LONG-TERM
QUALITY ALLIANCE

May 15, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development, Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-2023-0041

Long-Term Quality Alliance (LTQA) appreciates the opportunity to provide comments on CMS' proposal to revise Part C Medicare Advantage Reporting Requirements to require annual submission of data on the utilization and cost of supplemental benefits, published in the Federal Register on March 14, 2023.[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, 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 and policy recommendations to advance uptake and access further.[4] LTQA's comments on this proposal 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, known as the "SSBCI Leadership Circle," which provides guidance on our research.[5]

---

[1] Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-2023-0041. Available at: https://www.federalregister.gov/documents/2023/03/14/2023-05145/agency-information-collection-activities-proposed-collection-comment-request

[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.

[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] See full list of working group (known as the "SSBCI Leadership Circle") participants here.

LTQA strongly supports CMS' proposal to require Medicare Advantage Organizations (MAOs) to submit data to CMS annually on the utilization and cost of supplemental benefits, which is directly aligned with our policy recommendation that we have been promoting since November 2021.[6] This proposal, if implemented, will provide greater transparency into utilization and spending for supplemental benefits and valuable information for policymakers, researchers, beneficiaries, and the general public. This reporting requirement will open a line of sight into utilization of these benefits that has not existed since the new authorities to offer these nonmedical supplemental benefits were introduced.

In our research, we have continually emphasized how the lack of data on utilization of these benefits impedes the research and policymaking community from understanding who is accessing these benefits and how often. Without information on utilization, 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., age, race/ethnicity, language, geography, disability, gender identity).

We support CMS' proposal to report utilization and cost data matched to Plan Benefit Package (PBP) reporting categories and categorized by the authority under which each plan offers the benefits (mandatory, optional, mandatory-SSBCI, mandatory-UF). We also encourage CMS to consider implementing the following guidelines to improve the quality and value of the data that are collected:

- Require reporting of key demographic data – We urge CMS to require plans to report key demographic data along with the proposed utilization and spending measures. The SSBCI Leadership Circle highlighted equitable receipt of SSBCI as a guiding principle for the implementation of these benefits,[7] and yet it is not possible to assess this without demographic utilization data. One way that CMS could address this important data gap is by requiring plans to report data elements E-J (number of enrollees eligible for the benefit, through total out-of-pocket cost per utilization for enrollees) disaggregated by key demographic variables, starting with age and race/ethnicity/language. This would help to advance President Biden's Executive Order 13985 which calls for advancing equity for underserved populations as well as the CMS Framework for Health Equity 2022-2032 and the HHS Equity Action Plan.

- Provide more specific guidance around unit of utilization (data element D) – Currently, CMS has proposed an open-text field for the unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases). We caution CMS that in the absence of more specific definitions/standards around unit reporting, the data CMS receives will likely be highly inconsistent and impede CMS' ability to conduct apples-to-apples comparisons across MAOs. For example, for non-medical transportation, some plans may report trips as one-way trips while others may report roundtrips, without specifying this in the open-text field. CMS can mitigate this by providing more detailed specifications around the different types of units, particularly for the nonmedical benefits that may follow more unconventional unit reporting.

[6] In our Fall 2021 Policy Report, we recommended 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. We reinforced this recommendation to implement reporting requirements and incentives in our Spring 2022 policy recommendations for Congress, as well as in multiple comment letters to CMS, including in response to the CY 2023 Medicare Advantage and Part D Proposed Rule and CMS' Request for Information on Medicare Advantage (August 2022).
[7] See the Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill here.

- Consider additional guidance around utilization reporting for supplemental benefits accessed via debit cards – As more MAOs are moving towards offering supplemental benefits through debit cards, CMS should also consider how utilization of these benefits will be reported, especially in cases where multiple benefits can be purchased via a debit card. It may be useful to explore whether plans can report categories of spending from the debit cards. The CMS Value-Based Insurance Design (VBID) model has released guidance on reporting benefits made available via spending cards that should be used as a starting point for broader reporting on these benefits across all MA plans.

- Add a data field for MAOs to submit information on eligibility criteria for each benefit – Under the current proposal, plans would be required to submit data on the number of enrollees eligible for the benefit (data element E). While plans are required to submit in their bids the chronic conditions to which eligibility for supplemental benefits are tied, the new utilization and cost dataset would be enhanced by the inclusion of information on how plans determine who is eligible for a benefit across all three parts of SSBCI eligibility criteria. In addition to the chronic condition eligibility criterion, beneficiaries eligible for SSBCI must have a high risk of hospitalization or other adverse health outcomes and require intensive care coordination. Plans may also use social determinants of health (SDoH) as secondary targeting criteria. Thus, we recommend that CMS require plans to clearly specify all eligibility criteria for supplemental benefits (e.g., targeted chronic conditions plus hospitalization, or targeted chronic conditions plus prior year spending in the top 10 percent of members). Notably, for some PHRB for which all members are eligible, plans would report "none" for this field. Requiring reporting of these data will support CMS' and researchers' ability to compare eligibility, uptake, and spending across plans. Furthermore, as appropriate, CMS should consider how to collect data to distinguish between the eligible population and the targeted population for these benefits and should carefully consider which data fields to make publicly available. CMS may garner lessons from the new VBID utilization reporting that is currently underway, which makes this distinction.

- Consider adding a data field for "maximum number of utilizations among enrollees who utilized the benefit at least once" – While the current proposal would require plans to report the median number of utilizations among utilizers (data element H), collecting data on the maximum usage for each benefit would provide helpful context to interpret the median values. These data would offer a sense of variation in utilization for each benefit and which way the utilization curve skews.

- Explore potential options to capture incremental cost of service vs. overhead costs – In collecting cost data, CMS could consider asking plans to separate out cost to administer a benefit from the cost to deliver a service, in an effort to understand how much a unit of service is actually costing the plan. Having a more granular view of the unit costs vs. overhead costs would add additional insights to the MLR-related questions that are being posed around supplemental benefits.

Finally, we strongly urge CMS to make the data publicly available in a timely manner and in formats that facilitate analysis by researchers. From a research perspective, publicly releasing data within six months to a year after the end of a contract year would support responsive evaluation of the implementation of these benefits and continuous quality improvement. 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. We believe nonmedical supplemental

benefits are valuable for supporting Medicare beneficiaries with complex care needs, and we support proposals that advance these benefits and advocate for continued investment and growth in these benefits while avoiding a cooling effect on these offerings. We support public reporting of the data if they are released on a lagged time frame and report the most granular data feasible.

We are thrilled to see CMS taking this critical step to increase transparency into utilization and spending for supplemental benefits – a necessary step to move the needle on these benefits and to improve regulations around their design and delivery. We encourage CMS to start thinking ahead to capture lessons learned from this aggregated reporting to develop incentives and requirements for standardized beneficiary-level reporting in the future. Beneficiary-level reporting will be crucial to truly understanding the impacts of these benefits on health outcomes, healthcare utilization, and costs in the future.

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