services that could easily fit under these new authorities. These authorities provide an avenue for CBOs to diversify financing and to open the door to other contracts with MA plans.

While MAOs indicated a strong desire to work with CBOs, CBOs face several challenges to pursuing this opportunity. Some of these challenges include difficulties with competitive pricing, meeting service area expectations, and achieving economies of scale relative to non-CBO providers. In developing their infrastructure and setting up pricing, volume is important to make the financial investment worthwhile. CBOs may not have the margin to afford taking a loss leader compared to the private, venture capital (VC)-supported companies that have proliferated in this space.

Despite these challenges, partnerships between MA plans and CBOs can offer high value in MA. CBOs have close, extensive ties with their communities and are regarded as trusted providers who can most authentically appreciate the needs of their members. While it may be difficult for an individual CBO to contract with an MA plan, plans can consider exploring Aggregators or Network Lead Entities to form these partnerships. These entities can help package multiple services together in a contract to achieve higher volume. For clarity, descriptions of these two approaches are included below (**Table 1**).

- **The Role of Aggregator** – Aggregator companies play an important role in the delivery of supplemental benefits by reducing the administrative burden to plans having to form multiple contracts. By aggregating providers, these companies allow smaller providers or providers with limited resources to enter this space. See the table below for more on these aggregators.
- **The Role of Network Lead Entities (NLEs)** – While the aggregator platforms have the capacity to recruit CBOs into their networks, community-led initiatives like Network Lead Entities (NLEs) have enhanced opportunity to pool CBOs together and effectively bring CBOs into the MA supplemental benefits space. NLEs are most effective by lifting barriers and serving as a translator to both plans and providers. For CBO providers, NLEs can meet the administrative demands necessary to contract with MA plans. For plans, NLEs can comprehensively characterize the value of community-based services and, with a network of CBOs, meet plan needs. Contracting with NLEs allows plans to fulfill their desire to work with CBOs. See the table below for more on NLEs.

Table 1: Working with Solutions to Aggregate Services

The Benefits	The Challenges	The Opportunity
• Offer providers, especially smaller companies, an enhanced opportunity for greater volume or referrals • Alleviate the administrative burden of MA plan contracts by either assisting with, or directly fulfilling, administrative requirements (e.g., credentialing, technology and IT requirements) • Allow plans a single contract for their entire service area • Offer a single, streamlined point of contact for suite of services • Aggregators may be better positioned to negotiate prices given their existing relationship with the plan and ability to offer a suite of services	• Providers do not necessarily have the opportunity to build relationship with plans • Aggregator platforms charge plans a fee for their services, which may somewhat impact available funds for service network providers • Providers must rely on vendor/ technology to communicate value	• For aggregator platforms: Allow fulfillment of person-centered services through an aggregated system for both CBOs and for profit entities • For NLEs: Facilitate a means for CBOs to attain contracts with MA plans to deliver these services

To address some of the barriers faced by CBOs in contracting with MA plans and other health care entities, building upon work initiated by ACL, a multi-stakeholder workgroup (Partnership to Align Social Care) is developing scalable plans to align social services with health care. This effort emphasizes the need to support CBO network contracts with health plans and systems to deliver services that meet the social needs of Medicare and Medicaid beneficiaries. In our research, LTQA and ATI Advisory highlighted the work of the Western New York Integrated Care Collaborative (WNYICC), a CBO network that has successfully contracted with MA plans to deliver SSBCI. While the contracts are in their early stages of implementation, WNYICC included a provision in the contract that they must receive outcome data from the health plans once available.

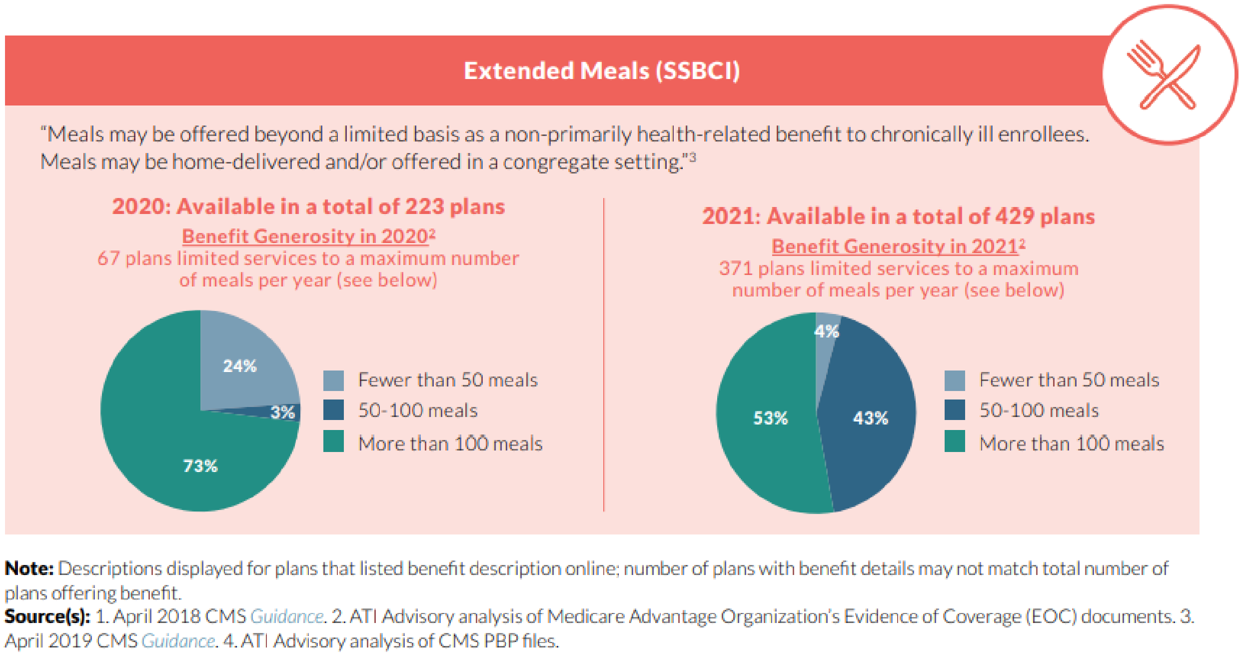
Another challenge CBOs are encountering is the emerging role of social care referral platforms. Regardless of whether plans form contracts with CBOs, the rise of social care referral platforms increases demand for these services, often without additional financing. Plans often contract with companies that aggregate providers on their platforms to facilitate referrals from plans. These referrals are typically being made without accompanying payment; however, several initial pilots to test incorporating payment are currently underway. CBOs also face challenges with duplication due to the lack of interoperability of these new referral platforms with their existing systems.

Supports for older adults and people with disabilities are fragmented across federal and state benefit structures and multiple funding streams. There is an opportunity for greater coordination and shared visioning among multiple agencies. CMS should consider partnering with ACL to explore opportunities for braiding of MA plan funding with other sources of funding, such as the *Older Americans Act (OAA)* funds, to address SDOH. CMS should also partner with ACL to develop resources and provide technical assistance for plans to contract with CBOs, possibly through a learning collaborative.

A.7. What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically-tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.

Benefits designed to help meet beneficiaries' nutritional needs, including Food and Produce and Meals (beyond limited basis), are the most popular SSBCI offerings in 2022. Food and Produce is defined as "food and produce used to assist chronically ill enrollees in meeting nutritional needs. Plans may include items such as (but not limited to) produce, frozen foods, and canned goods. Tobacco and alcohol are not permitted" and Meals (beyond limited basis) "may be offered beyond a limited basis as a non-primarily health related benefit to chronically ill enrollees. Meals may be home delivered and/or offered in a congregate setting". Based on internal ATI research, between 2020 and 2022, the number of plans with Food and Produce benefits grew from 101 to 763 (14% of all MA plans), with 13% of all MA enrollees (2.93 million) enrolled in 2022 plans offering this benefit. At the same time, Meals (beyond limited basis) has grown from 71 plans to 403 (7% of all MA plans), with 8% of all MA enrollees (1.99 million) enrolled in 2022 plans offering this benefit.

