

The SNP Alliance



A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

SNP Alliance Comments **2016 CMS Advance Payment Notice and Draft Call Letter** **March 6, 2015**

INTRODUCTION

The SNP Alliance appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed "Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter," released on February 20, 2015.

The SNP Alliance is a national organization exclusively focused on improving SNP and MMP policy and plan performance. Our 30 organizational members include the full spectrum of large and small organizations that sponsor over 300 public, for-profit and non-profit plans, and serve nearly one million beneficiaries. Our membership includes representation from every type of SNP and from every region of the US. We also work closely with leading State Medicaid agencies involved in dual integration efforts, inside and outside of demonstration authority, and with MMP sponsors from every state involved in the Financial Alignment Demonstration. We disproportionately represent SNPs with the longest history of dual integration innovation and the largest proportion of beneficiaries with complex medical needs.

SUMMARY

We commend CMS' interest in advancing policy for dually eligible beneficiaries through the spectrum of Medicare and Medicaid programs, in strengthening the role of D-SNPs to serve as a platform for integration, and advancing the alignment of Medicare and Medicaid functions inside and outside of national demonstration authority.

We also commend the interest of CMS' Center for Medicare in promoting dual eligible integrated plans and the leadership of the Medicare-Medicaid Coordination Office (MMCO) in playing a pivotal role in developing dual eligible integrated demonstrations, including the Financial Alignment Demonstrations, as well as promoting dual eligible initiatives throughout CMS. The SNP Alliance offers a number of comments and recommendations that seek to build on the array of CMS proposals outlined for promoting dual eligible integration.

The SNP Alliance continues to have serious concerns with regard to the ability of the CMS-HCC risk adjustment methodology to appropriately pay SNPs and MMPs that disproportionately serve poor, frail, and/or disabled persons, and beneficiaries with complex medical conditions, such as persons with severe and persistent mental illness. To address these issues in the short-term, while CMS seeks to fine-tune its risk adjustment methodology over time, we recommend that CMS reinstitute the 2013 CMS-HCC risk adjustment methodology for the 2016 payment year and consider expediting a strategy for addressing apparent disparities in payment for duals and non-duals sooner rather than later.

While we applaud and support CMS' efforts to address the influences of social demographic factors for dual beneficiaries on Star ratings over time, we are concerned the proposed strategy to reduce the weights for 6 of the 46 star measures by 50% will not provide meaningful relief for dual plans in the short term. We are eager

to work with CMS to find more meaningful relief for SES vulnerable plans in 2016, while advancing a more comprehensive, evidence-based, long term strategy commensurate with the general strategy CMS proposes.

The SNP Alliance greatly appreciates CMS' commitment to improving care for poor, frail, disabled, chronically ill persons. We would greatly appreciate an opportunity to meet with CMS staff, subsequent to this submission, to better understand selected CMS proposals and to explore options for refining risk adjustment, performance evaluation and integration of Medicare and Medicaid to optimize total quality and cost performance of SNPs and MMPs in serving Medicare's most needy, costly and fast-growing subgroups.

ADVANCE PAYMENT NOTICE

1. New CMS-HCC risk model (page 19).

Recommendations: The SNP Alliance is recommending that CMS reinstitute the 2013 CMS-HCC risk adjustment model until CMS is able to incorporate in the CMS-HCC risk adjustment model factors to address appropriately cost differences of beneficiaries who are dual eligible, who are frail elderly, who are adults with disabilities, and who have multiple chronic conditions. The SNP Alliance believes that the 2013 CMS-HCC risk adjustment model provides for a more accurate payment model for MAOs serving chronically ill beneficiaries. As the SNP Alliance has commented previously to CMS, we question CMS rationale justifying the changes affecting the HCCs for chronic kidney disease and diabetes. Returning to the 2013 CMS-HCC risk adjustment model would give CMS an opportunity to look more closely at the clinical implications of these changes, including their impact on the ability of MAOs and in particular special needs plans, to provide the substantial medical and support services needed for their enrollees.

Underlying the SNP Alliance's concern is our assessment that the impact of a full transition to the 2014 CMS-HCC risk adjustment model will have a negative impact on many SNPs significantly in excess of CMS' projected payment reduction of 1.7 percent. The 2016 Draft Call Letter clearly conveys the importance to CMS of promoting the growth of integrated plans. The SNP Alliance believes that the benefits of these programs will be undermined if many D-SNPs are unable to maintain financially viable programs because CMS' CMS-HCC risk adjustment model fails to adequately address the costs of serving beneficiaries who participate in these programs. Moreover, given other negative payment factors in the 2016 rates, the SNP Alliance believes that these concerns apply similarly to the current blend of the 2013 and 2014 CMS-HCC risk adjustment models.

The SNP Alliance believes that there is abundant evidence in the risk adjustment literature that the MA risk adjustment methodology under predicts costs for certain high-cost/high-risk beneficiaries and under values the cost of caring for duals vs. non-duals commensurate with costs in traditional Medicare. Our view is supported by a 2013 review of the state-of-the-art in risk adjustment published by the Robert Wood Johnson Foundation¹ as well as by findings from Milliman Actuarial Analysis of the 2014 HCC Model.

In 2013, Milliman conducted an actuarial analysis of changes in the 2014 CMS-HCC Model and the impact on about 15 specific high-risk/high-need subgroups, including duals vs. non-duals, institutional vs. non-institutional beneficiaries, under-65 adults with various types of disabilities and persons with

¹ Schone, Eric and Brown, Randall, Risk Adjustment: What is the current state of the art, and how can it be improved? Robert Wood Johnson Foundation, RESEARCH SYNTHESIS REPORT NO. 25, July 2013.

the various chronic conditions approved for exclusive enrollment in C-SNPs.² The analysis compared average FFS expenditures and MA risk-adjusted, county benchmark payments for these groups in 2014 using the Medicare 5% sample. Among the major findings are that 2014 MA risk adjusted benchmark payments for duals are nearly 8% less than for non-duals, compared to payment for duals and non-duals served in traditional Medicare, with comparable demographic factors, and significantly less for some dual subgroups, with benchmark payment rates actually less than fee-for-service (FFS) expenditures for certain high-risk/high-need dual subgroups. Since about 85% of all SNP beneficiaries are dually eligible, these findings indicate that SNPs are undercompensated relative to Medicare FFS for most beneficiaries.

