

August 31, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
U.S. Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013
Delivered Electronically

RE: Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure,

On behalf of ATI Advisory (ATI), we appreciate the opportunity to comment on the Medicare Advantage (MA) program. We respectfully submit the following comments and recommendations in response to the *Medicare Program; Request for Information on Medicare*, published in the Federal Register on August 1, 2022 and including a Request for Information (RFI) on the MA program.

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.

We applaud CMS on this RFI and the opportunity it presents to stakeholders to share their perspectives on important aspects of the MA program. This opportunity is especially important given the rapid evolution of the program and its role as the locus of innovation within Medicare. We know that MA will be a key tool for CMS in achieving its goal of ensuring all Medicare beneficiaries are in an accountable care relationship by 2030, and we believe that it is a critical time to consider program innovations and accountability mechanisms that will achieve the Medicare program's objectives.

Overall, the Medicare population is getting older and, because of that, will experience a higher prevalence of age-related chronic conditions and functional and cognitive impairments, which Black and Latinx beneficiaries experience at higher rates than white beneficiaries.¹ At the same time, it is critical that program design accommodates the need of younger Medicare beneficiaries with disabilities. In light of this, future MA policy must consider more deliberate opportunities to

¹ For example, ATI analysis of the 2019 Medicare Current Beneficiary Survey shows that, compared to white Medicare beneficiaries, Black and Latinx Medicare beneficiaries are 46% more likely to have 2 or more ADLs and 44% more likely to have cognitive impairment.

support person-centeredness, to recognize the outsized role that family caregivers play, and to integrate with Medicaid to promote equitable access and health outcomes.

In response to the issues that CMS has highlighted in this RFI, we note that CMS has the opportunity to support Medicare Advantage in delivering accountable, person-focused, high-quality healthcare through four primary areas:

- Improving data collection and offering greater transparency to researchers, states, and other stakeholders to assess how well non-medical benefits, value-based contracting, and other innovative approaches to care delivery are addressing Medicare beneficiary needs and to determine areas for improvement in post-acute care;
- Providing greater accountability for plans to invest in community infrastructure that supports families and caregivers in navigating systems for healthcare, social, and other non-medical supports;
- Reducing the burden on enrolled beneficiaries and their caregivers by streamlining and simplifying information around and access to plan choices, benefits, appeals processes, and other cumbersome practices; and
- Better incorporating beneficiary and caregiver perspectives to ensure that primary navigators of care can help the agency (and plans) reduce the burden of navigating care.

Sincerely,

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RFI Section 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.*

ATI supports the focus of CMS on assuring that all Medicare beneficiaries receive the care they need. We know that Medicare beneficiaries with functional need have costly medical care. 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 more than twice as expensive to Medicare as individuals who have multiple chronic conditions but no functional impairment.² We also know that the frailty and medical complexity of the Medicare population is only growing with the aging of the population.

A vital step for CMS to better ensure that all Medicare Advantage (MA) enrollees are able to receive the care they need is better data. For example, we recommend that CMS takes steps to ensure accurate encounter reporting for MA plans for all services – not just those that factor into HCC scores. We also recommend that CMS improve reporting on supplemental benefits, beginning with MA plan submission of utilization data to CMS. These efforts will enable CMS, researchers, and beneficiaries to better understand the care being received by beneficiaries enrolled in MA. We recognize this will create administrative costs for MA plans and encourage CMS to work with plans to minimize these costs and streamline reporting.

Building on improved data collection, CMS should also support efforts to collect standardized data (including data on social needs, functional limitations, and demographics). As we note elsewhere, z-codes and new social need data collection efforts in MA Special Needs Plans (SNPs) health risk assessments (HRAs) represent promising opportunities to collect additional data in standardized methods. CMS should consider ways to collect this data from MA plans so it can be combined with encounter data to advance the understanding of whether diverse beneficiaries and beneficiaries with social and functional needs are receiving the health services they need. Any increase in collection of standardized data needs to be weighed with the increased burden it causes, and CMS should be thoughtful in developing standardized and simple reporting methods with the highest potential impact.

² ATI Advisory. (November 2018). "CHRONIC Care Act: Making the Case for Non-Medical Services and Supports in Medicare Advantage Supplemental Benefits." https://atiadvisory.com/wp-content/uploads/2018/11/Anne-Tumlinson-Innovations_Chronic-Care-Act-Data-Brief_Nov-2018.pdf

Beyond the collection of the data, though, we also encourage CMS to drive MA plans to use the data collected to inform the care that their members receive. Collection of this data without it informing care creates additional burden on providers and will likely lead to frustration on the part of MA enrollees. We share information on promising practices to address social and functional needs in the next response.