Under these benefits, plan offerings range from twice-daily meals for 7 days up to 3 meals per day for 90 consecutive days. The image below summarizes the number of meals offered under 2020 and 2021 SSBCI meal benefit offerings and is from an ATI and LTQA report published in 2021 and entitled "Delivering on the Promise of the *CHRONIC Care Act*: Progress in Implementing Non-Medical Supplemental Benefits."



Extended Meals (SSBCI)

"Meals may be offered beyond a limited basis as a non-primarily health-related benefit to chronically ill enrollees. Meals may be home-delivered and/or offered in a congregate setting."[3]

2020: Available in a total of 223 plans

Benefit Generosity in 2020[2]
67 plans limited services to a maximum number of meals per year (see below)

2021: Available in a total of 429 plans

Benefit Generosity in 2021[2]
371 plans limited services to a maximum number of meals per year (see below)

Note: Descriptions displayed for plans that listed benefit description online; number of plans with benefit details may not match total number of plans offering benefit.
Source(s): 1. April 2018 CMS *Guidance*. 2. ATI Advisory analysis of Medicare Advantage Organization's Evidence of Coverage (EOC) documents. 3. April 2019 CMS *Guidance*. 4. ATI Advisory analysis of CMS PBP files.

Other benefits include monthly non-perishable meal boxes, monthly to yearly spending cards ranging from $15 to $500, and nutrition counseling.

While these are useful findings regarding the adoption and availability of supplemental benefits, we strongly encourage CMS to explore options that will result in MA plans sharing utilization data of these benefits. That data will enable significant improvements in understanding of the adoption of these benefits and can lay the groundwork for determining the impact these benefits are having on MA enrollees.

A.9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

Special Needs Plans Are More Likely to Offer SSBCI

Based on our analysis of Plan Year 2022 CMS PBP file data, Special Needs Plans (SNPs), especially Chronic Condition Special Needs Plans (C-SNPs) and Dual Eligible Special Needs Plans (D-SNPs), offer

SSBCI at higher rates than other MA plans (**Table 2**).[20] SNPs are targeted to beneficiaries with special and/or complex needs who may be especially well served by SSBCI, as these benefits are designed to help address the holistic healthcare needs of individuals with complex chronic conditions. C-SNPs, in particular, are most likely to offer SSBCI, at 53 percent, compared to non-SNP plans, which only offer SSBCI in 19 percent of their plans. D-SNPs also offer SSBCI at a high rate, available in 42 percent of all D-SNP plans.

Table 2: SSCBI Offerings Among Special Needs Plans (SNPs) in 2022

	Number of Plans Offering SSBCI	Total Number of Plans, PY 2022	Percent of Total (Row)
Chronic Condition Special Needs Plans (C-SNPs)	149	283	53%
Dual Eligible Special Needs Plans (D-SNPs)	308	729	42%
Institutional Special Needs Plans (I-SNPs)	42	186	23%
Total Number of Special Needs Plans (SNPs)	499	1,198	42%
Total Number of Non-Special Needs Plans	793	4,189	19%
TOTAL	1,292	5,387	24%

Note: Analysis by ATI Advisory of PY2022 PBP files. Excludes Employer Group Health Plans (EGHPs), Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE plans.

There are multiple reasons MAOs may choose to provide benefits in a Special Needs Plan (SNP). Providing supplemental benefits in a SNP allows plans to target benefits to a particular high-need population (in the case of a D-SNP, a low-income population) more likely to benefit from specific services, and to leverage the existing care model and care coordination infrastructure. Further, if providing a new benefit, for example In-Home Support Services, in a D-SNP, a plan can leverage an existing network infrastructure from the Medicaid side of the MA plan's parent company. Insurers report using D-SNPs as an opportunity to test these benefits and determine whether they should be expanded to the organization's general MA population.

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[20] ATI Advisory. (April 2022). "Growth in New, Non-Medical Benefits Since Implementation of the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC)* Care Act". https://atiadvisory.com/wp-content/uploads/2022/04/Data-Insight-Growth-in-New-Non-Medical-Benefits-Since-Implementation-of-the-CHRONIC-Care-Act.pdf

Offerings that prove successful in a SNP can then be considered for broader application in MA plans available to all Medicare beneficiaries. In our upcoming research, LTQA and ATI plan to explore the frequency of MAOs testing benefits in their SNPs before rolling them out to other non-SNP MA plans.

Considerations for CMS to Support D-SNPs

For D-SNPs specifically, CMS can support strengthened efforts to provide targeted, coordinated care for enrollees by facilitating more robust-data-sharing, providing some discretion to plans to promote a person-centered approach to these benefits, and ensuring that members can get the full range of benefits to which they are entitled. An analysis by ATI Advisory (**Table 3**) illustrates the proportion of D-SNPs vs. Non-D-SNPs offering each type of non-medical supplemental benefit (both SSBCI and EPHRB) in 2022.

Table 3: Proportion of D-SNPs vs. Non-D-SNPs Offering Each Type of Non-Medical Supplemental Benefit in 2022

Benefit	Number of D-SNPs Offering Benefit (% of D-SNPs)	Number of Non-D-SNPs Offering Benefit (% of Non-D-SNPs)	Total Number of Plans Offering Benefit (% of All Plans)
Special Supplemental Benefits for the Chronically Ill (SSBCI)			
Food and Produce	243 (33%)	520 (11%)	763 (14%)
Meals (beyond limited basis)	69 (9%)	334 (7%)	403 (7%)
Pest Control	83 (11%)	243 (5%)	326 (6%)
Transportation for Non-Medical Needs	113 (16%)	262 (6%)	375 (7%)
Indoor Air Quality Equipment & Services	58 (8%)	108 (2%)	166 (3%)
Social Needs Benefit	45 (6%)	199 (4%)	244 (5%)
Complementary Therapies	44 (6%)	79 (2%)	123 (2%)
Services Supporting Self-Direction	46 (6%)	105 (2%)	151 (3%)
Structural Home Modifications	13 (2%)	44 (1%)	57 (1%)
General Supports for Living	116 (16%)	212 (5%)	328 (6%)
"Other Non-Primarily Health-Related" Benefit	87 (12%)	272 (6%)	359 (7%)
Offer Primarily Health-Related SSBCI	116 (16%)	376 (8%)	492 (9%)
TOTAL SSBCI	**308 (42%)**	**984 (21%)**	**1,292 (24%)**

Benefit	Number of D-SNPs Offering Benefit (% of D-SNPs)	Number of Non-D-SNPs Offering Benefit (% of Non-D-SNPs)	Total Number of Plans Offering Benefit (% of All Plans)
Expanded Primarily Health-Related Benefits (EPHRB)			
Therapeutic Massage	23 (3%)	160 (3%)	183 (3%)
Adult Day Health Services	8 (1%)	42 (1%)	50 (1%)
Home-Based Palliative Care	6 (1%)	141 (3%)	147 (3%)
In-Home Support Services	180 (25%)	549 (12%)	729 (14%)
Support for Caregivers of Enrollees	16 (2%)	144 (3%)	160 (3%)
TOTAL EPHRB	**205 (28%)**	**829 (18%)**	**1,034 (19%)**
TOTAL Offering EPRHB and/or SSBCI	**308 (42%)**	**1,543 (33%)**	**1,851 (34%)**

Note: Analysis by ATI Advisory of PY2022 PBP files. Excludes Employer Group Health Plans (EGHPs), Prescription Drug Plans (PDPs), Medicare-Medicaid Plans (MMPs), Part B-only plans, and PACE plans.