The additional cuts through full implementation of the 2014 CMS-HCC payment model would only exacerbate current underpayments and increase disparities going into 2016. Further, these cuts potentially put at risk the financial viability of specialized managed care, not because of a lack of interest in the marketplace but because the existing HCCs do not account for the added costs and care complications associated with specializing in care of high-risk/high need persons. This could have a devastating effect on hundreds of thousands, if not millions, of vulnerable beneficiaries with complex care needs who have freely chosen to enroll in specialized managed care programs. It could create financial hardship for for-profit and not-for-profit companies that have taken it upon themselves to finance specialty care programs. It also could undermine the ability of Congress to control Medicare costs over time, even as Congressional leaders increasingly are looking to specialized programs and related risk adjusted payment methods as a foundation for addressing their concerns.

Specifically, the Milliman study showed that under the 2014 CMS-HCC payment model, MA risk adjusted benchmarks for some Medicare beneficiaries are actually less than payments under Medicare fee-for-service. The nondual subgroups considered to be disadvantaged the most because they have a benchmark-to-cost ratio lower than the nationwide average full Medicare population benchmark-to-cost ratio are institutional beneficiaries at 86.5% of Medicare FFS and CKD at 96.1% of Medicare FFS. The benchmark-to-cost ratios are even lower for dual eligible subgroups with certain conditions, including:

- Dual eligible with CKD (90.5%)
- All dual eligible with risk scores of 3.0 and above (94.7%)
- Dual eligible adults with physical disabilities (96.3%) and, specifically those with risk scores of 3.0 and above (91.7%)
- Dual eligible with chronic lung failure (96.4%)
- Dual eligible with drug and alcohol disorders (96.2%) and, specifically, those with risk scores of 3.0 and above (92.2%)

While the SNP Alliance has consistently supported parity in payment between MA and FFS, we do not support achieving this parity at the expense of poor, vulnerable, disabled, chronically ill persons. We also do not support paying plans that specialize in care of high-risk/high-need beneficiaries LESS, and in some cases, significantly less, than Medicare FFS providers.

The SNP Alliance asks that CMS conduct a more rigorous analysis of the potential adverse effects of the current payment method on plans specializing in care of these subgroups and take appropriate action where correction is warranted. We believe it is important for CMS to look at the clinical implications of the CMS-HCC payment methods, and seek to make improvements in how the model works in serving various population segments with significant cost and quality considerations, such as dually eligible

² CMS-HCC Risk Adjustment Methodology Analysis: Study of the Impact of the Change in CMS-HCC Risk Models Between 2013 and 2014 on Risk Scores and Medical Loss Ratios of Population Subgroups. Prepared for National Health Policy Group by Milliman, Inc., January 28, 2014.

beneficiaries, frail elders, persons with various types of disability, and persons with late-stage and/or complex medical conditions.

The SNP Alliance would like to work with CMS in this effort and would welcome CMS revisiting the analysis done by Milliman in 2014, but using the HCC payment method proposed for 2016. The SNP Alliance asks that CMS consider developing a predictive bias adjustment factor (PBAF) for the CMS-HCC risk model for the mutually exclusive subsets of duals and non-duals such that FFS costs are predicted accurately for these two subsets in aggregate (i.e., both subsets have the same benchmark-to-cost ratio for a given payment year). To implement the PBAFs within the MA program, CMS can simply apply PBAFs as an additional factor (either the dual factor or the non-dual factor, depending on the individual's dual status), along with the FFS normalization factors and the MA coding intensity factor, to the raw risk scores from the CMS-HCC risk model. Overall, the impact of implementing the PBAFs would be budget neutral, assuming there is not a difference in the percentage of the total population represented by duals in MA vs FFS. The Impact on plans that exclusively or disproportionately serve dually eligible beneficiaries would be to ensure payment equity with FFS providers and to enhance their capacity to address beneficiaries' special needs.

A recent study by The Robert Wood Johnson Foundation on the state of the art in risk adjustment also concluded that improvements are needed to risk adjustment and recommended a variety of options such as longer diagnostic histories to identify more patients with chronic conditions, including clinical data in risk adjustment, and the use of concurrent and prior use models. MedPAC and other government entities also have published research and recommendations in recent years to improve risk adjustment. A 2011 GAO report on MA risk adjustment found that, for beneficiaries with dementia, the revised community model used for PACE providers substantially improved the accuracy of MA payment adjustments by \$2,674, or about 16 percent of average actual expenditures.³

2. **Alternate Methodology for Coding Pattern Adjustment (page 20).**

Recommendations: CMS is proposing to cap payments to MAOs by calibrating the MA coding pattern adjustment to produce the result that payments to MA plans, in the aggregate, would be no greater than the level of payment that would have been made if we were still using the variables in the adjusted average per capita cost (AAPCC) payment system that was in effect prior to 2000. CMS explained that CMS would first estimate the risk of MA-enrolled beneficiaries relative to the risk of beneficiaries in FFS. Next, CMS would calculate the ratio of MA-to-FFS risk using the CMS-HCC model. Using the difference between the two ratios, CMS would calculate the MA coding adjustment factor.

The SNP Alliance opposes this proposal. Congress required CMS to abandon the demographic methodology 15 years ago because it believed that it was inadequate and developing risk adjusters principally based on diagnoses was a more accurate means of predicting costs and therefore a better model for rate development. We believe using this outdated model as a vehicle to create a cap on payment is arbitrary and undermines the basic objective of the risk adjustment model, which is to pay accurately based on risk adjustment factors of each enrollee. Moreover, absent CMS disclosing to the industry the impact of this proposal, it is impossible to understand fully its impact and impossible to formulate a meaningful comment.

3. **Frailty Adjustment for PACE organizations and FIDE SNPs (page 23).** CMS announced that the frailty factors for PACE will not change for FY 2016. CMS added that frailty for FIDE SNPs will be based on frailty factors associated with the 2014 risk adjustment model. Those factors are identified in a chart in the Advance Notice.

³ Medicare Advantage: Changes Improved Accuracy of Risk Adjustment for Certain Beneficiaries, December 2011, GAO-12-52.

Recommendations: The SNP Alliance supports applying a frailty adjustment to whatever HCC risk adjustment model is used, assuming that the findings in determining the frailty factor for any one FIDE SNP can be based on a comparable instrument and methodology used in determining the frailty factor for PACE.

4. **Updated version of the RxHCC risk adjustment model (page 27).**

Recommendations: CMS is proposing to make a number of changes to the methodology to reflect the 2016 benefit structure; to update the data years used to calibrate the model; to update the diagnoses included in some prescription drug hierarchical condition categories (RxHCCs); and to include MA-PD data in the model calibration.

In addition, CMS created a new RxHCC for chronic Hepatitis C, which was split from the chronic viral hepatitis RxHCC. Because the data used to calibrate the model was from years that preceded the new Hepatitis C medications, CMS applied an actuarial adjustment to the coefficient of the new chronic Hepatitis C RxHCC. The SNP Alliance commends CMS' decision to apply this coefficient in order to more appropriately reflect these new costs. These new drugs are very expensive and the SNP Alliance believes that these costs had a disproportionately large effect on SNPs that are more likely to have a larger portion of their enrollment serving members with Hepatitis C.