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?

Care Coordination

Assessment, care planning, and care coordination approaches can be powerful tools for advancing health equity – particularly those that assess enrollee needs and preferences holistically and incorporate this information into a care plan shared across clinical providers, non-clinical supports, and family and other caregivers (with member consent). Identifying family caregivers, who are disproportionately women and women of color, and providing resources and supports to them including care navigation is a promising practice that can advance health equity. **CMS should consider opportunities to provide meaningful supports for caregivers.**

Integrated care teams / interdisciplinary teams are a promising practice for improving enrollee outcomes through a person-centered approach that brings together knowledge across healthcare disciplines with a mindset of collaboration, shared decision making, and open communication. Inclusion of community health workers on the care team who may share ethnic, linguistic, cultural, or experiential connections with enrollees (due to similar backgrounds or living in the same community) is a promising practice for bridging the gap between enrollees and health plan or provider staff with whom they may not as readily establish trust, rapport, and shared understanding. **CMS should encourage all SNPs to explore opportunities to include community health workers in their Model of Care.** Tailored and individualized approaches support health equity goals by centering the lived experiences of enrollees and structuring care delivery in a way most likely to support their overall health and well-being.

CBO Partnership and Engagement

Community-based organizations (CBOs) are increasingly important partners for MA plans seeking to meet needs such as meal delivery, social engagement, and non-medical transportation. CBOs can be ideal partners given their familiarity with community members, established trust, and awareness of local resources. They may have networks and service delivery mechanisms spanning geographic areas, including within enrollee homes. However, MA plans may also struggle to contract with many smaller CBOs, particularly those with less prior experience in working with the healthcare sector. Innovations on the CBO side (including network formation and structures to streamline clinical-social sector partnerships and interactions) can support MA plans in partnering meaningfully with CBOs in ways that advance health equity. Given the critical role that CBOs play in addressing the social needs of Medicare beneficiaries, **CMS should continue to explore opportunities to enhance this sector –**

both through incentives for MA investment in CBO linkages as well as through cross-government partnerships (e.g., with ACL) – to take advantage of other governmental investments in CBOs.

Demographic Data Collection

We encourage CMS to incentivize MA plans to collect and report standardized enrollee data that support identification and reduction of health disparities – particularly demographic data, sexual orientation and gender identity (SOGI) data, and preferred language and English proficiency. We are supportive of recent CMS statements that the agency recognizes the complexity of this task and therefore the need to provide support to collect such data and is actively exploring options to collect self-reported demographic and social needs data via “development of Fast Healthcare Interoperability Resources (FHIR)-based questionnaires, application program interfaces, and mechanisms for bulk data submission.”³ Such data support person-centered care planning as well as efforts to examine health outcomes and other indicators to identify and ameliorate health disparities (including among intersectional groups, such as black Medicare beneficiaries living in rural areas).

CMS Role in Sharing MA Data With States And SHIPs

CMS can play a critical role in providing states with actionable MA enrollment and encounter data to support oversight of MA enrollees’ access to needed care and development of solutions to meet the needs of Medicare beneficiaries in a way that advances health equity. To maximize the utility of these data, **CMS should also allow states to merge MA enrollment and encounter data with linkable state data (e.g., race and ethnicity, language needs, sexual orientation and gender identity, disability assessments, HCBS service use, and measures of income assessed at eligibility).** This level of detail would allow a state to choose meaningful analyses to observe how Medicare programs (e.g., special needs plans) reach certain “small” populations, such as ethnic populations in rural areas, without major limitations caused when using aggregated data, which is subjected to blinding to assure privacy in published files.

We encourage CMS to also share with states and State Health Insurance Assistance Programs (SHIPs) information on MA plan benefit packages in a format that is readily usable and timely (in advance of open enrollment periods), specifically supplemental benefit and MA bid information. This information would assist the state and enrollment counselors (e.g., SHIPs) in understanding available benefits and supporting Medicare beneficiaries in plan selection and how they coordinate with Medicaid benefits, as well as identifying potential disparities in benefit access across the state. This information could also be linked with MA enrollment data to quantify access to various benefits by dual eligibility and demographic characteristics.