In recent guidance and the CY2023 Final Rule,[21] CMS noted that Medicare is the primary payer whenever Medicare and Medicaid cover the same services, and sought feedback on how states and D-SNPs can further coordinate supplemental benefits. **CMS should be aware that this proposed change is very complex to operationalize given the current limitations in data-sharing between states and non-fully-integrated programs, the dynamic nature of supplemental benefit structure and eligibility determination, and potential disruption of beneficiaries' regular services.**

A fundamental challenge in doing this is the outdated technological infrastructure that states rely on for coordinating these services. These systems- often referred to as Third Party Liability (TPL) systems- were designed to accommodate more traditional benefits such as dental, vision, and hearing. In addition to updates to allow them to accommodate newer non-medical benefits, the systems need updates that allow more granular tracking of services (e.g. number of hours, associated billing codes). **CMS should strongly consider an investment in state modernization of TPL systems.**

Another challenge is that plans and states currently do not have access to a data source that identifies the benefits that the other entity offers- even for fully-integrated programs. As such, states may not know the supplemental benefits that a D-SNP offers and may not know where overlap exists and to bill the D-SNP first. LTQA and ATI recommend that CMS require D-SNPs to provide states with a list of all supplemental benefits offered each year and states to provide D-SNPs with a list of Medicaid-covered services and contact information of community-based organizations that help to coordinate services.

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[21] The Centers for Medicare and Medicaid Service. "CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F)". (April 2022). https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

Secondly, the dynamic nature of supplemental benefit structure poses challenges to coordination. Since supplemental benefits are financed through limited, variable rebate dollars on an annual basis, the benefits plans offer may change substantially year-to-year, as would the extent to which they overlap with Medicaid benefits.

There is also a growing trend among plans to structure supplemental benefit as a “flexible benefit” with a set amount of credits or dollars that care managers and members work together to allocate to different benefits rather than a prescribed volume of benefits in traditional benefit design. Without having a discrete volume of a specific benefit an individual qualifies for, it will be challenging for states to know at what point the benefit has “run out” and to start billing Medicaid. Additionally, this “flexible benefit” design, by its very nature, serves as a complement to Medicaid benefits because the beneficiary is selecting, often in coordination with their care manager, how to spend these resources on what is not already available to them. **We want to encourage the continued delivery of these benefits in a person-centered way to allow for beneficiary choice to meet their individual needs**. **Importantly, we believe the flexible benefits should not be exhausted before the member can access their Medicaid benefits.** Beneficiaries should be allowed to use their MA supplemental benefits in the manner and at the time they prefer. For instance, a beneficiary may wish to hold off on using their benefit until they have a planned surgery later on in the year and require additional supports or respite for a regular caregiver.

Furthermore, given the individualized targeting of these benefits, states would need access to member-level data on Medicare plan enrollment and the supplemental benefits for which the plans have determined each beneficiary to be eligible. Likewise, plans would need member-level data on eligibility and enrollment in waiver programs and Medicaid managed care. CMS should consider how to support states and plans to develop more robust data exchange to help facilitate coordination and reduce duplication of benefits.

Finally, requiring Medicare to serve as primary payer may inadvertently disrupt a beneficiary’ ability to consistently receive needed, community-based supports due to differing provider networks for Medicare and Medicaid. Furthermore, requiring MA supplemental benefits to be exhausted first creates a barrier to an individual being able to access their ongoing services. This may be of particular concern for LTSS-like services offered under MA supplemental benefits which may overlap with Medicaid LTSS benefits. For instance, for ongoing LTSS (e.g., personal care attendants), the MA plan may not wish to disrupt the regular caregiver that is providing a service under Medicaid by switching to the MA supplemental benefit and a different network of providers. This also adds burden on individual and family caregivers to coordinate a limited benefit and multiple providers.

Given the limited funding and scope of these supplemental benefits, it is important that states and beneficiaries do not view these benefits as a substitute for Medicaid coverage. We encourage CMS to caution states against being overly prescriptive and requiring specific supplemental benefits through their state Medicaid contracts with D-SNPs. Since plans have limited rebate dollars available to finance these benefits, state requirements to offer specific benefits could prevent plans from offering other supplemental benefits they had designed to target its specific population or otherwise wanted to offer. This may have the unintended consequence of D-SNPs becoming less competitive compared to non-D-SNP MA plans in the same markets, leading dually eligible beneficiaries to opt for less integrated options.

A.11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

Since these new authorities were made available, we have observed a large increase in the percentage of MA plans using rebate dollars to provide non-medical supplemental benefits. The percentage offering either expanded primarily health-related benefits (EPHRB) or SSBCI more than doubled from 14% in 2020 to 34% in 2022. ATI and LTQA have done extensive analyses on the benefit offerings based on the publicly available Plan Benefit Package (PBP) data; however, there is a major gap in the public understanding of the rates at which these benefits are being utilized, which specific benefits are being utilized at the highest frequency, and by whom. It is clear that these benefits are being used to address social needs but without utilization data and an ability to link utilization of these benefits to health outcomes, we cannot determine progress in promoting health equity.

Now that SSBCI have been available to beneficiaries for several years, CMS has a critical opportunity to plan for and conduct an evaluation of the impact of these benefits. Given that SSBCI represent a significant change in Medicare policy, a robust evaluation is needed to assess the impact of this new authority on beneficiaries and the healthcare system and to support Congress, CMS, and stakeholders' decisions on how to improve the future delivery of these benefits. In developing an evaluation framework, it is important to consider the policy goals for SSBCI as well as a realistic process for collecting data to support such an evaluation.

In the *CHRONIC Care Act*, Congress initially charged the U.S. Government Accountability Office (GAO) with producing an evaluation of SSBCI within five years of enactment including analyses of the following:

> 1) The type of supplemental benefits provided, total number of enrollees receiving each benefit, and whether the supplemental benefit is covered by the standard benchmark cost of the benefit or with an additional premium;
>
> 2) The frequency in which supplemental benefits are utilized by such enrollees; and
>
> 3) The impact of benefits on indicators of quality of care, including the overall health and function of enrollees receiving benefits; utilization of items and services covered under Parts A and B of the original Medicare FFS program, and the amount of bids submitted by Medicare Advantage Organizations (MAOs).viii

As of 2022, the third year since plans could start offering SSBCI, data are not publicly available to conduct this evaluation.

However, even if all the data on SSBCI and other healthcare utilization were publicly available, it would be extremely difficult to isolate an individual benefit's impact on a beneficiary's Medicare spending. It is challenging to establish causation with these limited, upstream benefits, especially when a benefit is used along with a broad suite of other interventions and confounding variables. For example, while it is reasonable to assume Pest Control would have a positive impact on one's health, it may be difficult to prove a direct association with reduced healthcare utilization.

While impact on healthcare utilization may be hard to demonstrate, this should not lead Congress or CMS to conclude a lack of value associated with SSCBI. An evaluation focused on who is utilizing these benefits and their impact on the consumer experience would be a more pragmatic approach to assessing the value of these benefits in the near-term, and as a potential pathway to a future evaluation of the benefits' impacts on avoidable utilization and health outcomes.

1. Phase 1: Benefit Utilization
2. Phase 2: Consumer Experience
3. Phase 3: Health Status, Health Care Utilization, and Medicare Spending

We recommend that CMS take a phased approach to evaluating these benefits for several reasons:

1) It will take time to develop the reporting infrastructure to support more robust outcomes reporting and evaluation.
2) It will take time to see the impacts – consumer experience measures may lie on the causal pathway towards lower utilization – and could be viewed as outcomes in and of themselves.

Based on our policy recommendation in LTQA and ATI's Spring Policy Report to Congress (pg. 16-18), below we outline additional details on a phased approach to evaluation of SSBCI. *See our response to B.9 for additional considerations and specific data elements recommended for each evaluation phase.*

Phase 1: Benefit Utilization

Given the lack of transparency into uptake of these benefits at present, the first logical step is to is to assess how these benefits are being delivered to and experienced by beneficiaries. We first need to understand how many people are receiving these benefits, who they are, which benefits, and at what frequency.

Phase 2: Consumer Experience

Once evaluators have a sense of uptake of these benefits, they could examine how consumers experience the benefits as they have great potential to improve their quality of life. There are many possible mediating variables lying on the causal pathway between benefit utilization and impacts on health status and total health care utilization. For instance, in the beneficiary example highlighted above, Transportation for Non-Medical Needs may lead to many outcomes that are valuable and worthy of measuring, including a greater sense of autonomy, decreased social isolation, and other needs being met including spiritual and nutritional needs.