2016 DRAFT CALL LETTER

1. **Contracting Organizations with Ratings of Less Than Three Stars in Three Consecutive Years (page 81).**

Recommendations: The SNP Alliance supported CMS' September 8, 2014, decision not to exercise its discretion to terminate contracts of MAOs that had sub 3-star ratings for three successive years. The SNP Alliance's understanding is that CMS' decision not to exercise this authority coincided with its decision to review the Star Rating methodology to assure that there was not any bias against MAOs that enroll a large proportion of dual eligibles.

Given that CMS is continuing to explore this issue, the SNP Alliance believes it is premature for CMS to terminate contracts of MAOs that have been unable to meet this standard. The SNP Alliance recommends that CMS continue to forego exercising this discretion until CMS has appropriately addressed this important issue.

Moreover, while CMS continues to explore how to revise the Star Rating methodology to remove this bias, an additional issue that CMS needs to consider is the implications of terminations on Medicaid beneficiaries and State Medicaid programs. Our understanding is that several states were concerned that D-SNPs that were threatened with contract termination withdrew from their markets. These withdrawals undermine the efforts by these states to move toward integrated programs as well as cause general market instability. These withdrawals created significant problems for dual eligibles and their caregivers in these states.

Furthermore, one state believes that when the state must oversee mass migrations from one D-SNP to others, or from the D-SNP program to original Medicaid managed care, on an annual basis, confidence in the platform among policy makers, stakeholders and providers erodes. In short, termination is a threat to continuing D-SNP as an integration platform as it renders difficult the decision to promote D-SNPs or build upon them using other flexibilities if there is an overarching concern that fundamental program stability and return on investment in integration is outside of the State's control. Program

stability is vital for states pursuing managed long-term services and supports in a FIDE SNP package. While most FIDE SNPs have higher stars and performance ratings than less integrated D-SNPs, it is important to consider that termination, should it occur, is even more of a risk to the health and safety of MLTSS enrollees, the most vulnerable of the vulnerable.

2. **Enhancements to the 2016 Star Ratings and Beyond (page 81).**

a. **Development of an integrated Star Rating system for Medicare-Medicaid Plans (MMPs) (page 82).**

Recommendations: CMS is exploring the development of an integrated Star Rating system for MMPs participating in the capitated Financial Alignment Initiative. The purpose of this effort is to develop a rating system that acknowledges the additional needs of Medicare-Medicaid enrollees and measures the performance of the MMPs in integrating Medicare and Medicaid benefits. CMS states that it will provide more information about its intentions in the first quarter of 2015.

Our understanding of this proposal is that it is a longer-term objective which would not be undertaken with the intent of implementing a Star Rating program for MMPs in their initial three-year demonstration period. To confirm this is the case, we ask that CMS clarify the timeframe for development and implementation of a new rating system for integrated plans. The SNP Alliance commends CMS' efforts to develop new metrics and methods that account more fully for the unique needs of dual beneficiaries. As CMS pursues this effort, we encourage CMS to build in flexibility and variances for serving diverse population segments within the overall dual population and expand and apply the benefits of a new integrated Star Rating system to FIDESNPs and to other integrated D-SNPs that are not participating in the demonstrations. We look forward to the opportunity to provide further input on this issue later this year and emphasize the importance of ongoing involvement of stakeholders, including integrated plans, in the development of any new rating system.

b. **Addressing concerns that plans with a large number of dual eligible or LIS beneficiaries are being disadvantaged by the Star Ratings Program (page 98).**

Recommendations: The SNP Alliance thanks CMS for taking steps in the Draft Call Letter to evaluate the effects of dual eligible and LIS status on MA Star Ratings. Over the past year, the SNP Alliance and other organizations noted to CMS that Star Rating measures do not account for the effects of socio-economic status and related beneficiary characteristics that have been shown by long-standing research to influence patient use of health care services and their health outcomes. As a result, we have raised concerns that measures in the Star Rating system underestimate the performance of health plans that treat a disproportionate share of beneficiaries with low socio-economic status and related factors. The Draft Call Letter takes an important step in facilitating dialogue on the impacts that dual eligible and LIS status may have on MA Star Ratings. In addition, CMS' recent issuance of a Request for Information (RFI) for analyses demonstrating a link between dual status and lower quality ratings brought a welcome opening for input on the issues.

The SNP Alliance commends CMS for beginning to conduct internal research on this topic and summarizing some of the findings in the Draft Call Letter. We support the open dialogue CMS has started with the RFI and Draft Call Letter and believe it is the best way to develop long-term policies. We urge CMS to continue the public dialogue by releasing the results of its internal statistical analyses so that plans and the public can learn from and comment on the findings.

The SNP Alliance also commends CMS for proposing interim steps that target relief to plans with significant dual eligible and LIS enrollment. Interim steps are essential because plan Star Ratings are used to allocate payments to plans under the Quality Bonus Program (QBP). Underestimates of Star Ratings can lead to lower benchmarks and thus cause withholding of resources from plans that serve vulnerable beneficiaries and communities.

Although we fully support CMS in the pursuit of interim relief, we have the following concerns about CMS' proposal:

1. CMS' proposed interim step has minute impacts on Star Ratings of plans with substantial dual and LIS enrollment. The impact for SNP Alliance members ranges from a negative change in Star Ratings to a minute positive change. For example, the Star Rating for one SNP Alliance member that exclusively serves dual eligible beneficiaries on the West Coast would increase 4/100th of a Star under the CMS proposal – from 3.25 to 3.29. Another member that exclusively serves dual eligible beneficiaries in the Mid West would see a negative and even larger impact from the proposal. Inovalon analysis shows that the reduced weighting will have virtually no impact on Star Ratings on a nationwide basis.

One reason for minimal impact is that CMS includes only 6 of 46 Star Rating measures in the interim proposal. CMS' internal analyses identified 19 measures with disparities among low income and non-low income beneficiaries. According to the Inovalon analyses, dual eligible status had an independent effect on at least 7 measures, 3 of which CMS includes in its interim step. In addition, some of the 6 measures CMS targets, such as Osteoporosis Management in Women who had a Fracture, provide no impact for a number of plans because they do not have enough enrollment of beneficiaries with the condition specified to count toward their Star Ratings. Thus, the effect of CMS' proposal is diluted because of the small number of measures it targets as well as the type of measure in some cases.