³ Hughes, Dora Lynn. (March 3, 2022). “CMS Innovation Center Launches New Initiative To Advance Health Equity.” Health Affairs Forefront.
<https://www.healthaffairs.org/doi/10.1377/forefront.20220302.855616/>

Supplemental Benefits (Data Collection, Sharing, and Targeting by LIS and Dual Status)

Supplemental benefits can address a broad range of MA enrollee needs. Transparent and accessible data on availability and use of such benefits (across racial and ethnic groups, income levels, rural/urban status, and other factors) is critical for identifying potential disparities and opportunities to advance health equity goals. **We suggest that CMS develop incentives for MA plans to submit data on supplemental benefits**, including utilization data and key demographic information when available, to support efforts to measure and ensure equitable access to these benefits. **We also encourage CMS to consider using evidence from VBID to expand SSBCI eligibility criteria to include Part D low-income subsidy (LIS) status and dual-eligibility status through CMMI authority**, if the evidence base is sufficient and the Office of the Chief Actuary approves such a change. This would allow plans to leverage existing structures for determining need based on income as a proxy for other health related social needs, particularly enabling the 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, with the goal to prevent spend down into Medicaid eligibility.

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?

Data standardization is critical to effectively screen and document SDOH needs. CMS promotion of established SDOH standards (e.g., those included in the [United States Core Data for Interoperability](#) (USCDI)) can send a significant signal to the market about CMS' commitment to standardized SDOH data. The current lack of standardization creates duplicative data collection and limits provider and CBO ability to address SDOH needs.

Complementary to this work, and as noted in our joint response with LTQA, the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, first implemented in 2015, also 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, according to CMS findings, in 2019, only approximately 1.59% of Medicare FFS beneficiaries had claims with Z-codes due to low provider uptake.⁴ Increasing the use of Z-codes can help pave the way to provide standardized data on SDOH for potential future updates to risk adjustment, though more research is needed in this area.

⁴ The Centers for Medicare and Medicaid Services Office of Minority Health. "Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019." <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>

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.*

We appreciate that CMS is considering the role of CBOs in providing care to Medicare beneficiaries. We encourage CMS to continue engagement with the [Partnership to Align Social Care](#). The Partnership consists of community-based organizations, health plans and systems, national associations and advocacy organizations, philanthropic organizations, foundations, academic institutions, federal agencies, and other key participants who are working together to build tools and resources that will support CBOs in collaborating amongst each other and establishing meaningful partnerships with healthcare entities. The Partnership is designed to align with the [CMMI's Strategy Refresh](#) and, as we have noted elsewhere, will better enable the critical healthcare to community linkages that help advance value-based care efforts.

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 bases), 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".⁵ 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.⁶ At the same time, Meals (beyond limited

⁵ The Centers for Medicare and Medicaid Services Guidance. (April 2019).

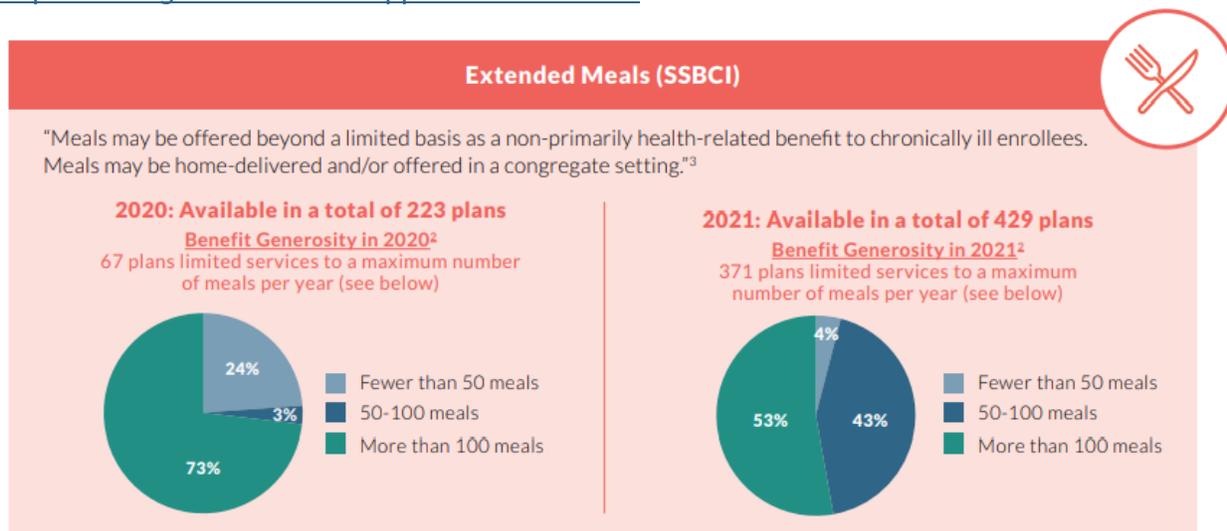
https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

