March 7, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
Attention: CMS–1751–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure:

The Long-Term Quality Alliance (LTQA) appreciates the opportunity to provide comments on the Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs proposed rule, published in the Federal Register on January 12, 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.

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 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 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 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]

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[1] 87 Fed. Reg. 1842 (Jan. 12, 2022).
[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 non-medical supplemental benefits in Medicare Advantage.

In Fall 2021, we published policy recommendations for CMS to advance the uptake and utilization of these benefits.[5] LTQA's comments on this Proposed Rule draw from our extensive research on these 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]

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 on the provisions with potential impacts on non-medical supplemental benefits:

- Requiring standardized questions on Social Determinants of Health (SDoH) will provide Special Needs Plans (SNPs) with actionable information on SDoH but they will lack authority to address the issues that are identified. LTQA encourages CMS to provide additional flexibilities to equip plans with the ability to address the social needs for which standardized data collection is being proposed in this rule.
- We caution CMS that the Maximum Out-of-Pocket (MOOP) limit changes will most certainly lead to a reduction in the supplemental benefits offered to MA beneficiaries, and dually eligible beneficiaries in particular.
- The proposed changes around coordinating MA supplemental benefits with Medicaid benefits are very complex to operationalize given the current limitations in data-sharing, the dynamic nature of supplemental benefit structure and eligibility determination, and potential disruption of beneficiaries' regular services. LTQA encourages CMS to address these operational challenges and provide some discretion to plans to promote a person-centered approach to these benefits and ensure members can get the full range of benefits to which they are entitled.
- We recommend that CMS 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 to address beneficiary confusion.
- Medical loss ratio reporting on supplemental benefits will provide greater transparency into spending and utilization for non-medical supplemental benefits. 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.

We provide additional details on each of these considerations below.

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment (§ 422.101)

CMS proposes that starting in 2024 or 2025, all Special Needs Plans (SNPs) will be required to include in their Health Risk Assessment (HRA) one or more standardized 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

[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] See full list of working group participants here.

in 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 is 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. If this provision is finalized, 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, given that dually eligible beneficiaries may be asked similar questions for their Medicaid coverage, CMS should consider policies to reduce duplicative information being captured in order to minimize assessment burden on beneficiaries.

Additionally, if this provision is finalized, 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.[7] LTQA encourages CMS to provide additional flexibilities to give plans the ability to address the social needs for which standardized data collection is being proposed in this rule. Per one of our policy recommendations from our Fall 2021 policy report, CMS should consider allowing plans to target using indicators of SDoH need outside of low-income subsidy (LIS) status as primary targeting criteria through the Value-Based Insurance Design (VBID) demonstration under Center for Medicare and Medicaid Innovation (CMMI) authority. This can serve as a pilot for potentially expanding the eligibility criteria for SSBCI in the future if the evidence base is sufficient.

Attainment of the Maximum Out-of-Pocket (MOOP) Limit (§§ 422.100 and 422.101)

CMS proposes to modify MOOP limits in MA plans (after which the plan pays 100% of the MA costs for Part A and B services) to include third-party payments, including from the State. This would apply even in instances where State lesser-of payment policy results in the State not paying an out-of-pocket cost because of State limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing. If this provision is finalized, state spending on dually eligible beneficiaries will decrease as a result of MOOP limits being attained sooner. Providers may be more willing to serve dually eligible beneficiaries, as they will receive the full amount they are owed for serving these beneficiaries sooner, increasing dually eligible beneficiaries' access to care.

While this proposed change may assist states and providers, we caution CMS that this policy will likely result in a reduction in the supplemental benefits offered to MA beneficiaries, and dually eligible beneficiaries in particular. This proposed change is estimated to cost MA organizations an additional $22.99 per member per month (PMPM), or $9.43 PMPM when accounting for the percentage of dually eligible enrollees with cost-sharing protections above the mandatory MOOP level. Higher PMPM costs will result in a decrease in the rebate dollars available for plans to spend on supplemental benefits. Given that, on average, plans use $29 in rebate dollars PMPM on all Part A and Part B Supplemental

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[7] According to the *Bipartisan Budget Act of 2018*, a chronically ill enrollee is defined as an enrollee who: "has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; has a high risk of hospitalization or other adverse health outcomes; and requires intensive care coordination." *Bipartisan Budget Act of 2018.* https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf

Benefits (including dental, vision, and hearing benefits), 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.

Since D-SNPs serving a large population of dually eligible individuals will be disproportionately impacted by the MOOP limit changes, this policy change will result in reduced supplemental benefit offerings for dually eligible beneficiaries who stand to benefit from these benefits the most. 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. Additionally, a reduction in supplemental benefit offerings will negatively impact partial-benefit and "community-well" dually eligible beneficiaries, who receive cost-sharing support for Medicare but are either not yet eligible to receive any services through Medicaid or LTSS services in particular if they do not meet the LTSS eligibility standards in the state—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. If this policy change results in D-SNPs offering fewer supplemental benefits compared to MA-only plans in the same markets, this could drive dually eligible beneficiaries away from more integrated options, undermining CMS' goal of advancing duals integration. Furthermore, the MOOP policy change will likely impact the smaller or regional and local D-SNPs the most because these plans do not have a broader portfolio against which to cushion the financial burden, especially if the organization does not have any non-duals MA products. This provision 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.