2. Reducing weights of 6 Part C measures has the effect of making CAHPS and HOS measures count more toward the Overall Star Rating. The SNP Alliance has expressed concerns for many years that CAHPS and HOS measures as currently defined are problematic for beneficiaries with behavioral health and related conditions such as cognitive impairment. CMS would have to reweight several or all of the HOS and CAHPS measures in the interim step to at least maintain the current relative emphasis between HEDIS, CAHPS and HOS in the Star Ratings.

3. CMS' interim step provides virtually no financial relief to plans with substantial dual and LIS enrollment. While we are grateful to CMS for proposing an interim step, reweighting 6 measures does not provide enough impact to move plans with substantial dual and LIS enrollment into higher benchmark ranges or into higher rebate percentages that have been made available by Congress under the QBP. We believe financial relief is warranted because the current Star Rating issues identified by CMS in the Call Letter are impeding these plans from participating in the QBP and creating a financial hardship for them as a result.

4. CMS' interim step would not provide financial relief soon enough. The proposal would affect Star Ratings in 2016, which does not affect plan payment until 2017. The proposal. The Star Ratings issues raised by CMS are having substantial negative impacts on plans with substantial dual and LIS enrollment in 2015.

We believe Congress gave CMS significant latitude to design, implement, and refine a five-star rating system that allocates funds under the QBP. We also believe CMS has broad authority under the QBP to design a range of interim steps that can target relief to plans that are impeded

from achieving 4-star ratings with the current specification of Star Rating measures. We urge CMS to use its broad authority under the QBP to provide financial relief to plans in need while it continues to work on a long-term solution to the Star Rating issues raised in the Call Letter.

Below are recommendations from the SNP Alliance:

- 1. CMS' interim step should provide immediate relief in 2016.** We strongly urge CMS to design an interim step that provides immediate financial relief in payment year 2016 until the Star Rating system can be modified to accurately allocate resources under the QBP.
- 2. An interim step should target financial relief to the plans CMS says need it most – plans with significant dual eligible and low-income enrollment.** We believe that an interim step should not apply to all plans.
- 3. Provide a temporary adjustment to CY16 MA benchmarks for plans with significant dual eligible and low-income enrollment.** We believe a benchmark adjustment is the most direct approach to providing financial relief in the short term. The evidence for making a benchmark adjustment are the findings that CMS summarized in the Draft Call Letter – that dual and low income factors influence at least 19 or 46 Star measures. CMS has broad authority under the QBP that could be used to remove impediments to QBP payments for plans with large dual and LIS populations while it continues to work on longer-term solutions to the issues it raised in the Draft Call Letter. We recommend that any benchmark adjustment include requirements that added resources only be used by plans to provide targeted interventions to improve quality of care for low-SES populations. Plans could be required to specify low-SES interventions to CMS in their bids. Plan Star Ratings and rebate percentages would not be affected.

We believe it may be possible that Star Rating adjustments can be designed to achieve the same or similar results. However, this approach would likely require CMS to reweight a large number of measures to have real impact – including reweighting of HEDIS, CAHPS, and HOS measures. It also could require CMS to further reduce weights of measures, likely to zero. We are concerned that changes of this magnitude could have unintended consequences in the Star Rating system and still not provide meaningful relief. At this time, we are cautious about this approach because we have not yet been able to model the effect of these further changes. We are open to this approach or other approaches, however, as long as it provides meaningful relief in 2016.

Understanding the link between SES (and its many related factors) and quality of care is a complicated endeavor that will take months if not years to complete. It will require a combination of sophisticated statistical analyses and a deep understanding of how lower income patients connect with the health system and vice versa. We urge CMS to pursue interim steps that provide meaningful and targeted financial relief to plans in need in 2016, until longer-term policies that address the impact of dual and low-income status on measures in the Star Rating system are in place.

- c. Predetermined star thresholds (page 84).

Recommendations: Consistent with our response to CMS' request for comment on 2016 STARS, we remain very concerned about the impact of eliminating predetermined 4-STAR thresholds on SNPs' quality improvement activities and star ratings/quality bonus payments, and continue to recommend that the current predetermined 4-STAR thresholds be retained.

We believe there is merit to retaining pre-determined thresholds. Standards that allow plans to evaluate their performance in relation to known thresholds has both led to performance improvement and has been a stabilizing component of the star rating system to date. In addition to using these thresholds internally, our members report that the pre-determined thresholds have been helpful to them in working with their contracted providers and vendors on quality improvement activities for which they can establish well-defined expectations.

Further, we remain concerned that elimination of the predetermined thresholds will have a disproportionate negative impact on SNPs for reasons we have laid out elsewhere in our response, i.e., it is much more difficult for plans serving duals to achieve 4-STAR ratings on numerous measures. While we appreciate CMS' providing information on its 2015 simulations, it remains unclear from what is reported in the Draft Call Letter as to whether SNPs are disproportionately impacted.

d. **Proposed Changes to 2016 Stars and Beyond (pages 82-110).**

Recommendations: On page 109, CMS invites comments on additional measures, including SNP-specific measures. The focus of our current comments has been the concern of the SNP Alliance that the Star Rating measures do not account for the effects of socio-economic status and related beneficiary characteristics. The SNP Alliance has previously submitted comments to CMS with regard to the adoption of SNP-specific measures. We refer CMS to our previously submitted comments, including our December 19, 2013, "Comments to CMS' Proposed Enhancements to the 2015 Star Ratings and Beyond" and our December 17, 2014, "SNP Alliance Response to CMS Request for Comment (R4C): Proposed Enhancements to the 2016 Star Ratings and Beyond"

3. **Integrated Dual-Eligible Special Needs Plans (page 110).**

Recommendations: The SNP Alliance commends CMS' goal of streamlining administrative requirements in order to offer Medicare-Medicaid enrollees a more seamlessly integrated benefit in order to facilitate state efforts to use D-SNPs as a vehicle for delivery of coordinated Medicare and Medicaid benefits and to ease the regulatory burden on MAOs that contract to offer highly integrated D-SNPs. We particularly note the importance of the MMCO to states, MMPs and D-SNPs in its role of coordinating CMS efforts to align Medicare and Medicaid policy. The SNP Alliance appreciates the opportunity to comment on these important issues, and we commend CMS' willingness to extend features of the Minnesota D-SNP demonstration to other states and D-SNPs.

The SNP Alliance also believes that, in order for D-SNPs to be successful in meeting the expectations for which they were created, more attention must be paid to the role of states in D-SNP procurement, oversight and contracting. D-SNPs must have interest and cooperation from states in order to exist and to pursue higher levels of integration. States continue to face barriers in interfacing with D-SNPs despite interest among both D-SNPs and state personnel to pursue improvements in integration. We are hopeful that CMS proposals outlined here will reduce those barriers for states.