⁶ 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>

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.⁷

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.](#)"



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 an important chassis in the MA program to serve individuals with complex needs. This type of MA plan was first offered in 2006 and is designed to provide targeted care for Medicare beneficiaries with complex care needs, including for those dually

⁷ Ibid.

eligible for Medicare and Medicaid (Dual-Eligible Special Needs Plans, or D-SNPs), individuals with certain chronic conditions (Chronic Condition Special Needs Plans, or C-SNPs), and those with a long-term care level of need (Institutional or Institutional-Equivalent special needs plans, or I- and IE-SNPs). As we have studied the growth of these plan types, we have identified areas for strengthening how these programs serve their enrolled populations and include recommendations below.

D-SNPs have become a strong tool for promoting integration between Medicare and Medicaid for dual eligible individuals, and we applaud CMS for the continued attention to improving the program. Similarly, many I/IE-SNPs have developed clinical programs tailored to the unique medical needs facing individuals residing in long-term care and senior living settings, including onsite primary care and telehealth access to specialists. ATI has published many recommendations and opportunities for CMS to consider as it continues to advance integration, particularly using the D-SNP platform.⁸

In addition to these prior recommendations, we encourage CMS to equip states with more robust and timely information about supplemental benefits. States would benefit from this information in a readily accessible format, to incorporate into state coordination programs and systems. States would also benefit from technical assistance on how to coordinate with supplemental benefits, to ensure services are not redundant between Medicare and Medicaid, but also to ensure that the coordination of benefits process does not create disruption for beneficiaries as a benefit moves from Medicare as the primary payer to Medicaid as the secondary payer. CMS should also provide some discretion to plans to promote a person-centered approach to these benefits and ensure that members can get the full range of benefits to which they are entitled.

We provide additional detail on state needs related to supplemental benefit data in responses. In addition, we encourage CMS to continue improving Medicare Plan Finder as a tool to promote awareness and enrollment into integrated DSNP products for dual eligible individuals. We also provide more information on this below.

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?

⁸ These previous recommendations include: the Center for Medicaid and CHIP Services (CMCS), the Medicare and Medicaid Coordination Office (MMCO), and as applicable, the Division of Medicare Advantage Operations (DMAO) in the Center for Medicare should coordinate approval of Medicaid programs involving dual eligible beneficiaries; CMS should require assessment of plans serving dual eligible beneficiaries on their ability to manage the unique care needs of this population; plans serving dual eligible beneficiaries should be required to offer a D-SNP in their Medicaid service area; and MMCO should explore whether states / CMS can allow a blended medical loss ratio for D-SNPs, inclusive of Medicaid and Medicare expenditures. Additional details and recommendations can be found in two recent ATI reports- [Advancing Medicare – Medicaid Integration through Medicaid Programs: A Policy Roadmap](#) and [Enhancing Medicare – Medicaid Integration: Bringing Elements of the Financial Alignment Initiative into Dual-Eligible Special Needs Plans](#).

As noted in our joint response with LTQA, 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 healthcare utilization and 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 number of bids submitted by MA plans.

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 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 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 in a manner that protects 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.

RFI Section B: Expand Access: Care and Coverage

B1. 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?

Beneficiaries need tools that provide them with a comprehensive, tailored set of coverage options that directly address their unique needs and preferences. Tools should guide beneficiaries on what to assess when choosing a coverage option, including in-network providers, cost of services, formulary, supplemental benefits, as well as considerations of care coordination available through D-SNPs.

An important source of information for Medicare beneficiaries are the State Health Insurance Assistance Programs (SHIPs). These are a trusted voice in the community and help Beneficiaries and their families navigate enrollment options. However, these programs often lack sufficient or timely information to fully counsel Medicare beneficiaries, including understandable supplemental benefit information. **CMS should make supplemental benefit information available to states and SHIPs in advance of the Open Enrollment Period, to equip states and SHIPs with information to assist Medicare beneficiaries. As an alternative or additional approach, CMS should develop a template for states to request benefit and coverage information from MA plans**, such as who is eligible for care coordination in SNPs and what care coordination would mean for a given beneficiary. 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. States can then be responsible for sharing these data in September of each year with their SHIPs to disseminate to counselors.

