C-TAC
COALITION TO TRANSFORM ADVANCED CARE

January 2, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises more than 200 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life, or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

Serious illness is also a health equity issue. A history of disenfranchisement has led to healthcare gaps across the country. Per a 2021 Commonwealth report on racial and ethnic health equity, communities of color live fewer years, on average, than white people do, are more likely to die from treatable conditions, and are also at higher risk for many chronic health conditions. For serious illness, the lack of access to health insurance and primary care mean many are diagnosed only at a late or end stage of illness, when disease-modifying treatment is typically no longer effective. Those from historically under-resourced communities who also have serious illness experience poorer care and access, making improving their care a health equity opportunity.

Improvements to Drug Management Programs

We support the proposed change that expands the definition of exempted beneficiaries to more broadly refer to enrollees being treated for cancer-related pain to include beneficiaries undergoing active cancer treatment, as well as cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance only. We have long felt that this group needs to be recognized as needing long-term pain management, often appropriately with opioid medications. We therefore agree that they should exempted from drug management programs meant to identify potential inappropriate opioid use.

We also support the other exempted beneficiary groups as previously finalized: enrollees being treated for active cancer-related pain, or have sickle-cell disease, residing in a long-term care facility, have elected to receive hospice care, or are receiving palliative or end-of- life care. We would note, however, that the use of the term "palliative care" here should refer to people at any point in a serious illness receiving these services, not just those receiving them at the end of life. This is in line with the CMS definition of palliative care as "Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. *Palliative care throughout the continuum of illness* involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." Palliative care and end-of-life care overlap but are two different things and patients receiving palliative care early in an illness, and also needing opioid medications, are likely being appropriately treated and followed regarding those medications.

Special Supplemental Benefits for the Chronically Ill (SSBCI)- Evidence as to Whether a SSBCI Has a Reasonable Expectation of Improving the Health or Overall Function of an Enrollee

We support the proposed changes to the SSBCI policy with the following comments:

- Demonstrating that the reasonable expectation standard has been met: We agree that planned use of these benefits should be reported to CMS by MA plans, rather than the other way around.

- Supported by evidence: We agree that any such benefits should be based on evidence. However, the evidence base for some home-based services, is limited and so we would encourage CMS to accept any published evidence rather than require it be from a large randomized controlled trial or a multi-site trial. Evidence should also report outcomes

beyond just cost and utilization as SSBCI's also improve quality of life for the person and their family caregiver and contribute to higher patient satisfaction. These are important metrics that should also be considered when evaluating their use.

- Enrollee overall health and function: Finally, we would note that improving or maintaining the overall health or function of an enrollee, while a worthy goal, is not possible for those in the last stages of a serious or progressive illness. A more appropriate goal there is to slow the decline of function and to help improve quality of life, ideally achieving whatever the enrollee's personal goals are for their care. Home-based palliative care, for instance, deliver such goals and so should be available when needed given its positive evidence base. We therefore suggest CMS consider modifying the definition to allow for this possibility.

Annual Health Equity Analysis of Utilization Management Policies and Procedures
This is an interesting proposal and we support the goal behind it of reducing disparities in access to care that current utilization policies and procedures may cause to those from under-resourced communities. However, we are concerned that too many aspects of this proposal are not yet clearly defined. The proposed rule notes that qualifications for the health equity expert required for this position are not yet consistently confirmed and this may make it difficult for MA plans to find appropriate candidates. Also, we question whether there is sufficient evidence that adding such a role to this process will indeed improve health equity. We also think that enrollees should also be part of this evaluation process. Therefore, we encourage CMS to perhaps test this new process first so as to inform future rulemaking on this issue.

Amendments to Part C and Part D Reporting Requirements
We support the proposed revisions to update §§ 422.516(a) and 423.514(a). However, we suggest a further revision: Section 422.516 currently reads, "Each MA organization must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the *doctor*-patient relationship, statistics and other information." Since health care is increasingly delivered by a wider range of roles than just physicians, please change the phrase "doctor-patient relationship" to "clinician-patient relationship". Privacy and confidentiality are an issue in any relationship a patient has with their health care team, not just with their doctors.

Enhance Guardrails for Agent and Broker Compensation
We support these proposed changes and any that enhance guardrails for these MA roles. We believe this is an equity issue as well as enrollees with low health literacy need all possible protections to ensure they make appropriately informed and understood health plan decisions. To that end, we also suggest that agents and brokers be required to include traditional Medicare as an option when providing materials that compare plans. Traditional Medicare is always an option and beneficiaries should be regularly made aware of that.

Marketing and Communications Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI)

We support the proposal to expand the current required SSBCI disclaimer to include more specific requirements, with the intention of increasing transparency for beneficiaries and decreasing misleading advertising by MA organizations and the proposed expansion of the SSBCI disclaimer to clarify enrollee eligibility for the SSBCI. These are important services but should be made clear in their marketing materials so enrollees can make fully informed choices.

Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization

We support these proposed changes as well and appreciate CMS' plan for future rulemaking to improve the fairness of any MA marketing processes and facilitate enrollees making appropriately informed choices. We agree that currently there may indeed be "perverse incentive for D-SNPs to offer certain types of supplemental benefits for Medicare marketing purposes even when the same services are already available to all enrollees in the plan through Medicaid." The dually eligible population is a vulnerable one and so CMS should continue to take steps to safeguard them regarding marketing to them.

We are also concerned that Medicaid enrollment is variable with D-SNP participants losing access to those programs when they stop qualifying for Medicaid. The recent widespread Medicaid disenrollments are particularly on our minds in this regard. We therefore encourage CMS to consider this issue in future rulemaking and to explore possibly providing extended D-SNP access for some amount of time to help maintain continuity of care when someone's Medicaid enrollment stops.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

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