The following are the SNP Alliance's more specific comments and recommendations with regard to a number of more specific issue areas:

a. **Expansion of the scope of the integration initiative:**

At the outset, we note that integration is moving forward in two important areas: (1) the fully integrated D-SNP Financial Alignment demonstrations and other integrated demonstration programs, such as the program offered in Minnesota and (2) initiatives by States that are not ready for full integration to use the D-SNP platform and MIPPA contracts as a means to promote greater

integration. The importance of this latter initiative is reflected in the December 1, 2014, letter from the National Association of Medical Directors (NAMD) to Sean Cavanaugh, Patrick Conway, and Melanie Bella where NAMD included in its recommendations this second arena by recommending enhancing existing integration pathways. The SNP Alliance urges CMS to explore improving administrative efficiencies both for fully integrated programs as well as programs where State Medicaid agencies and plans are striving to achieve integration along the lines discussed in the NAMD December 1, 2104 letter.

Thus, the SNP Alliance believes that restricting administrative flexibility to only those D-SNPs and states that are already at high levels of integration as specified in 40.4.4 of Chapter 16b of the Medicare Managed Care Manual is too narrow a focus for this laudable effort, and that the initiative needs to be expanded to provide for pathways for states and D-SNPs to make incremental progress toward integration over time.

Integration cannot be achieved overnight. Moreover, plans cannot achieve it without the assistance of states, many of which lack information and resources to pursue integration. Many of the most successfully integrated programs to date have had many years to evolve to their current levels of integration. Integration efforts take investment and resources to overcome administrative challenges and require advance planning and a secure long range D-SNP platform along with administrative flexibility. While we understand why CMS would start with D-SNPs in states that meet the Chapter 16b criteria in this new initiative, we suggest that CMS expand this provision to D-SNPs and states that submit joint letters of request to CMS to achieve further integration. This would help create the necessary pathways to increase the number of D-SNPs that meet the Chapter 16b definition.

b. Need for ongoing dialogue and appropriate consideration of role of States:

The SNP Alliance understands the complexities surrounding many of the underlying challenges that serve as barriers to reducing the administrative burdens. To address these barriers, the SNP Alliance requests that CMS maintain an ongoing dialogue with the SNP Alliance and other stakeholders, including NAMD and the National Governors Association, to assure that these complex issues are thoroughly and thoughtfully considered and addressed. We will be following up with a request for a series of further discussions to explore these topics and related recommendations below in more depth.

The SNP Alliance believes that the creation of the Medicare-Medicaid Coordination Office (MMCO) has been critical to increasing communications between states, CMS and D-SNPs around these issues. We recommend that MMCO serve as the focal point at CMS for the ongoing discussions necessary to shape development of these pathways.

Fostering this ongoing dialogue as quickly as possible is particularly important as some of the early Financial Alignment Demonstrations are reaching the mid-point in their three year demonstrations. States remain unsure of the future of the D-SNP platform as it awaits Congressional reauthorization and competing D-SNP and MMP models add confusion within some states. There has never been more support and enthusiasm for improving coordination of Medicare and Medicaid for dually eligible beneficiaries than we have now, yet next steps for integrated programs are unclear for all parties. It is important that CMS come to consensus and provide direction about these next steps so that we don't lose the important experience, investments and momentum that have been achieved.

c. Expansion of the role of the Integrated Care Resource Center (ICRC):

Consistent with our previous recommendation, we also want to applaud CMS' renewed emphasis on providing information and support to states through the role of the ICRC, which continues to provide resources and information on MIPPA contracting and other Medicare requirements. MIPPA contracts can be used to assist in implementation of these proposed administrative flexibilities. Continued enhancement of the ICRC role in this area will assist with efforts to expand and enhance D-SNP-state relationships in order to increase the number of D-SNPs reaching higher levels of integration.

d. Development of Materials:

Consistent with our earlier recommendations, the SNP Alliance recommends that CMS extend member material modifications allowed for Medicare-Medicaid MMPs under the Financial Alignment Demonstration and Minnesota Senior Health Options (MSHO) demonstration to integrated D-SNPs outside of these demonstrations. It should be noted that some MMP materials may need further adjustment when being applied to D-SNPs.

The SNP Alliance recommends that CMS work with states and D-SNPs to add additional languages to CAHPS and HOS surveys based on prevalence of languages among dual eligibles enrolled in Medicaid in the state. We also recommend that CMS include options for people with disabilities to complete surveys through electronic or communication devices.

e. Enhanced state-federal-D-SNP Communications and Coordination:

As recommended more generally above, the SNP Alliance recommends that CMS establish three way communications channels for D-SNPs, states and CMS to work out details for timely joint review of integrated materials including file and use options, management and communications to resolve administrative or policy conflicts, identification of pathways to increase integration and coordination of quality and performance improvement related communications and requirements. We recommend that MMCO be the focal point for these communications. This concept has been supported by NAMD, numerous states and the SNP Alliance and is a critical first step toward improving experience for beneficiaries enrolled in D-SNPs including reducing administrative duplication and complexity. In particular, CMS should use this communications channel to provide timely advance notice and direct information to states about D-SNP changes, such as performance based D-SNP terminations and changes impacting state MLTSS programs, and to work with states to assure smooth transitions for frail beneficiaries.

f. State Quality of Care Priorities:

The SNP Alliance recommends that CMS utilize the process developed in Minnesota to reduce conflicts between CMS requirements and state managed long term services and supports (MLTSS) requirements by incorporating state MLTSS requirements into Models of Care (MOC) and assuring that states and D-SNPs can utilize an integrated model of care approach. CMS should adjust audit protocols to assure that they can accommodate state MLTSS priorities. D-SNPs in some states and under the Minnesota demonstration have been able to integrate state requirements for managed long term services and supports into their models of care. However, in some cases such integrated features have been questioned by auditors or have been hampered by conflicts between state requirements and CMS MOC expectations.

We recommend that, as part of the state-specific ongoing dialogue between states, CMS and D-SNPs

that would be established under the communications channels recommended above, all parties would examine opportunities for including state level priorities in Medicare and Medicaid oversight and performance improvement programs such as quality improvement plans, QIPs, PIPs, HEDIS data collection, and CAHPS surveys. The goal would be to reduce administrative duplication by providing options to consider state specific topics, measures or questions. While some improvements may be relatively straightforward (HEDIS data collection), other changes may be challenged by technical, data and timeline issues for states and D-SNPs. Thus, we recognize the need for appropriate balancing of objectives. However, administrative simplification should be careful to preserve access by D-SNPs and states to data needed for state and plan level Medicaid analytics and Medicaid oversight purposes as well as for assuring that all state Medicaid requirements continue to be met.

