February 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4201-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

Long-Term Quality Alliance (LTQA) appreciates the opportunity to provide comments on the Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs proposed rule, published in the Federal Register on December 27, 2022.[1]

LTQA is a 501(c)3 membership organization aimed at improving outcomes and quality of life for people who need long-term services and supports (LTSS), and their families.[2] LTQA advances person- and family-centered, integrated LTSS through research, education, and advocacy.

Beginning in 2019, with funding support from The SCAN Foundation, LTQA and our research partners at ATI Advisory have conducted a multi-year study tracking the industry's progress over time on the implementation of nonmedical supplemental benefits in Medicare Advantage (MA), including both nonmedical benefits under the expanded definition of "primarily health-related benefits" (PHRB)[3] as well as Special Supplemental Benefits for the Chronically Ill (SSBCI). Over the past several years, LTQA and ATI Advisory have analyzed MA Plan Benefit Package data and interviewed over 40 organizations,

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[1] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program. 87 FR 79452. Available at: https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[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 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.

including MA plans, service 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]

In Fall 2021, we published policy recommendations for CMS to advance the uptake and utilization of these benefits.[5] This report was followed by a second report, published in May 2022, with policy recommendations for Congress.[6] LTQA's comments on this Proposed Rule draw from our extensive research on these benefits as well as our ongoing engagement with a working group comprised of national experts on MA and LTSS, which provides guidance on our research.[7]

LTQA appreciates CMS' efforts to support MA beneficiaries with serious, chronic conditions and functional needs through this Proposed Rule. In our comments below, we highlight several considerations for the provisions with potential impacts on nonmedical supplemental benefits.

Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit

Health Equity in Medicare Advantage (MA) (§§ 422.111, 422.112, and 422.152)

Digital Health Education for MA Enrollees Using Telehealth

LTQA applauds CMS for proposing regulatory updates aimed at improving access and quality of care for diverse populations. Specifically, we are pleased to see CMS' proposal around digital health education. We encourage CMS to provide more specific guidance around how MA plans can leverage nonmedical supplemental benefit authority to maximize the impact of this proposed requirement.

Under CMS' proposal, MA organizations would be required to develop and maintain procedures that identify low digital health literacy among enrollees and education/assistance to support those individuals. MA organizations would have flexibility to determine how low digital health literacy is identified and the education that is provided to enrollees.

As CMS notes, this proposal would be a first step for MA organizations to assess the landscape of health equity in telehealth in their plans and help enrollees navigate telehealth. By requiring MA plans to screen enrollees for digital health literacy in a standardized way, MA plans will have actionable data on the technological access and digital health literacy needs of their member population (e.g., internet access, device access, technological skills). Once they have this information, plans can consider leveraging nonmedical supplemental benefits to help deliver digital health literacy interventions and related items/services (e.g., devices, cellular data plan, Internet).

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

[5] ATI Advisory and LTQA. Policy Recommendations for the Administration to Advance Non-Medical Supplemental Benefits. (November 2021). https://atiadvisory.com/wp-content/uploads/2021/12/Policy-Recommendations-for-the-Administration-to-Advance-Non-Medical-Supplemental-Benefits.pdf

[6] ATI Advisory and LTQA. Fulfilling the Promise of the *CHRONIC Care Act*: Policy Recommendations for Congress to Advance New Supplemental Benefits in Medicare Advantage. (May 2022). https://atiadvisory.com/resources/wp-content/uploads/2022/11/Fulfilling-the-Promise-of-the-CHRONIC-Care-Act-Policy-Recommendations.pdf

[7] See full list of working group (known as the "Leadership Circle") participants on our project website (under "Background & Other Resources").

Typically, if an MA plan provides technological devices (i.e., smartphones, tablets, etc.) and cellular data plans as a supplemental benefit to support enrollees in accessing telehealth technology, the devices must only be used for primarily health-related purposes and cellular data plans can only be provided if use of these plans is locked and limited to health-related activities. However, CMS specifically notes that SSBCI may be used to justify provision of equipment (phone or tablet) and a cellular data plan without limitations when the benefit is limited to a chronically ill enrollee and has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

We encourage CMS to provide more specific guidance to MA plans around opportunities to leverage SSBCI to broaden the uses of the devices they provide to allow for uses that address other social determinants of health, communication, isolation, and related factors that also contribute to their overall health. Relatedly, in 2023, under the Center for Medicare and Medicaid Innovation (CMMI) Value-Based Insurance Design (VBID) model, several plans are offering utility cards that can be used to pay for Internet. CMS should clarify whether plans can do this under SSBCI authority, which can help to address disparities in Internet access.