Phase 3: Health Status, Health Care Utilization, and Medicare Spending

The final phase of the evaluation should culminate in measuring health status, overall health care utilization (including avoidable emergency department use and hospital and institutional stays), and Medicare spending for Medicare beneficiaries who use SSBCI and a similar group of beneficiaries who do not. A centralized evaluator that can aggregate data across plans can link claims or encounter data from plans with the Medicare beneficiary enrollment file and conduct regression analyses to evaluate the healthcare spending and utilization of beneficiaries who accessed SSBCI compared to a comparison group that is similar in demographic and clinical characteristics but did not receive SSBCI.

MLR Reporting as an Interim Step

In the meantime, CMS finalized in the 2023 Final Rule that starting in 2023, plans will be required to submit to CMS the data needed to calculate and verify the medical loss ratio (MLR) and remittance amount, if any, for each contract, including the amounts of incurred claims for Medicare-covered supplemental benefits.

While the finalized MLR reporting provision will not answer the policy questions of who is accessing these benefits and how often, we believe this proposal is a step in the right direction as data on spending can serve as a proxy for how often these benefits are being utilized. This policy will provide greater transparency into spending and utilization for supplemental benefits and valuable information for policymakers, researchers, beneficiaries, and the general public. This reporting requirement will open up a line of sight into utilization of these benefits that has not existed since the new authorities to offer these non-medical supplemental benefits were introduced. This information will also allow beneficiaries to compare spending on supplemental benefits between plans.

We urge CMS to align reporting requirements for SSBCI with those for primarily health-related benefits. We support the collection of clear, timely information at the most granular level that still respects plans' privacy. As initially drafted in the Proposed Rule, all benefit sub-categories would be rolled up into a single line each for “All Other Primarily Health Related Supplemental Benefits” and “Non-Primarily Health Related Items and Services that are SSBCI.” Given the broad range of supplemental benefits that fall within these two categories, reporting expenditures in aggregate will provide limited sight into the specific types of benefits that members are accessing at the greatest frequencies.

In the final provision, it is unclear whether CMS intends to update the required supplemental benefit reporting categories based on which benefit types surpass the 10% threshold CMS used to determine the categories based on Contract Year 2021 data. **We recommend that CMS review the list of required categories and consider expanding it to include the most popular non-primarily health-related SSBCI.** Our research has tracked the exponential growth of these non-medical benefits over the past several years and we expect them to continue to expand, with large percentages of plans offering them, and we encourage parity between the reporting requirements for these benefits with primarily health-related benefits. Additionally, we want to highlight the nuances in how plans file these non-medical benefits under various authorities – similar benefit types may be filed as primarily health-related benefits (under the expanded definition) or as SSBCI. As those benefits continue to grow in popularity, there may be value in considering pulling them out into separate reporting if they surpass the 10% threshold, the standard applied for primarily health-related benefits.

On the other hand, we have also heard concerns from MA plans that more detailed reporting may reveal sensitive information around benefit design, payment arrangements, etc. that could discourage plans from offering these benefits. Plans may also face challenges with reporting according to the categories CMS has identified or to changing required reporting categories year-to year. We believe these non-medical benefits are extremely valuable for supporting Medicare beneficiaries with complex care needs, and we support proposals that advance these benefits and advocacy for continued investment and growth in these benefits while avoiding a cooling effect on these offerings. We support public reporting of the data if it protect plans’ intellectual property. Additionally, from a research perspective, publicly releasing data within six months to a year after the end of a contract year would support more responsive evaluation of the implementation of these benefits and continuous quality improvement.

B. Expand Access: Coverage and Care

B.1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

B.2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

B.3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

Consolidated Response to Section B, Questions 1-3

Supplemental benefits are a key differentiator for Medicare beneficiaries choosing between different options for obtaining Medicare coverage and among different choices for MA plans. Currently, there are limited resources available to beneficiaries to support them in understanding available non-medical supplemental benefits and to compare offerings in a systematic way, leaving them vulnerable to misleading or biased information. **CMS has a significant opportunity to improve the way that this information is organized and delivered to beneficiaries to help them make the most informed choice to support their individual needs.**

Beneficiaries learn about MA supplemental benefits through a variety of sources including word-of-mouth, advertisements, plan outreach, local resources (e.g., SHIPs), Medicare Plan Finder, and brokers and agents. In particular, beneficiary advocates observed that a large number of beneficiaries are learning about these new benefits through television commercials sponsored by insurance broker companies. They also noted that confusion around eligibility for these benefits can lead to beneficiaries choosing a particular plan to access a benefit that they later learn they are not eligible to receive.

We have identified the following gaps in the resources available to support beneficiaries:

- **Lack of Easy-to-Use Beneficiary Tools** – In our research, we found there is a lack of easy-to-use beneficiary tools to compare their options with regards to non-medical supplemental benefits.
    - Plan documents: Plans publish "Evidence of Coverage" documents which include a list of benefits; however, these documents are typically several hundred pages long and the supplemental benefits are not clearly identified and/or defined.
    - Medicare Plan Finder: One important tool available to beneficiaries for shopping between plans is the web-based Medicare Plan Finder. However, non-medical supplemental benefits are not clearly displayed and easily navigable in this tool. On the

results page, only eleven supplemental benefits are listed,[22] none of which are SSBCI–beneficiary advocates commented that the list of benefits seems arbitrarily selected and omits important details describing the benefits. For example, “in-home support” is displayed as a benefit but the included services and eligibility criteria are not clearly defined. Beneficiaries are also unable to filter for specific supplemental benefits in Medicare Plan Finder. The listed benefits are only defined as having “some coverage” or “not covered.” Adding more clarity around when limits apply (e.g., number of meals included in benefit, limits on the number of supplemental benefits members may receive, limits based on chronic conditions) would help beneficiaries better understand their choices.

  - Other Online Decision Tools: My Care, My Choice is an online decision support tool developed by The SCAN Foundation to help individuals in California who are dually-eligible for Medicare and Medicaid explore the integrated care options available to them. With support from ACL, the National Council on Aging expanded this person-centered tool which has been piloted in 2022 with beneficiaries and counselors in the SHIP in Ohio, and plans to add more states over time. CMS and ACL can build upon this tool to provide information on non-medical supplemental benefits as it is expanded to other states.

- **Lack of Training and Data Tools for Beneficiary Counseling Resources** - In our research, we heard that beneficiaries often turn to brokers, agents, SHIP counselors, and other counseling resources for information as they navigate their Medicare choices. However, these entities lack training and appropriate data tools to advise enrollees on non-medical supplemental benefits. For brokers or agents, some of whom are contracted with multiple plans, it is vital that they understand these benefits and how to convey eligibility to prevent member confusion. SHIP counselors lack a centralized resource to reference for availability of non-medical benefits in the geographic areas they serve. Counseling beneficiaries on these benefits can be difficult as eligibility requirements are not always clear. A complicating factor is the tight timeline under which CMS and plans finalize benefit packages, which results in CMS releasing data on benefits directly before or concurrent to the Open Enrollment Period (October 15-December 7) and the Medicare Advantage Open Enrollment Period (January 1-March 31). Given these constraints, it would be valuable for CMS to provide SHIP counselors and brokers with clear information and resources on supplemental benefits and qualifying criteria to help them learn quickly.
  - For example, the State of Minnesota SHIP compiles the MA supplemental benefit offerings across all plan types, including but not limited to D-SNPs, into a reference material for SHIP counselors, allowing counselors to better guide beneficiary plan selection. It is important that those counseling beneficiaries are given comprehensive education on the options available to beneficiaries for greater transparency and beneficiary empowerment. **CMS could encourage states to include requirements to facilitate this relationship with the state’s SHIP and timely data-sharing to support other states in developing a similar beneficiary/counselor tool.**

- **Lack of Standardized Disclaimer Language** - While CMS added a requirement for plans to include an SSBCI disclaimer to required materials for current and prospective enrollees, CMS did

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not provide standardized disclaimer language for plans to use. As a result, plans are operationalizing this requirement differently, which poses challenges to beneficiary understanding of these benefits and their limits.