In addition:

- CMS should update Medicare Plan Finder to clearly indicate to dual eligible individuals what 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 consider providing more educational text on the Medicare Plan Finder to support dual-eligible beneficiaries in making a plan choice. Beneficiaries would benefit from help text on the Medicare Plan Finder that explains the value of integrated products like D-SNPs for dual eligible beneficiaries. In addition to existing language that D-SNPs are "designed for beneficiaries with Medicare and Medicaid," it would be helpful to explain that a D-SNP plan includes both Medicare and Medicaid benefits.
- CMS should also include information on a broader set of supplemental benefits in Medicare Plan Finder.
- 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.
- Once enrollees have chosen a plan, state access to user-friendly MA plan benefit package data merged with beneficiary-level Medicaid information would facilitate

coordination of benefits and third-party liability requirements. Third party liability with state Medicaid programs can be triggered for a range of Medicaid benefits that may be covered by Medicare benefits, particularly with recent supplemental benefit policy expansions that allow for non-medical supplemental benefits.

- In addition, having information on MA benefits would help 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.

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?

As noted in the previous response, CMS should:

- Include information on a broader set of supplemental benefits in Medicare Plan Finder;
- For dually-eligible individuals, update Medicare Plan Finder to clearly indicate what plans are integrated with Medicaid, and what the value of integration is; and
- Plan Finder should also prioritize integrated plan search results 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.

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?

As noted in above responses, CMS can support potential enrollees in understanding their benefits by:

- Updating Medicare Plan Finder to clearly indicate to dual eligible individuals what 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.
- Providing more educational text on the Medicare Plan Finder to support dual-eligible beneficiaries in making a plan choice. Beneficiaries would benefit from help text on the Medicare Plan Finder that explains the value of integrated products like D-SNPs for dual eligible beneficiaries. In addition to existing language that D-SNPs are "designed for beneficiaries with Medicare and Medicaid," it would be helpful to explain that a D-SNP plan includes both Medicare and Medicaid benefits.
- Including information on a broader set of supplemental benefits in Medicare Plan Finder.
- Maintaining 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.
- Once enrollees have chosen a plan, providing states access to user-friendly MA plan benefit package data merged with beneficiary-level Medicaid information to facilitate coordination of benefits and third-party liability requirements. Third party liability with state Medicaid programs can be triggered for a range of Medicaid benefits that may be

covered by Medicare benefits, particularly with recent supplemental benefit policy expansions that allow for non-medical supplemental benefits.

Additionally, 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. **CMS should establish standardized disclaimer language that clarifies that coverage of an SSBCI benefit is not guaranteed.**

B.6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

While CMS, MA plans, and industry partners have focused significant attention on MA beneficiaries' access to primary care and specialty care, the challenges facing MA beneficiaries in accessing post-acute care (PAC) services, including home health and skilled nursing care, need to be addressed. Increasingly, MA plans are outsourcing post-acute care benefit management to third-party organizations such as naviHealth and CareCentrix. These PAC management organizations leverage sophisticated analytics to develop high-performance home health and SNF networks and guide the plan members' use of PAC services.

Working with partners that can employ data and sophisticated analytics to optimize PAC utilization in terms of clinical outcomes and efficiency makes sense, but CMS needs better insight into how the use of these third-party platforms is impacting beneficiaries' access to critical PAC services. Specifically, while the MA plan network adequacy standards include access requirements for some PAC providers (e.g., time and distance requirements for network SNFs), it is less clear how an MA plan member's actual access to critical post-acute services may be adversely impacted by the PAC management organizations, especially those beneficiaries residing in under-resourced, underserved communities. **Before refining network adequacy standards related to PAC services, we recommend that CMS first study how MA plans and their outsourced PAC management partners are shaping the actual home health and SNF networks that their members can access.**

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?

As noted in our joint response with LTQA, with support from the SCAN Foundation, ATI Advisory and LTQA have conducted interviews with over 30 plans and providers 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:

- What benefits 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. It's 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 (like healthAlign) or by a community-based provider (like Western New York Integrated Care Collaborative);
- 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.