Comment Solicitation on Coordination of Medicaid and MA Supplemental Benefits

With the expansion of MA supplemental benefits to include non-medical services (i.e., LTSS and services to address social needs), there is increased opportunity for overlap in the benefits covered by D-SNPs and Medicaid. Supplemental benefits might be used to complement or fill gaps in Medicaid coverage. Currently, Medicare is the primary payer whenever Medicare and Medicaid cover the same services. CMS is seeking comment 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. If this provision is finalized, LTQA encourages CMS to address any operational challenges and provide some discretion to plans to promote a person-centered approach to these benefits and ensure members can get the full range of benefits to which they are entitled.

For 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. If this provision is finalized, LTQA recommends 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.

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, the proposed change 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 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.

We support the proposal to include an amendment to current regulations to state that supplemental benefits meet uniformity requirements in cases where some dually eligible individuals receive the benefit under the FIDE SNP's Medicaid managed care contract while other enrollees receive the benefit as an MA supplemental benefit because they are not eligible for Medicaid benefits under state Medicaid eligibility criteria. This amendment would be valuable for the pre-dually eligible population to help address individual needs prior to the beneficiary becoming fully eligible for Medicaid LTSS.

Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§§ 422.2260 and 423.2260, 422.2267, and 423.2267)

CMS has observed a significant increase in third-party marketing and in marketing-related beneficiary complaints attributed to third-party marketing organizations (TPMOs) activities. As such, CMS proposes to define TPMOs more broadly and explicitly to capture the full range of types of entities that may be in a position of marketing Medicare health and drug plans. TPMOs will be required to use a standardized disclaimer that states that they do not offer every plan available in beneficiaries' area. Plans will also be responsible for greater oversight of TPMOs.

While these marketing provisions do not directly address supplemental benefits, LTQA believes there is a potential opportunity to leverage these new requirements and increased accountability for these entities to help address confusion around the availability of and eligibility criteria for supplemental benefits. Supplemental benefits are often cited in marketing activities by TPMOs to attract beneficiaries to certain plans when they may not be eligible for them. 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.

Proposed Regulatory Changes to Medicare Medical Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data (§§ 422.2460,422.2490, and 423.2460)

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. For the first time, expenditures will be separately reported for a specified set of supplemental benefit types or categories, which are the categories offered by more than 10% of all MA plans in 2021. A notable exception is the "Non-Primarily Health Related Items and Services that are Special Supplemental Benefits for the Chronically Ill (SSBCI)" category, which was included to help CMS assess the impact of the 2021 rule change that allows 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

expenses to be included in the MLR numerator. CMS also included a category for "All Other Primarily Health Related Supplemental Benefits" to capture all other primarily health-related benefits outside of the ones explicitly listed. Expenditure data will be publicly reported no sooner than 18 months after the end of the applicable contract year. Data will not be released when they would reveal plan-level expenditures for a specific benefit offered under a single plan.

LTQA commends CMS for this proposed change, which 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 support this proposal, and encourage CMS to consider parity in the reporting requirements between primarily health-related benefits and SSBCI.

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. In the *CHRONIC Care Act,* Congress charged the U.S. Government Accountability Office (GAO) to produce a report on this information; unfortunately, we do not believe this will be feasible given the lack of utilization data that is publicly available.[9] We recognize the difficult balance between requiring detailed reporting for accountability on how taxpayer dollars are being spent and incentivizing MA organizations to continue offering these optional benefits by protecting their intellectual property and minimizing reporting burden. 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. While the proposed MLR reporting 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.

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. Under the current proposal, 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 proposed provision, it is unclear whether CMS intends to update the required supplemental benefit reporting categories based on which

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[9] In the *Bipartisan Budget Act of 2018*, Congress charged GAO with producing a report on the following:

(A) The type of supplemental benefits provided to such enrollees, the total number of enrollees receiving each supplemental benefit, and whether the supplemental benefit is covered by the standard benchmark cost of the benefit or with an additional premium.

(B) The frequency in which supplemental benefits are utilized by such enrollees.

(C) The impact supplemental benefits have on— (i) indicators of the quality of care received by such enrollees, including overall health and function of the enrollees; (ii) the utilization of items and services for which benefits are available under the original Medicare fee for-service program option under parts A and B of such title XVIII by such enrollees; and (iii) the amount of the bids submitted by Medicare Advantage Organizations for Medicare Advantage plans under such part C.

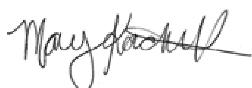
benefit types surpass the 10% threshold CMS used to determine the categories based on Contract Year 2021 data. We recommend that CMS review the list of required categories and consider expanding it to include the most popular non-primarily health-related SSBCI. Our research has tracked the exponential 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 they are released on a lagged time frame and no single benefit for a specific plan can be identified to protect plans' intellectual property. Given the proposal to allow states to create a new pathway for D-SNP-only contracts, we encourage CMS to clarify whether supplemental benefits falling under "All Other Primarily Health Related Supplemental Benefits" and "SSBCI" categories will be publicly reported in a rolled-up category for contracts in which there is only one plan (i.e., a single D-SNP). 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.

Conclusion

Overall, LTQA applauds CMS' efforts to promote health equity, improve beneficiary experience, and increase transparency on MA plans' spending. Many of the proposed provisions have the potential to support MA beneficiaries with serious, chronic conditions and functional needs who are eligible for non-medical supplemental benefits. However, some provisions may have the unintended consequences of limiting access to these benefits for those who stand to benefit from them the most. 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 non-medical supplemental benefits in Medicare Advantage. If you have any questions, please contact me at mkaschak@ltqa.org.

Sincerely,



Mary Kaschak
Executive Director