To address these challenges, LTQA and ATI recommend that CMS consider the following:

1. Expand the categories of supplemental benefits listed in Medicare Plan Finder and indicate more clearly when limits apply.
2. Develop resources and training for SHIP counselors about non-medical supplemental benefits and provide information on the available benefits each year as early as possible.
3. Establish standardized disclaimer language that clarifies that coverage of an SSBCI benefit is not guaranteed.

B.7. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?

Supported by The SCAN Foundation, ATI Advisory and LTQA have conducted interviews with over 30 organizations, including MA plans, providers, consumer advocacy groups, policy experts, researchers, and other stakeholder groups, culminating in two reports on the state of supplemental benefits in Medicare Advantage:

- A 2020 report "Providing Non-Medical Supplemental Benefits in Medicare Advantage: A Roadmap for Plans and Providers," laid out a number of factors that contribute to an MAO's decisions regarding which benefits will be offered. The Roadmap lays out a five-step process for MAOs in terms of developing supplemental benefits:
    1) Build Support for Innovative Benefits within the Plan
    2) Make Plan / Provider Connection and Develop Network
    3) Design Benefits and Develop Bid
    4) Educate and Implement
    5) Learn / Iterate for Better Results
- A 2021 report "Delivering on the Promise of the *CHRONIC Care Act*: Progress in Implementing Non-Medical Supplemental Benefits," provides an update on the landscape of supplemental benefits and the current state of SSBCI and other non-medical benefits.

Based on our research, plans factor in many considerations when determining which supplemental benefits to offer:

- Benefits that care coordinators, providers, brokers, and members themselves report members want and need,
- Benefits that will help meet member health-related social needs and have high potential to reduce avoidable medical costs,
- Price of the benefit, especially relative to expected ROI,
- Ease of implementation and ability to effectively target,
- The strength of the available providers, and their ability to cover service area, fulfill requests, meet contracting requirements, and communicate well,

- Expected impact on enrollment and retention,
- Likelihood of the benefit improving STARS measures, including member satisfaction, and
- What their competitors are offering.

MA plans are partnering with third parties to deliver SSBCI and other benefits in a variety of ways.

Make Plan / Provider Connection and Develop Network
It is imperative to have providers who can reliably deliver high-quality services. Providing new benefits – things like food delivery, homemaking services, social club memberships, or pest control – requires partnering with new provider types. These providers are often not "Medicare-certified" and many have little or no experience contracting with MA plans. Likewise, MA plans do not have experience working with these groups. In many instances, providing these benefits requires building a new provider network from scratch. The limited geographic reach of some of these community-based providers can also conflict with the MA plan's often larger geographic footprint. And even when a provider can be identified that is able to partner with an MA plan despite all of the challenges listed above, establishing a contractual relationship between the two entities can be difficult given the complexity expected of MA plan contracts, the limited history that community-based providers may have with pricing their services, and the infrastructure necessary to coordinate (e.g. referral systems). Ultimately, the multiple hurdles have the potential to delay or prevent access to service fulfillment for eligible members. These are all factors that MA plans take into account when determining which supplemental benefits to offer.

Despite this list of challenges, promising practices have also emerged that point a path forward on how MA plans and community-based providers are partnering to offer these benefits. These practices include:

- Leveraging efforts to aggregate service providers across a broad geographic area, whether done by a convening organization or by a community-based provider;
- Engaging external entities to provide infrastructure support (e.g. national associations, franchisors, and third-party entities building support for activities like legal review of contracts, developing technology infrastructure, and supporting data sharing, reducing the cost for any single organization); and
- MA plans simplifying contract terms for the sake of coordination with community-based providers.

B.8. How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?

As noted in a previous response, beneficiaries learn about MA supplemental benefits through a variety of sources including word-of-mouth, advertisements, plan outreach, local resources (e.g., SHIPs), Medicare Plan Finder, and brokers and agents. In particular, beneficiary advocates observed that a large number of beneficiaries are learning about these new benefits through television commercials sponsored by insurance broker companies. They also noted that confusion around eligibility for these benefits can lead to beneficiaries choosing a particular plan to access a benefit that they later learn they are not eligible to receive.

As ATI and LTQA have followed the progression of offerings of novel supplemental benefits, we have seen increased uptake of these benefits. As noted in our joint report from 2021 – "Delivering on the Promise of the *CHRONIC Care Act*: Progress in Implementing Non-Medical Supplemental Benefits", we still see opportunities to increase adoption of these benefits by targeting both MAO staff and members with additional supports.

For Plan Staff

Across multiple benefit types, plans and providers reported increased uptake of these non-medical benefits. Plans who saw increased uptake in these benefits emphasized the crucial role of care and case managers in supplying referrals. Plans reported providing additional educational sessions and materials to inform, as well as remind, care managers, brokers, and other member-facing staff about these new benefits. Some plans also noted that primary care provider groups could support referral to benefits. Lastly, some plans have shared that they make their benefit resources available on customer service portals.

For Plan Members

Overall, SSBCI authority is complex and plans still wrestle with how to appropriately publicize and market these benefits in a way that is thorough, yet not misleading. Plans are attentive of this balance because, on one hand, they want members to access the benefit they have designed and rolled out. However, confusion around eligibility for these benefits may result in complaints to the plan, which may ultimately affect the plan's star rating. Because of the intricacy of these authorities and general lack of awareness of these benefits, many beneficiaries do not understand whether these benefits are available to them.

One way to increase access to these benefits is for plans to build networks of providers for beneficiaries to access, rather than having a beneficiary pay for services and receive reimbursement. Designing a benefit such that a beneficiary must first find a provider and then pay for services can be prohibitive, especially for low-income beneficiaries. While developing these networks takes effort on the part of the plan, it allows ease for the beneficiary and, ultimately, promotes access to these services.

Another factor inhibiting beneficiary knowledge of these benefits is lack of training and appropriate data tools for beneficiary resources. Beneficiary resources, especially brokers, agents, and state resources like SHIPs, lack sufficient resources to advise enrollees on these benefits. For brokers or agents, some of whom are contracted with multiple plans, continued education is necessary to keep brokers up to date on these benefits and eligibility criteria. It is vital that agents and brokers understand how to convey chronic condition eligibility for these services to prevent member confusion. SHIPs also face challenges advising beneficiaries on these benefits as they lack a centralized resource to reference for availability of non-medical benefits year over year.

Best Practices

A key factor in encouraging uptake of these benefits this year came from providing plan staff, especially case and care managers, as well as brokers and agents, resources to help members navigate these benefits. Some plans, as well as providers, cited offering additional sessions with plan staff and brokers to educate them on these new benefits and eligibility limitations. One plan described designing benefit 'one-pagers' in the organization's portal as another method of making this information readily available to key staff.

Recommendations

In an accompanying report- “Policy Recommendations for the Administration to Advance Non-Medical Supplemental Benefits”, we recommend that CMS should do the following to address some of the challenges around awareness and complexity of navigating the details of benefits:

- Develop resources and training for SHIP counselors about non-medical supplemental benefits and provide information on the available benefits each year as early as possible.
- Require training on these benefits in the 2023 agent and broker training and testing guidelines.
- Update Chapter 4 of the Medicare Managed Care manual to reflect current guidelines around nonmedical supplemental benefits.
- Establish standardized disclaimer language that clarifies that coverage of an SSBCI benefit is not guaranteed.
- Expand the categories of supplemental benefits listed in Medicare Plan Finder and indicate more clearly when limits apply.

B.9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)?

LTQA and ATI strongly encourage CMS to develop a mechanism for appropriate reporting of supplemental benefit utilization at the beneficiary-level as well as to outline a framework for a meaningful and realistic evaluation of the impacts of these benefits.