- g. Other areas to explore administrative efficiency.** In addition to the areas that are identified in the 2016 Draft Call Letter, the SNP Alliance believes that improved administrative efficiency can be achieved in the following areas: procurement; model of care requirements; data collection and reporting; and consumer protection requirements. The SNP Alliance looks forward to working with CMS on these areas as well as those discussed above.

4. **Seamless Conversion Enrollment Option (page 111).**

Recommendations: CMS explains in the 2016 Draft Call Letter that entities that offer Medicaid Managed Care Organizations (MCO) and also offer integrated D-SNPs can promote coverage of an integrated Medicare and Medicaid benefit through seamless conversion enrollment of Medicaid MCO members as they become eligible for Medicare. CMS notes that the criteria for CMS approval are outlined in Section 40.1.4 of Chapter 2. The SNP Alliance believes that one of the key barriers to MAOs being able to take advantage of this process is the inability of MAOs to have timely access to information in advance of their Medicaid enrollees becoming initially eligible for Medicare.

In the Draft Call letter, CMS notes:

In order to access information on Medicare eligibility dates for individuals who will become eligible for Medicare because of disability, plans may work with the state Medicaid agency, which receives advanced notice of individuals' eligibility via their "State MMA" file exchange with CMS.

With regard to this issue, the SNP Alliance has the following three comments:

- a. One state has noted that the MMA file is the preferred way to be notified of newly eligible Medicare beneficiaries. However, that state also conveyed that the MMA file only identifies about 77% of the newly eligible Medicare beneficiaries. CMS in collaboration with States needs to continue to consider other ways in which the newly eligible Medicare beneficiaries that are not captured in CMS' existing processes, can be identified.
- b. Section 40.1.4 of Chapter 2 of the Manual requires that members be given at least 60 days' notice prior to the conversion date. It is very difficult to meet this 60 day notice requirement. We recommend that CMS adopt one of two optional approaches. One approach would be to reduce the period to 45 days. The second option is to reduce the period to 30 days but to give the beneficiary the option to retroactively disenroll from the MA plan during the first month of enrollment.

- c. The SNP Alliance is seeking a clarification of CMS' policy. Is it permissible for an MA plan to proceed with using the seamless enrollment provisions if it notifies all current members of whom the sponsor is aware who are becoming eligible for Medicare? The question has arisen whether an organization's lack of knowledge of all members who will be becoming eligible for Medicare would preclude the organization from using this process. We assume the answer is "no", but we are requesting clarification of this issue.

The SNP Alliance commends CMS' efforts to encourage States to share this information with MAOs. We are pleased that several states have begun to access this information and share it with MAOs. Consistent with our recommendations and comments above, the SNP Alliance recommends that CMS continue to promote this opportunity by encouraging States to share this information with its MAOs.

5. Promoting Integrated D-SNPs (page 111).

Recommendations: The SNP Alliance commends CMS for encouraging States to support and promote integrated D-SNP plan options. The SNP Alliance recommends that within CMS, both the Center for Medicare and MMCO utilize ICRC resources to collect effective strategies for this outreach from plans and states and conduct joint information sessions for plans and states to identify barriers and develop specific strategies that states and plans could adapt to promote integration efforts. Possible strategies used in some states with highly integrated programs that could be promoted include:

- Use of letters or other communications provided by states directly or for use by plans which explain the program and outline benefits of enrollment;
- Use of approved joint integrated enrollment forms meeting Medicare and Medicaid criteria which allow members to indicate their choice for D-SNP enrollment at the same time as their Medicaid enrollment. (It would be less disruptive from a beneficiary standpoint to provide a shortened notice period in order to preserve their option for seamless enrollment because it could help to avoid their auto assignment to an entirely separate and new Part D plan instead of being able to remain in the same plan without disruption.);
- Encourage education activities (through State Health Insurance Assistance Programs (SHIP) or Medicaid enrollment brokers that provide information to potential enrollees about Medicare including coordinated Medicaid/D-SNP enrollment choices;
- Use of state sponsored cultural outreach programs designed to educate specific populations about their Medicare and Medicaid enrollment options and benefits of integrated products;
- Outreach to stakeholder groups including disability and senior advocates agencies, community clinics and other community organizations serving dual eligibles to educate them about integrated options along with efforts to address their issues and concerns; and
- Outreach to provider organizations to allay fears of integrated options and to provide education about the benefits of integrated options, such as the inclusion of Part B and Part D pharmacy benefits under one plan. Our understanding is that access to all pharmacy benefits under one plan can be particularly effective for both beneficiaries and providers Medicaid nursing facilities where it can reduce administrative complications of dealing with multiple Part D plans as well as multiple Medicaid plans.

6. Benefit Flexibility for Highly Integrated, High Performing D-SNPs (page 112).

Recommendations. In the Draft Call Letter CMS discusses the flexibility that CMS has given to certain D-SNPs that meet high integration and performance standards to offer supplemental benefits beyond those permitted for MA plans, such as non-skilled in-home support services, caregiver supports, assistive devices for home safety and the other benefits described in the CY 2013 Final Call Letter. CMS stated in the Draft Call Letter that it is interested in expanding the number of D-SNP enrollees who

could benefit from this flexibility and are using this draft Call Letter to remind D-SNPs, as well as the states that contract with D-SNPs for delivery of Medicaid benefits, of the availability of this flexibility.

The SNP Alliance appreciates CMS offering this benefits flexibility and the opportunity to comment on this provision. However, we note that a primary reason there are few high performing highly integrated D-SNPs taking advantage of this provision is that the additional benefit set spelled out and allowed in the CY 2013 call letter overlaps and duplicates the home and community based waiver services provided through state MLTSS contracts. The services listed include the most common Medicaid home and community based services offered under most state plan and/or community based waiver programs. Therefore many of the very D-SNPs most likely to meet criteria for offering these additional benefits are precluded from offering them because they are already providing them through Medicaid benefits and could duplicate those Medicaid benefits for a large segment of enrollees.

In addition, even if the D-SNP is not already providing the services through the Medicaid program, because of the frailty of most D-SNP populations and the high needs for such services, the number of enrollees who might qualify for such services could be extremely high. Given the parameters of the services as defined by CMS, it would be difficult to design a benefit narrowly enough to preclude large demand for these benefits. Therefore, including these additional benefits may result in bids that require additional premiums or cost sharing that dual eligibles cannot afford to pay. Highly integrated high performing D-SNPs in low benchmark areas would be particularly vulnerable to ending up with premiums or cost sharing under the current requirements for these services.