If finalized, we recommend that CMS encourage plans to consider how SSBCI can be a pathway for operationalizing requirements around digital health education. For instance, plans can build digital health education into other supplemental benefits, such as in-home support services and social needs benefits, which for some plans involves one-on-one support with IADLs.

Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

CMS is proposing a number of changes to MA and Part D marketing aimed at strengthening CMS' ability to ensure MA and Part D marketing to beneficiaries is not misleading, inaccurate, or confusing.

Many of these proposed changes will increase regulation on the marketing activities of third-party marketing organizations (TPMOs) and improve the quality and clarity of information beneficiaries receive regarding their Medicare options, including greater clarity on which plans the TPMOs are selling or sponsored by and limiting the advertisement of benefits in service area where those benefits are not available.

In our research, we have heard concerns that beneficiaries often contact a TPMO after seeing an advertisement highlighting the availability of supplemental benefits, including nonmedical supplemental benefits. The beneficiary then is connected to an agent/broker that sells plans that may not include those benefits that were advertised, or the beneficiary may not be eligible for the benefits.

These changes have the potential to partially address the misleading use of supplemental benefits to attract beneficiaries to plans without being fully informed of whether they can actually access them. While this takes a more indirect route to regulating communications around supplemental benefits, LTQA believes there is a potential opportunity to more directly address confusion around the availability of and eligibility criteria for supplemental benefits.

We recommend that CMS should consider adding to the proposed standardized disclaimer additional language around how supplemental benefits may not be available in every plan to every member in the plan, as we have recommended in our Fall 2021 Policy Report. According to the Medicare Communications and Marketing Guidelines, MA organizations must include an SSBCI disclaimer when SSBCIs are mentioned to convey that the benefits are part of SSBCI and that not all members will

qualify.[8] This disclaimer should also apply to TPMOs and be included in MA plans' increased oversight of these entities.

Definitions of Severe or Disabling Chronic Condition and C-SNPs

LTQA strongly supports CMS' proposed changes to the definition of severe or disabling chronic condition and list of chronic conditions for purposes of C-SNP eligibility determination. We commend CMS for broadening the previously more clinical diagnosis-focused concept of "chronic condition" to a more holistic definition that accounts for the overall health and functional ability of an individual, including functional and cognitive needs. These changes are aligned with our Fall 2020, Fall 2021, and Spring 2022 policy recommendations to CMS and Congress to clarify that functional need/frailty and cognitive need meet the definition of "chronic condition" for purposes of determining SSBCI eligibility and waiving uniformity requirements.

For background, in the *Bipartisan Budget Act (BBA) of 2018*, Congress did not explicitly define "chronic condition" for purposes of SSBCI eligibility. 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. 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. However, in our research, we found that many major MA plans still determined SSBCI eligibility based on the C-SNP chronic condition list. Furthermore, 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.

By aligning the C-SNP definition with the BBA of 2018's definition, this proposed change reinforces the linkage between C-SNP and SSBCI eligibility (since this same definition is also used for SSBCI eligibility determination in the BBA of 2018). This may encourage more plans to use functional and cognitive need to target SSBCI eligibility, which they previously were less comfortable with doing based upon the original set of C-SNP qualifying conditions, per our research.

In considering which sub-population or issue was most inadequately captured by the current eligibility criteria for SSBCI, based on the population the *CHRONIC Care Act* was meant to cover, it was our assessment that functional need/frailty and cognitive need represent a large opportunity for improving care for Medicare beneficiaries, especially with the growing aging population with longer life expectancies. 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 highest-cost Medicare beneficiaries.

While these definitional and eligibility changes are a step in the right direction, it is critical to pair the eligibility expansion with appropriate incentives and supports for plans to actually implement the desired changes on the ground. CMS should consider the challenges C-SNPs may face in providing functional and cognitive supports to their members without any existing mechanism to provide these

[8] The Centers for Medicare and Medicaid Services. Medicare Communications and Marketing Guidelines. (February 2022). https://www.cms.gov/files/document/medicare-communications-marketing-guidelines-2-9-2022.pdf

services (i.e., an existing relationship with a Medicaid plan). Given the limited rebate dollars available to finance supplemental benefits, these benefits are not a sufficient vehicle for providing functional and cognitive supports to individuals who need them. If CMS expands C-SNP eligibility as proposed, CMS should work with stakeholders to identify any barriers to and opportunities for facilitating design and implementation of C-SNPs that can realistically and adequately address functional and cognitive needs.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186)

Care for Older Adults – Functional Status Assessment (Part C)

CMS is proposing to add the Care for Older Adults (COA) – Functional Status Assessment measure back to the Star Ratings for SNPs, beginning with the 2026 Star Ratings and 2024 measurement period, with updates to the definition of a complete functional status assessment.