Current Evaluation Efforts Among MA Plans

When asked about tracking and reporting data on outcomes of non-medical supplemental benefits, MAOs responded that they are not yet able to measure ROI. They tend to approach ROI with a broader framework, which includes the impact of these benefits on member attraction, experience, and retention. It can be difficult and resource-intensive to isolate the impact of a single intervention, when multiple interventions are working together, and the outcomes for SDOH interventions are often longer-term. While some providers reported challenges with receiving outcomes data from plans, several providers were able to collaborate with plans on matched case-control studies when their services were aligned with the MAOs’ strategic goals.

According to our research, plans are collecting data on utilization and could report these to CMS if required. Importantly, plans are not required to report data on other supplemental benefits, so there is no existing precedent for a reporting requirement. However, because of the experimental nature of these benefits and the strict targeting criteria that do not accompany other supplemental benefits, data will be extremely critical to proving the value of these benefits and evolving and improving implementation of the benefits. When developing policy options to facilitate data reporting, it is important to consider plans’ intellectual property and assure that only appropriate information is shared publicly. Data made publicly available should be aggregated so that no beneficiary-level data are shared. Policymakers also should balance the risk that adding reporting requirements may deter plans from offering these benefits altogether.

Recommendation for a Phased Evaluation Approach

As noted in our response to A.11, even if all the data on SSBCI and other healthcare utilization were publicly available, it would be extremely difficult to isolate an individual benefit's impact on a beneficiary's Medicare spending. It is challenging to establish causation with these limited, upstream benefits, especially when a benefit is used along with a broad suite of other interventions and confounding variables. For example, while it is reasonable to assume Pest Control would have a positive impact on one's health, it may be difficult to prove a direct association with reduced healthcare utilization.

While impact on healthcare utilization may be hard to demonstrate, this should not lead CMS to conclude a lack of value associated with SSCBI. An evaluation focused on who is utilizing these benefits and their impact on the consumer experience would be a more pragmatic approach to assessing the value of these benefits in the near-term, and as a potential pathway to a future evaluation of the benefits' impacts on avoidable utilization and health outcomes.

1. Phase 1: Benefit Utilization
2. Phase 2: Consumer Experience
3. Phase 3: Health Status, Health Care Utilization, and Medicare Spending

We recommend that CMS take a phased approach to evaluating these benefits for several reasons:

3) It will take time to develop the reporting infrastructure to support more robust outcomes reporting and evaluation.
4) It will take time to see the impacts – consumer experience measures may lie on the causal pathway towards lower utilization – and could be viewed as outcomes in and of themselves (Figure 3).

Based on our policy recommendation in LTQA and ATI's Spring Policy Report to Congress (pg. 16-18), below we outline additional details on a phased approach to evaluation of SSBCI, including considerations for each evaluation phase.

Phase 1: Benefit Utilization

Given the lack of transparency into uptake of these benefits at present, the first logical step is to is to assess how these benefits are being delivered to and experienced by beneficiaries. We first need to understand how many people are receiving these benefits, who they are, which benefits, and at what frequency.

Considerations:

- This could involve pulling together a sample of beneficiaries receiving the benefit across different plans and profiling the demographic and health characteristics of these individuals, allowing evaluators to ascertain whether SSBCI are being accessed by the target population for the benefits.
- Due to the flexibility and person-centeredness of these benefits, utilization of specific benefits may be driven more by consumer preference rather than need or eligibility. This is especially the case when plans offer a "flexible benefit" structure, where beneficiaries are given a set amount of dollars or credits to allocate towards different benefits of their choice, in partnership with a care manager.

Phase 2: Consumer Experience

Once evaluators have a sense of uptake of these benefits, they could examine how consumers experience the benefits as they have great potential to improve their quality of life. There are many possible mediating variables lying on the causal pathway between benefit utilization and impacts on health status and total health care utilization. For instance, in the beneficiary example highlighted above, Transportation for Non-Medical Needs may lead to many outcomes that are valuable and worthy of measuring, including a greater sense of autonomy, decreased social isolation, and other needs being met including spiritual and nutritional needs.

Considerations:

- An evaluation of consumer experience should begin with a qualitative study, including interviews and focus groups with beneficiaries, to explore the universe of impacts on beneficiaries and determine how beneficiaries define value for these benefits. Some potential measures include quality of life, social connectedness, ability to live independently, ability to access healthy foods, etc.
- After completing a qualitative study, evaluators will need to consider how to measure consumer experience in a quantitative study and whether additional data collection tools are needed. This could involve self-reported outcomes in surveys or other emerging methods such as life-space mobility as a measure for social isolation and loneliness.

Phase 3: Health Status, Health Care Utilization, and Medicare Spending

The final phase of the evaluation should culminate in measuring health status, overall health care utilization (including avoidable emergency department use and hospital and institutional stays), and Medicare spending for Medicare beneficiaries who use SSBCI and a similar group of beneficiaries who do not. A centralized evaluator that can aggregate data across plans can link claims or encounter data from plans with the Medicare beneficiary enrollment file and conduct regression analyses to evaluate the healthcare spending and utilization of beneficiaries who accessed SSBCI compared to a comparison group that is similar in demographic and clinical characteristics but did not receive SSBCI.

Considerations:

- **This evaluation would be best conducted by a centralized entity that can aggregate data across plans rather than by MAOs themselves.** While this is the ideal final phase of the evaluation, this will be complex and may take time to collect the data from plans and build the analytic capacity, and may also benefit from more time to allow plans to increase uptake of SSBCI among beneficiaries and for the impacts to begin to manifest.
- **These benefits were not designed as a test of specific interventions with a control group – by definition, benefits are available to all beneficiaries who qualify - and so the ability to assess direct causality will be limited.**
- **While challenging, there is potential for an evaluator to compare plan offerings and measure the impacts by intervention intensity across plans (e.g., number of hours or units of service.**
- **Another possibility is to explore the impacts of these benefits on Medicaid entry to see if these benefits can help prevent spenddown**. While it will be difficult to demonstrate a causal relationship between these benefits and Medicaid spenddown, there could be directional insights that could be gleaned from a descriptive analysis of the population receiving SSBCI and Medicaid entry.

C. Drive Innovation to Promote Person-Centered Care

C.9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

The expansion of supplemental benefits in the past several years has introduced a variety of new service offerings that MA plans are providing to their members, including non-medical benefits. CMMI's Medicare Advantage Value-Based Insurance Design (VBID) model is supporting this expansion of benefit offerings, alongside legislative changes (particularly the Special Supplemental Benefits for the Chronically Ill (SSBCI) created by Congress through the *CHRONIC Care Act* and enacted as part of the *Bipartisan Budget Act of 2018*).

Given CMMI's mandate to operate as a testing grounds for innovations in Medicare and Medicaid, the VBID model serves as an ideal opportunity to meaningfully collect data on cost, utilization, and outcomes of these non-medical benefits in an effort to understand the cost and quality impacts associated with the services. We strongly support the VBID model's Health Equity Incubation Program and its efforts to support MAOs in their benefit offerings that will advance health equity. However, we think there is an opportunity to further advance the field's understanding of the impact of these benefit offerings by evaluating who is utilizing these benefits and their impact on the consumer experience. This data could also serve as a potential pathway to a future evaluation of the benefits' impacts on avoidable utilization and health outcomes. *We share a more detailed evaluation strategy in response to question B.9 above.*

By collecting this data, and ultimately sharing it publicly, CMMI has an opportunity to motivate MAOs to focus on providing benefit offerings that provide a clear impact to the member populations that they serve. This would have the additional benefit of ensuring appropriate stewardship of CMS dollars should the findings influence further guidance by the agency on particular benefit offerings.

C.10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity?

CMMI should consider using demonstration authority to add to the VBID demonstration new eligibility categories, such as functional need and other indicators of SDOH need outside of LIS status. This would allow plans to test and collect evidence on these new targeting criteria before potentially expanding them to SSBCI. Further eligibility expansion for SSBCI may require congressional action.

Beyond the VBID model, as we have mentioned elsewhere, we believe that CMS should consider expanding eligibility for SSBCI to enhance plans' ability to target meaningful benefits to people who need them. While allowing plans to make SSBCI available to all members would have the greatest impact, another approach is to allow functional limitations to meet the eligibility criteria for SSBCI.