While interviewees did not report primary care provider groups playing a large role in referrals, some plans flagged that these providers could be leveraged if the correct incentives were employed. Additionally, some plans described making their benefit resources available on customer service portals. While plans are engaging in efforts to promote awareness within the plan, and uptake appears to be increasing, some plans still report low uptake and are exploring additional opportunities to market these services.

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 2022 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)?

As noted in our joint response with LTQA, **we 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, MA plans 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 MA plans' 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 the regulations around them. 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.

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 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 MA plans 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 intensity of the intervention 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, directional insights could be gleaned from a descriptive analysis of the population receiving SSBCI and Medicaid entry.

B.10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

The MA program allows for innovations and efficiencies to be introduced into the delivery of healthcare. Some of the tools that MA plans use to introduce efficiencies- like prior authorization and utilization management- appropriately support the “rightsizing” of service delivery. However, these tools also introduce the risk that inappropriate limitations will be placed on care for individuals enrolled in these plans.

ATI's network of family caregivers has provided anecdotal evidence that these tools may be creating a tremendous amount of friction in receipt of care, especially for beneficiaries and their caregivers who are navigating a complex system. While we support the continued use of these tools, we also advocate for additional work being done by MA plans to make prior authorization and appeals processes easier to navigate, and in establishing value-based contracts with providers that align financial incentives and reduce reliance on these "efficiency tools". In support of this, CMS should identify opportunities to invest resources in understanding the experience of families and caregivers in navigating care management and should find ways to support members, families, and caregivers in not just the plan selection process but also the plan navigation process.

B.11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

As noted in the previous response, ATI advocates for additional work being done by MA plans and CMS to make prior authorization and appeals processes easier to navigate. In support of this, **MA plans and CMS should identify opportunities to invest resources in understanding the experience of families and caregivers in navigating care management and should find ways to support members, families, and caregivers in not just the plan selection process but also the plan navigation process.**

Importantly, we also recommend that CMS take steps to ensure accurate encounter reporting for MA plans for all services, including post-acute care. In order to evaluate Medicare Advantage member access to post-acute services, and the impact of prior authorization and utilization management, it is vital that researchers have access to accurate encounter data for all services, not just those services that feed into risk adjustment. We encourage CMS to strengthen incentives for accurate reporting to assure that CMS, researchers, and beneficiary advocates have timely data necessary to assess utilization patterns and outcomes for Medicare Advantage members compared to Medicare FFS beneficiaries. As Medicare Advantage enrollment nears half of all Medicare beneficiaries, we simply must have better data to understand and assess Medicare beneficiary access to and utilization of all Medicare services, including across markers of diversity and SDOH need.

RFI Section C: Drive Innovation to Promote Person-Centered Care

- C.1. *What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?*
- C.2. *What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?*

(Consolidated response to Questions C1 and C2)

There is significant opportunity for CMS to accelerate value-based contracting within the Medicare Advantage program. While MA plans and providers have partnered on advanced risk arrangements, including ACOs and global risk contracts, in certain geographies, most notably in California and South Florida, ATI finds that the adoption and diffusion of VBC in MA lags the Medicare FFS program in many markets. In part, this reflects the fact that a given MA plan may not represent a significant proportion of a physician group or health system's payer mix, and likewise, a given provider may only serve a small proportion of an MA plan's population.

However, even when plans and providers develop VBC partnerships, scale remains a challenge and innovative arrangements fail to take root. From the provider's perspective, the lack of uniformity in terms of payment methodology and performance metrics across payers creates additional infrastructure and staffing costs and creates confusion from a clinical management standpoint. Additionally, providers rarely receive the requisite claims, ADT, and other data from MA plans in a timely manner to inform clinical decision making at the point of care and track performance. For their part, MA plans struggle in identifying providers with the clinical and administrative capabilities to excel in risk-based arrangements, and they are reluctant to fund infrastructure development that benefits other health plans.

ATI recommends that CMS continue to build on the work of the Health Care Payment Learning and Action Network and survey all MA plans on an annual basis regarding their VBC contracting. This helps with determining the level of risk contracting and the types of arrangements, and it can help the industry in identifying innovative models and best practices to spur new VBC arrangements. **CMS could also take a page from several states' Medicaid regulatory playbook by setting requirements for MA plans related to their level of VBC contracting.** States like Arizona, Pennsylvania, and South Carolina require Medicaid managed care organizations (MCOs) to make a specific percentage of provider payments through state-approved VBC models. Other states, including New York, require that MCOs migrate to increasingly advanced VBC arrangements (i.e., models that shift greater accountability and risk to providers) over the lifespan of the provider contract.