The SNP Alliance reiterates the recommendation it has made previously that it allow this additional flexibility to be extended to all D-SNPs. This would allow additional D-SNPs, especially those that may not already be providing MLTSS, to take advantage of providing these services although there would continue to be the issue raised above that the benefit would need to be sufficiently defined to be financially viable. In addition, the SNP Alliance recommends that this additional flexibility should be expanded to I-SNPs, IE-SNPs and C-SNPs who serve high numbers of beneficiaries who are dually eligible as well as other populations who would benefit substantially from these expanded benefits. For example, I-SNPs that serve an institutional equivalent population in the community need greater flexibility to address medically related conditions that are important in helping their enrollees continue to live at home.

7. **State Access to D-SNP CAHPS Data (page 113).**

Recommendations: CMS stated that certain states that contract with D-SNPs for delivery of Medicaid benefits to Medicare-Medicaid enrollees have expressed interest in receiving beneficiary-level data on CAHPS survey for D-SNPs with which they contract in order for the state to obtain a more granular picture of plan performance and assess disparities in care. States may obtain this beneficiary-level data for their use by entering a data use agreement with CMS. More information is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/States.html> or through contacting CMS at DataUseAgreement@cms.hhs.gov.

The SNP Alliance believes that this proposal could be very helpful to states that wish to accept the Medicare CAHPS survey for Medicaid purposes as well as states that merely want to have access to the results. Typically both Medicare and Medicaid require CAHPS surveys, and dual eligible beneficiaries may be surveyed twice, once for each program. Using one survey for the same population can improve survey response rates and strengthen the value of the surveys for all parties.

However, because CAHPS surveys are usually done at the contract level, there are complexities that arise if most of the enrollees under the contract are not D-SNP members. In such an instance, CMS would need to extract the data for the D-SNP members to provide the states with appropriate

information. However, if the sample is small, there also may not be enough meaningful data available to share due to small numbers and potential identification of individual members.

The SNP Alliance believes that CMS may want to broaden the scope of this initiative in order to consider state needs when determining sample sizes and methodologies to assure that they accommodate Medicaid needs. In addition, some states have added specific questions to their Medicaid CAHPS surveys that they may need to assess state specific issues. CMS should develop a process for allowing states to add such questions.

Finally, we suggest that CMS Medicaid offices and/or the MMCO provide further communication to states on this topic, to assure states that such integrated CAHPS surveys would meet Medicaid requirements.

8. **Value-Based Contracting to Reduce Costs and Improve Health Outcomes (page 113).**

Recommendations: CMS is seeking comments with regard to payment models that MAOs use to promote value-based purchasing. SNPs are very interesting in pursuing value-based purchasing through incorporating a variety of contract standards and payment mechanisms in their provider contracts. Many of these arrangements involve targeting areas that need improvement and making available to providers financial incentives if the providers achieve certain targets.

The SNP Alliance's understanding is that these arrangements fall outside of the physician incentive regulations and therefore MAOs have a great deal of flexibility in designing these programs to promote particular quality-related objectives. The SNP Alliance recommends that CMS acknowledge and affirm this flexibility in the 2016 Final Call Letter. In addition, we recommend that, as part of this discussion, CMS acknowledge that incentives based on quality measures fall outside the physician incentive rules where the amount of funds available for the quality bonus are determined based on meeting predetermined financial performance standards during a year.

In making these value-based contracting arrangements, we want to offer a note of caution that the evidence base for serving persons who are frail, disabled, and with complex medical conditions is still emerging and needs to vary according to a host of complex and interrelated care issues. It is therefore important to maintain flexibility in establishment of value-based contracting structures for providers serving high-risk/high-need beneficiaries and take into account a host of nonmedical factors that may be as or more important to beneficiaries served.

9. **Guidance to Verify that Networks are Adequate and Provider Directories are Current (page 134).**

Recommendations: For online directories, CMS is proposing that MAOs update information in real-time, and provide complete information regarding providers who are available to new patients/enrollees. Also, CMS is proposing that, at least quarterly, an MAO reach out to its providers to confirm their continued availability.

While the SNP Alliance appreciates the importance of enrollees and prospective enrollees having a current understanding of the providers in a network that are available to them, we have concerns about the administrative workability of this proposal. As part of a provider's obligations to meet an MAO's policies and procedures, a provider is obligated to notify the MAO if the provider is no longer accepting new patients. In addition, the MAO would know if the provider is no longer under contract to participate in its network. We question the need to affirmatively reach out to providers on an at least quarterly basis to confirm that they are still accepting new patients. In lieu of this proposal, we recommend that CMS ensure that MAOs monitor problems with providers no longer participating in

the MAO's network and take appropriate steps against providers that do not notify the MAO.

With regard to the proposal to update online directories on a real-time basis, the SNP Alliance does not support this proposal. Updating an online directory, including making sure that all of the quality checks are done, is very time consuming. Members are informed that they should contact the plan directly if they want to confirm the availability of a provider. If CMS believes that the provider directory ought to be updated on a regular basis, the SNP Alliance recommends that the updating occur every 30 days. This is consistent with NCQA standards, as follows:

“NCQA Standard RR 4 Physician Hospital Directories provides the requirement to provide information to help members and prospective members choose physicians and hospitals. The standard provides the specific information that must be provided and requires the organization to update the physician and hospital directories within 30 calendar days of receiving new information from the physician or hospital. The directories must state how the information is collected and any limitations. It must also state how often the items are validated or the last validation date. This would be at least as often as recredentialing, which is every three years. The organization must conduct usability testing at least every three years.”

10. **Guidance for Off-cycle Submission of Summaries of Model of Care (MOC) Changes (page 136).**

Recommendations: CMS is proposing a mechanism by which SNPs would notify CMS when they make certain revisions to their approved MOC. In the draft Call Letter, CMS identifies the MOC changes requiring CMS notification and how SNPs should submit their MOC changes to CMS. SNPs that make significant changes to their MOCs must submit a summary of the pertinent modifications to the approved MOC in HPMS. The SNP Alliance appreciates CMS clarifying this issue. The examples provided by CMS are very useful. We are aware of confusion among SNPs with regard to their responsibilities to notify CMS of changes to its MOC.

11. **Standardizing the Health Risk Assessment (HRA) (page 138).**

Recommendations: At this point it is not entirely clear whether CMS is considering requiring or simply strongly recommending that all MAO's including SNPs use, at a minimum, the Centers for Disease Control and Prevention's (CDC) Model HRA presented in the appendix to "A Framework for Patient-Centered Risk Assessments, Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries" (<http://www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf>), in combination with the other elements of the annual wellness visit.