According to ATI analysis of Medicare survey and claims data, there appears to be a strong correlation between functional limitations and healthcare spending. Medicare beneficiaries with multiple chronic conditions and functional impairment are nearly twice as expensive to Medicare as individuals who have multiple chronic conditions but no functional impairment. This implies that individuals with functional impairment have a high risk of hospitalization or other adverse health outcomes and may require intensive care coordination. Given the potential to impact spending for this high-cost population, there is a strong case for clarifying that the presence of functional limitations meets the eligibility criteria for SSBCI.

D. Support Affordability and Sustainability

D.1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

CMS has previously explored and may continue to explore changes to the Maximum Out-of-Pocket (MOOP) limit, and certain changes will most certainly lead to a reduction in the supplemental benefits offered to dually eligible individuals. In the CY 2023 MAPD Final Rule, CMS finalized a provision modifying MOOP limits for dually eligible beneficiaries to include third-party payments (such as the state), even in instances where state lesser-of payment policy results in the state not paying an out-of-pocket cost.

While CMS' primary intent in finalizing this change is to produce savings for states while increasing payment to providers serving dually eligible beneficiaries, this change will result in fewer dollars available to MA plans serving dually eligible individuals. The consequence is likely to be a reduction in the supplemental benefits, particularly in smaller or regional D-SNPs that are unable to spread this reduction across a large MA portfolio. This may further the divide between large and national plans that can afford to bear the financial costs of this provision and the smaller plans that cannot, limiting the supplemental benefits the smaller D-SNPs can offer and therefore making them less attractive to dually eligible beneficiaries that may otherwise benefit from their more regional or local focus.

We have heard through our research that this will have a direct and negative impact on the supplemental benefit offerings available to MA beneficiaries. It remains to be seen which benefits plans would cut, but given limited rebate dollars, it is possible that plans may prioritize retaining benefits that attract members to their plan rather than those that may impact healthcare spending and/or improve outcomes over multiple years but have less immediate measurable impact.

At the member level, the largest cost impact will be borne by full-benefit dually eligible beneficiaries and Qualified Medicare Beneficiaries (QMBs), for which the state has a cost-sharing liability. This reduction in supplemental benefit offerings is likely to most negatively impact "community-well" dual eligible individuals, who receive cost-sharing support for Medicare but are not eligible for Medicaid LTSS services. Non-medical supplemental benefits are particularly meaningful to these individuals if they have LTSS needs.

In CY 2022, D-SNPs were more likely to offer benefits through SSBCI authority as compared to all MA plans as a whole (42% of all D-SNPs vs 24% of all MA plans), highlighting the importance of these benefits to D-SNPs' care models and their beneficiaries. A reduction in D-SNPs offering supplemental benefits compared to MA-only plans in the same markets could drive dually eligible beneficiaries away from more integrated options, undermining CMS' goal of advancing duals integration. CMS needs to carefully consider implications on plan availability and competition when considering further changes in this area.

Beyond the MOOP limits, CMS should consider opportunities to gather more granular data on beneficiaries served in MA. We encourage CMS to consider the following ways to better understand the MA population and ultimately informing care and payment policies:

- Increasing collection of encounter data from MA plans for all services, including post-acute care
- Broader social needs data capture, particularly through increased use of Z-codes (discussed in detail in the next response) and promotion of SDOH data standards (including those being created by the Gravity Project and incorporated into HHS / CMS programs via the United States Core Data for Interoperability standards releases)
- Additional requirements for MA plans to conduct functional needs assessments on their members

D.5. What are notable barriers to entry or other obstacles to competition within the MA market generally, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program?

As plans design these benefits, smaller, regional plans face unique challenges compared to larger, national carriers. While smaller plans exhibit more flexibility and can work swiftly in designing and implementing benefits, they have limited resources. Smaller plans are largely focused on their ability to offer what are considered table stakes in MA: benefits like dental and vision or fitness memberships. Additionally, smaller or newer plans that have not yet earned a Star rating may be unable to utilize some flexibilities, such as the VBID model, which requires a three-star overall quality rating. Alternatively, while larger carriers are typically well-resourced, navigating the multitude of teams, national and local structures, and competing priorities can present challenges.

On a separate note, given the interest by CMS of integration across plans for the dually-eligible population, we encourage CMS to caution states against requiring specific supplemental benefits through their state Medicaid contracts with D-SNPs. Since plans have limited rebate dollars available to finance these benefits, state requirements to offer specific benefits could prevent plans from offering other supplemental benefits they had designed to target its specific population or otherwise wanted to offer. Requiring specific benefits could have the unintended consequence of D-SNPs becoming less competitive compared to non-D-SNP MA plans in the same markets, leading dually eligible beneficiaries to opt for less integrated options.

On a similar note of competitiveness, CMS should carefully consider any changes that might be made to the Maximum Out-of-Pocket (MOOP) limit changes given the disproportionate impact this could have on smaller or regional / local D-SNPs. Changes to the MOOP limit could result in D-SNPs offering fewer supplemental benefits compared to MA-only plans in the same markets, driving beneficiaries away from more integrated plan offerings. This could lead to a disproportionate impact on smaller or regional / local D-SNPs given that these plans are unlikely to have a broader portfolio against which to cushion the financial burden, especially if the organization does not have any non-duals MA products. In order to remain financially viable, the smaller D-SNPs may limit their supplemental benefit offerings and therefore become less attractive to dually eligible beneficiaries that may otherwise benefit from their more regional or local focus.

E. Engage Partners

E.1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?

As referenced in response to Question B.1, **CMS has a significant opportunity to improve the way that supplemental benefit information on plans is organized and delivered to beneficiaries to help them make the most informed choice to support their individual needs.**

We have identified the following gaps in the resources available to support beneficiaries:

- **Lack of Easy-to-Use Beneficiary Tools** – In our research, we found there is a lack of easy-to-use beneficiary tools to compare their options with regards to non-medical supplemental benefits.
    - Plan documents: Plans publish "Evidence of Coverage" documents which include a list of benefits; however, these documents are typically several hundred pages long and the supplemental benefits are not clearly identified and/or defined.
    - Medicare Plan Finder: One important tool available to beneficiaries for shopping between plans is the web-based Medicare Plan Finder. However, non-medical supplemental benefits are not clearly displayed and easily navigable in this tool. On the results page, only eleven supplemental benefits are listed[23], none of which are SSBCI– beneficiary advocates commented that the list of benefits seems arbitrarily selected and omits important details describing the benefits. For example, "in-home support" is displayed as a benefit but the included services and eligibility criteria are not clearly defined. Beneficiaries are also unable to filter for specific supplemental benefits in Medicare Plan Finder. The listed benefits are only defined as having "some coverage" or "not covered". Adding more clarity around when limits apply (e.g., number of meals included in benefit; limits on the number of supplemental benefits members may

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    receive; limits based on chronic conditions) would help beneficiaries better understand their choices.
  - Other Online Decision Tools: My Care, My Choice is an online decision support tool developed by The SCAN Foundation to help individuals in California who are dually-eligible for Medicare and Medicaid explore the integrated care options available to them. With support from ACL, the National Council on Aging expanded this person-centered tool which has been piloted in 2022 with beneficiaries and counselors in the SHIP in Ohio, and plans to add more states over time. CMS and ACL can build upon this tool to provide information on non-medical supplemental benefits as it is expanded to other states.