Additionally, CMS could leverage state support to advance value-based contracting

arrangements. States would benefit from CMS sharing Medicare provider participation status in Medicare fee-for-service ACOs and in MA plans' networks, by plan. For example, states could identify the providers who engage, or do not engage, with dually eligible beneficiaries or racial or ethnic subpopulations, as states develop their own programs to serve these individuals. This information could assist states in identifying potential provider partnership opportunities, as well as education opportunities in the state. This would assist states in understanding trends and gaps across geographies as well, such as rural versus urban access to ACO models.

C.3. What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?

CMS should provide best practices or technical assistance to states and health plans for VBC models that support integration between Medicare and Medicaid, align incentives between the programs, and that maximize the ability of individuals to remain in the community. These might be models targeted at post-acute care transitions or other ways to serve the whole person. These approaches will become increasingly important and should be more attainable as MA plans continue to grow their programs offering non-medical coverage through novel supplemental benefits, and as more MA organizations offer integrated products to dual eligible individuals.

C.4. How are providers and MA plans incorporating and measuring outcomes for the provision of behavioral health services in value-based care arrangements?

Several factors inhibit inclusion of behavioral health services in Medicare Advantage value-based contracting arrangements. For example, current quality systems such as the Medicare Star Rating program lack standardized, widely-accepted behavioral health quality measures. In addition, there is limited uptake of health information technology systems among behavioral health providers due to exclusion from the HITECH Act of 2009, a major source of funding for other providers to update their health IT systems. This also results in a lack of data sharing between and across providers that is crucial to successful VBC arrangements.

To improve coordination related to BH services, we encourage CMS to:

- Continue iterating on behavioral health integration billing codes to incentivize care coordination between physical and behavioral health providers;
- Facilitate behavioral health provider access to health information technology systems necessary for effective coordination. For example, CMS could partner with the Office of the National Coordinator (ONC) to create certification standards for behavioral health IT systems. This aligns with a recommendation from MACPAC in June 2022 and would help behavioral health providers understand what EHR features are desirable or important, particularly in the context of privacy and data sharing. As was done for other health care providers through the HITECH Act of 2009, Congress could authorize funds to improve EHRs for behavioral health care.
- Consider leveraging lessons from Medicaid managed care on behavioral health value-based arrangements. For example, some states (e.g., LA, NM) have required that Medicaid managed care plans participate in alternative payment models with a

behavioral health component, while many other states have incentivized behavioral health integration into primary care through Medicaid managed care contracts.⁹

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 (notably the Special Supplemental Benefits for the Chronically Ill (SSBCI) created by Congress through the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (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 MA plans 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 enrollee experience.** This data could also serve as a potential pathway to a future evaluation of the benefits' impacts on avoidable utilization and health outcomes.

CMS should also expand opportunities for states to participate in CMMI models or for states to partner with local providers/plans in CMMI models, particularly with the goal to serve dual eligible individuals, near/pre-duals, and individuals who are pre-LTSS. For example, because states are accountable for the Medicaid experience of dual eligible individuals, facilitating state participation in Medicare ACOs serving dual eligible individuals would improve experiences for these individuals. It would also allow states to share in savings that accrue to Medicare when the state is investing in in-home and community supports that ultimately reduce hospitalizations and emergency department utilization.

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?

As noted in our joint response with LTQA, **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

⁹ Commonwealth Fund. (October 2019). "[Primary Care Payment Methods, Incentives and Disincentives: Medicaid Managed Care Contract Analysis Database.](https://www.commonwealthfund.org/medicaid-managed-care-database#/topics/primary-care-payment-methods-incentives-disincentives)" <https://www.commonwealthfund.org/medicaid-managed-care-database#/topics/primary-care-payment-methods-incentives-disincentives>

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, **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 more than 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.

RFI Section D: Support Affordability and Sustainability

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

As we noted in our joint response with LTQA, 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 state Medicaid agencies 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 DSNPs 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 especially 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 inform care and payment policies:**

- Increasing collection of encounter data from MA plans for all services, including post-acute care
- Increasing the collection of functional impairment data and its incorporation into risk adjustment efforts, given the research that we have cited in other responses indicating that Medicare beneficiaries with multiple chronic conditions (i.e., limited to clinical diagnoses) and functional impairment are more than twice as expensive to Medicare than individuals who have multiple chronic conditions but no functional impairment
- Broader social needs data capture, through increased use of Z-codes (discussed in detail in the next response) and promotion of SDOH data standards (including those being 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?