CMS' proposal to add this measure back to the Star Ratings is a positive step towards increasing standardization of data on functional need for Medicare beneficiaries. As we noted in our Spring 2022 report to Congress, while we recommended using a broader definition of chronic condition for SSBCI eligibility to include functional and cognitive need, using these 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.

The updated specification around documentation of a complete functional status assessment and the associated Star Ratings incentive reflects CMS' enhanced focus on standardizing collection of functional need data and will move plans in this direction. However, the impact of this proposed change is still limited since the requirement remains open-ended with regards to how functional status is assessed and continues to only apply to SNPs at this time. We recommend that CMS continue to explore options to collect information on functional needs for Medicare beneficiaries and the possibility of applying the measure to MA plans more broadly.

Health Equity Index Reward

LTQA supports CMS' efforts to improve health equity through revisions to the current reward factor within the Star Ratings program. We support CMS' proposal to reward high performance across recipients of the Part D low-income subsidy (LIS), individuals dually eligible for Medicare and Medicaid, and those who have a disability, given their complex health and health-related social needs of these populations.

CMS should be aware of the impacts of this policy on rebate dollars available for plans to provide supplemental benefits to address health-related social needs that impact beneficiaries' health. CMS should also consider aligning the targeting criteria of these benefits with social risk factors (SRFs) identified for this HEI reward.

If finalized, implementation of the HEI reward will impact the Star Ratings that plans receive, which in turn impacts the amount of rebate dollars they have to finance supplemental benefits. In 2022, the average rebate dollar amount was $164, and on average, $36 were spent on Part A and Part B

supplemental benefits (i.e., including dental, vision, and hearing benefits). According to CMS' simulations using data from the 2020 and 2021 Star Ratings, 7 (1.7 percent) MA-PD contracts gained one-half star on the overall rating and 54 (13.4 percent) MA-PD contracts lost one-half star on the overall rating compared to the 2021 Star Ratings. As such, in the short-term, this proposed change will likely result in a reduction in the supplemental benefits offered to MA beneficiaries.

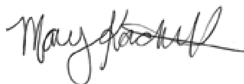
Ideally, this effect will be mitigated in the long-run by plans taking concerted steps to attain the HEI reward. However, plans who see a reduction in their Star ratings (i.e., not meeting thresholds to receive the HEI reward) will see a disproportionate impact on their rebate dollars, meaning they will have fewer resources to fund supplemental benefits and cost-sharing reductions that will help address disparities.

Furthermore, given that the HEI reward is based on performance among members who are dually eligible, receive the LIS, and/or have a disability, plans will be incentivized to improve care for these high-risk members. Nonmedical supplemental benefits are a valuable tool for addressing the holistic needs of these members that may impact their quality of care. However, under current eligibility criteria, nonmedical benefits cannot be targeted based on the three SRFs identified for the HEI reward (note: this current rule proposes updates to the C-SNP conditions which incorporates a broader definition of disability within "chronic conditions", which may encourage plans to target SSBCI based on disability status). As such, we would like to reinforce our recommendation that CMS 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 (per our Fall 2021 policy report to CMS).

Conclusion

Overall, LTQA applauds CMS' efforts to promote health equity, improve beneficiary experience, and strengthen quality measurement through this proposed rule. We support the enhanced focus on disability status in CMS' efforts to advance health equity in Medicare Advantage, as well as a shift towards a more holistic definition of "chronic condition" that accounts for the overall health and functional ability of an individual rather than focusing solely on a clinical diagnosis. The proposed changes also create new requirements and incentives for MA plans to address health equity, for which expanded primarily health-related benefits and SSBCI can be leveraged as powerful tools. We welcome the opportunity to discuss the policy changes in this proposed rule as well as our policy recommendations based on several years of research on the landscape of nonmedical supplemental benefits in Medicare Advantage. If you have any questions, please contact me at mkaschak@ltqa.org.

Sincerely,



Mary Kaschak
Chief Executive Officer