- **Lack of Training and Data Tools for Beneficiary Counseling Resources** - In our research, we heard that beneficiaries often turn to brokers, agents, SHIP counselors, and other counseling resources for information as they navigate their Medicare choices. However, these entities lack training and appropriate data tools to advise enrollees on non-medical supplemental benefits. For brokers or agents, some of whom are contracted with multiple plans, it is vital that they understand these benefits and how to convey eligibility to prevent member confusion. SHIP counselors lack a centralized resource to reference for availability of non-medical benefits in the geographic areas they serve. Counseling beneficiaries on these benefits can be difficult as eligibility requirements are not always clear. A complicating factor is the tight timeline under which CMS and plans finalize benefit packages, which results in CMS releasing data on benefits directly before or concurrent to the Open Enrollment Period (October 15-December 7) and the Medicare Advantage Open Enrollment Period (January 1-March 31). Given these constraints, **it would be valuable for CMS to provide SHIP counselors and brokers with clear information and resources on supplemental benefits and qualifying criteria to help them learn quickly in advance of the Open Enrollment Period.** As an alternative or additional approach, CMS should develop a template for states to request benefit and coverage information from MA plans. Currently available plan benefit package files are difficult to link and are not fully available until after a contract year begins and enrollment decisions are already made.
  - For example, the State of Minnesota SHIP compiles the MA supplemental benefit offerings across all plan types, including but not limited to D-SNPs, into a reference material for SHIP counselors, allowing counselors to better guide beneficiary plan selection. It is important that those counseling beneficiaries are given comprehensive education on the options available to beneficiaries for greater transparency and beneficiary empowerment. CMS could encourage states to include requirements to facilitate this relationship with the state's SHIP and timely data-sharing to support other states in developing a similar beneficiary/counselor tool.

- **Lack of Standardized Disclaimer Language** - While CMS added a requirement for plans to include an SSBCI disclaimer to required materials for current and prospective enrollees, CMS did not provide standardized disclaimer language for plans to use. As a result, plans are operationalizing this requirement differently, which poses challenges to beneficiary understanding of these benefits and their limits.

To address these challenges, LTQA and ATI recommend that CMS consider the following:

1. Expand the categories of supplemental benefits listed in Medicare Plan Finder and indicate more clearly when limits apply.

2. Develop resources and training for SHIP counselors about non-medical supplemental benefits and provide information on the available benefits each year as early as possible.
3. Establish standardized disclaimer language that clarifies that coverage of an SSBCI benefit is not guaranteed.
4. CMS should maintain a point-of-contact list for SHIPs and states to contact at MA plans. The currently available Contract Directory on CMS.gov includes plan contact information that is often populated with a generic, centralized customer hotline, unrelated to specific states.

Recommendations Specific to Dually-Eligible Individuals

In addition, CMS should update Medicare Plan Finder to clearly indicate to dual eligible individuals which plans are integrated with Medicaid, and what the value of integration is. Plan Finder also should prioritize integrated plans for dual eligible individuals, rather than requiring dual eligible individuals to sift through pages of results on the tool before the first D-SNP shows.

CMS should improve the ability to compare supplemental benefits information across plans on the Medicare Plan Finder, especially for dual eligible beneficiaries who may leverage supplemental benefits to fill gaps in their Medicaid coverage. The "Plan Features" section of the Plan Finder, which indicates which supplemental benefits a plan covers using checkmarks, is not granular enough to help beneficiaries make an informed plan choice. More detailed information on hearing, dental, and vision benefits is provided in the "Extra benefits" section of plan details, but information on most supplemental benefits coverage is limited to "some" or "no" coverage indicators with no further information to compare benefit details across plans.

The SCAN Foundation developed the My Care, My Choice online decision support tool to help individuals in California who are dually-eligible for Medicare and Medicaid explore the integrated care options available to them. With support from ACL, the National Council on Aging expanded this person-centered tool which has been piloted in 2022 with beneficiaries and counselors via the SHIP in Ohio, and there are plans to add more states over time. This represents another effort to try to provide better information to potential enrollees regarding their plan options.

Having information on MA benefits would not only help potential enrollees but also the Medicaid agency, SHIPs, and Medicaid managed care plans to promote full use of supplemental benefits where beneficiaries are in need and are eligible for those benefits. For dually-eligible individuals served by non-fully-integrated programs, plans and states currently do not have access to a data source that identifies the benefits that the other entity offers. As such, states may not know the supplemental benefits that a D-SNP offers and may not know where overlap exists and to bill the D-SNP first. CMS should require D-SNPs to provide states with a list of all supplemental benefits offered each year and states to provide D-SNPs with a list of Medicaid-covered services and contact information of community-based organizations that help to coordinate services.

E.2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

Supports for older adults and people with disabilities are fragmented across federal and state benefit structures and multiple funding streams. There is an opportunity for greater coordination and shared visioning among multiple agencies. CMS should consider partnering with ACL to explore opportunities for braiding of MA plan funding with other sources of funding, such as the *Older Americans Act (OAA)* funds, to address SDOH. CMS should also partner with ACL to develop resources and provide technical assistance for plans to contract with CBOs, possibly through a learning collaborative.

These types of partnerships do not need to be limited to CMS and ACL, or to within HHS, either. For example, in instances in which a group of CMS beneficiaries is also living in Department of Housing and Urban Development (HUD)-supported housing, coordination between CMS and HUD is critical to ensure that wraparound supports are provided to this population in a coordinated fashion.

CMS should also explore options to create a learning collaborative to collect and aggregate supplemental benefit offering data, including under SSBCI authority, from MA plans- whether via a CMS-convened group (i.e. under the authority of the Health Care Payment Learning and Action Network) or through an externally-convened group. No individual MA plan's data would be published, but plans would receive a regular report benchmarking their individual plan's data against the aggregated data of all participating companies. In addition to promoting continuous learning and improvement for plans, this approach would outsource the analysis of data to a central entity rather than requiring plans to develop internal systems for reporting and analysis, but its success would depend on the number of plans participating.

E.4. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

As we note in response to question A.6, given the increasing attention being paid to social needs and SDOH, and the critical role that community-based organizations (CBOs) play in resolving these needs, partnerships and authentic engagement in communities and with CBOs should be a critical focus going forward of the MA program and MAOs. It is important that CMS be aware of the challenges that exist in doing this work currently. While MAOs are increasingly interested in working with CBOs, several factors inhibit them from doing so, including:

- Difficulty making connections between CBOs and MAOs given the lack of experience that each sector has of working with the other
- Limited service areas given that CBOs often do not have the national / regional scope of an MAO
- The complexity of MAO contracts for CBOs, who are generally not used to the restrictions that MAOs typically deal with and address via contractual terms
- Pricing services, given limited history on the part of CBOs of being paid per service

To address some of these barriers, building upon work initiated by ACL, a multi-stakeholder workgroup is developing scalable plans to align social services with health care. This effort emphasizes the need to support CBO network contracts with health plans and systems to deliver services that meet the social needs of Medicare and Medicaid beneficiaries. CMS should be aware of and engaged in this effort- the Partnership to Align Social Care – particularly given the Partnership's explicit focus on alignment with CMMI's Strategy Refresh.

Another challenge CBOs are encountering is the emerging role of social care referral platforms. Plans often contract with companies that aggregate providers on their platforms to facilitate referrals from plans. These referrals are typically being made without accompanying payment; however, several initial pilots to test incorporating payment are currently underway. CBOs are also being asked to onboard to numerous platforms, overwhelming their already-limited staff and at times leading to a volume of referrals that they are not equipped to deal with. CBOs also face challenges with duplicative data entry due to the lack of interoperability of these new referral platforms with their existing systems.

Lastly, supports for older adults and people with disabilities are fragmented across federal and state benefit structures and multiple funding streams. There is an opportunity for greater coordination and shared visioning among multiple agencies. CMS should consider partnering with ACL to explore opportunities for braiding of MA plan funding with other sources of funding, such as the *Older Americans Act (OAA)* funds, to address SDOH. CMS should also partner with ACL to develop resources and provide technical assistance for plans to contract with CBOs, possibly through a learning collaborative.

Conclusion

Thank you for the opportunity to provide input on the future of the critically important Medicare Advantage program. LTQA and ATI Advisory welcome the opportunity to discuss our responses to this RFI as well as our policy recommendations based on several years of research on the landscape of non-medical supplemental benefits in Medicare Advantage. We look forward to continued engagement with CMS on potential opportunities to leverage non-medical supplemental benefits to meet CMS' overarching goals for the MA program and to better serve MA beneficiaries with serious, chronic conditions, functional needs, and health-related social needs.

If you have any questions, please contact us at our emails below.

Sincerely,

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