ATI recognizes the importance of choice for beneficiaries within the MA program and the potential threat that plan consolidation poses to that choice. However, it is worth noting that the average U.S. county has 26 different MA plans available, and comparing and contrasting costs and benefits across 26 plans is both challenging and time consuming for beneficiaries.¹⁰

In order to support informed choice on behalf of consumers, CMS should:

- Improve the support that SHIPs can offer to individuals by making supplemental benefit information available to states and SHIPs in advance of the Open Enrollment Period;
- Update Medicare Plan Finder to clearly indicate to dual eligible individuals what plans are integrated with Medicaid, and the value of integration;
- Prioritize integrated plans for dual eligible individuals on Plan Finder;
- Include information on a broader set of supplemental benefits in Medicare Plan Finder;
- Maintain a point-of-contact list for SHIPs and states to contact at MA plans to enable more direct fact finding;
- Provide to states a user-friendly MA plan benefit package data for merger with beneficiary-level Medicaid information to facilitate coordination of benefits and third-party liability requirements; and
- Develop a template for states to request benefit and coverage information from MA plans, such as who is eligible for care coordination in SNPs and what care coordination would mean for a given beneficiary.

¹⁰ ATI Advisory. "Is Too Much Choice a Bad Thing?" <https://atiadvisory.com/is-too-much-choice-a-bad-thing/>

Additionally, we noted the following concern in our joint response with LTQA:

- 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.

D.6. Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?

States and CMS alike have an interest in improving health outcomes relative to public spending for all beneficiaries. Blended MLRs can align Medicare and Medicaid accounting within government and among plans. Blended MLRs would be useful for oversight and payment, especially applicable to aligned plans, like D-SNPs. **CMS should provide best practices and technical assistance to states on using a blended MLR across Medicare and Medicaid,** such as how to execute on a blended MLR, given differences in plan and contract level reporting in Medicare versus Medicaid, and how states might use 1115 authority to develop a blended MLR, separate from CMS' requirements on the MA MLR, and potential for reinvestment into the beneficiary and local community if the blended MLR is lower than a state-established target.

RFI Section 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?

Encounter data, including data on post-acute care, is a significant data gap. As we have noted elsewhere, the lack of availability of this data prevents researchers from understanding important aspects of the care received by MA enrollees. **CMS should require reporting and sharing of this data that will allow for improved understanding and assessment of Medicare beneficiary access to and utilization of all Medicare services, including across markers of diversity and SDOH need, and CMS should consider incentives that will help the agency accomplish this goal.**

Additionally, we have laid out elsewhere a roadmap to improving our understanding of supplemental benefits and their impact on the populations receiving these services. **The first step in that roadmap is increasing collection of utilization data of supplemental benefits. This should be another priority data gap that CMS works to close.**

Earlier responses describe data that allow states to better understand the MA program and improve experiences of Medicare residents in the state, and to communicate important information about MA options and their overlap with Medicaid – including in underdeveloped domains such as information about non-medical benefits.

A considerable gap in information pertains to the overlap of the MA program with Medicaid, which has important distinctions depending on the MA plan benefit package, the Medicaid managed care plan, and the county under consideration. More broadly this gap is seen in a dearth of resources for SHIPs to understand the changing and unique characteristics of dual beneficiaries, as well as the coordination of benefits between the two programs. **CMS should partner with the Administration of Community Living (ACL) to provide technical assistance to SHIPs to serve the unique needs of dual beneficiaries.** This may include CMS and ACL collaborating to share state-specific information about the unique needs faced by dual beneficiaries, and special programs or plans available to dual beneficiaries. As noted previously, CMS should maintain a point-of-contact list.

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?

As noted in our joint response with LTQA, 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 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.3. What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

As we have noted elsewhere in our responses, MA enrollees and **their caregivers** are essential voices that CMS needs to incorporate for the sake of improving policy related to the complex populations served in MA. Not only should enrollees and caregivers have an opportunity to engage in improvements that are necessary to streamline cost control techniques used by MA plans, but **CMS should make a meaningful effort to engage these populations in generally understanding their experience navigating such a complex system.** This needs to extend support to enrollees and caregivers all the way from the plan selection process to navigating use of the plan once enrolled.