But, since CMS is considering future rulemaking in this area, the SNP Alliance requests that CMS consider in advance of publishing a proposed rule how this proposal will impact the goal of integrating Medicare and Medicaid services through D-SNPs. While adoption of this policy may be advantageous to the Medicare Advantage program, we strongly recommend that CMS provide additional flexibility to D-SNPs to ensure that they can continue to work toward integration of Medicare and Medicaid service delivery with state Medicaid programs. Specifically, CMS should provide flexibility to allow D-SNPs working toward integration with states to tailor their related assessment functions and tools to state Medicaid MLTSS and related assessment requirements to avoid duplication and confusion for beneficiaries and should exempt D-SNPs from any requirement for this policy while conducting additional research into how this policy would impact efforts to align Medicare and Medicaid assessment and care planning requirements.

CMS should also consider how this policy might impact other SNPs serving populations with large numbers of LIS eligibles such as I-SNPs, I-SNPs and C-SNPs where there may also be use of specific assessment instruments tailored to the population served, or processes that interface with state Medicaid MLTSS, behavioral health or related requirements. Without such measures the SNP Alliance believes that this proposal could result in severe disruption for SNPs serving large numbers of LIS eligible members or providing MLTSS and related state Medicaid services, and particularly for those where assessment and care planning functions are already highly integrated or where states and SNPs are planning further integration.

We are particularly concerned about different types of assessments that are needed by different subpopulations and trying to align with multiple requirements established by the State and CMS. A potential consequence of requiring a single HRA tool is that it could cause D-SNPs to have to administer two different tools to meet two overlapping requirements or having to conduct an assessment simply for compliance purposes while conducting other supplemental assessments that the plan believes are important for addressing the unique issues of importance to various subpopulations. Standardization, while beneficial in concept, can also adversely affect addressing a variety of issues in advancing person-centered care. Ultimately SNP Alliance members believe standardization as outlined in the CMS proposal will result in having to conduct separate and duplicative assessment processes in order to meet separate Medicare and Medicaid requirements for MLTSS populations. Further explanations of this concern along with additional recommendations are provided below.

D-SNPs are unique within the Medicare program in that they are required to contract with state Medicaid programs and are now being further encouraged to further integrate Medicare and Medicaid service delivery including administration of behavioral health and MLTSS programs. D-SNPs that provide MLTSS and behavioral health services or are planning with states to provide such services are required by states to utilize specific Medicaid assessment instruments and assessment questions as well as assessment schedules and processes, and must coordinate or integrate HRA assessments with those requirements to avoid duplication and burden for the beneficiary. While we recognize the overall value of having a minimum set of elements to be included in an HRA, we are concerned that requiring a specific assessment instrument could have a number of unintended consequences on D-SNPs and states and their current efforts to integrate Medicare and Medicaid.

Within a broad set of criteria, CMS Medicaid policy allows states to develop state specific assessment tools. Therefore, states have long established Medicaid assessment tools and care planning criteria that D-SNPs must meet when providing MLTSS and related services. Many of these assessment tools have been highly researched, vetted by stakeholders and tailored to specific population needs and state determined levels of care. Currently states and D-SNPs have the flexibility to determine how best to integrate or coordinate the HRAs with those state requirements. D-SNPs and states have developed a variety of mechanisms for incorporating and integrating HRA requirements and other model of care elements with MLTSS requirements for face-to-face assessments, person centered care planning, community and social services authorization and care coordination/case management functions.

For example, one state has incorporated HRA elements (as worked out with all participating D-SNPs)

into its electronic MLTSS assessment system. As part of their development effort that state reviewed the tool that CMS proposes to use and found it lacking for their purposes. If specific questions, formats and processes are now required by Medicare, there will be concern that these new requirements will interfere with their state system, resulting in additional administrative costs for both states and D-SNPs and duplicative assessments which will be confusing for beneficiaries.

Furthermore, requiring HRA assessments to be incorporated into annual wellness visits as put forth in the CMS referenced tool make the assessment part of a medical function. An important element in current HCBS assessments is to account for the social needs of an enrollee using person centered planning processes. Further “medicalization” of the HRA and related assessment processes will pose new barriers to integration of these functions with more costs and less efficiency and raise concerns with advocates who have been very vocal about the need to preserve person centered planning and attention to social needs in MLTSS integration efforts.

Therefore the SNP Alliance recommends that CMS consider our comments and modify this proposal accordingly for D-SNPs at this time to allow D-SNPs the flexibility to tailor their HRAs to state MLTSS, behavioral health and related requirements. In lieu of requiring that the CDC HRA be used by D-SNPs, CMS could note its availability and value while acknowledging that it would not necessarily be appropriate in all circumstances. If CMS wants to explore a minimum set of elements that would need to be covered in an HRA for D-SNPs CMS should undertake additional research as suggested below.

Prior to any regulatory activity related to D-SNPs, the SNP Alliance recommends that CMS consult the MMCO and CMS Medicaid staff to understand more about required Medicaid assessment processes for MLTSS populations, what is generally included in current MLTSS assessment tools and how tools are administered by states. CMS should take into account long standing processes used by highly integrated D-SNPs and Medicare-Medicaid plans participating in the Financial Alignment demonstration to integrate these requirements and conduct a comprehensive analysis (across both Medicare and Medicaid) of which functions should be provided under which program for which purposes as well as outline how duplication can be avoided and integration can be achieved with the goal of ensuring that beneficiaries are not further confused by these changes. With this knowledge CMS could consider defining common elements for inclusion by D-SNPs in HRAs broad enough to coordinate with established Medicaid requirements for possible regulatory activity.

12. **Guidance for In-Home Enrollee Risk Assessments (page 139).**

Recommendations: The SNP Alliance commends CMS’ decision to withdraw its prior proposal to exclude, for payment purposes, diagnoses collected from enrollee risk assessments that were not confirmed by a subsequent clinical encounter. The SNP Alliance also appreciates CMS’ acknowledgement that in-home assessments can have significant value as care planning and care coordination tools.

In the 2016 Draft Call Letter CMS is strongly encouraging plans to adopt, as a best practice, a core set of components for the in-home assessments they perform. CMS’ stated goal is to provide plans an incentive to adopt comprehensive in-home assessments consistent with the components CMS has identified as best practices.

Similar to our comments on item 11 above, we recognize that this goal is important to improving care for beneficiaries in the overall Medicare Advantage program and support the overall intent. However, we recommend that CMS allow additional flexibility to D-SNPs working with state Medicaid agencies to make sure they can continue to move forward with integration efforts. Specifically, CMS should provide flexibility to allow D-SNPs working toward integration with states to tailor their in home visits and related assessment functions to state Medicaid in-home visit and assessment requirements to avoid duplication and confusion for plans and beneficiaries.

D-SNPs are unique within the Medicare program in that they are required to contract with state Medicaid programs. CMS policy encourages D-SNPs to further integrate Medicare and Medicaid service delivery including provision of MLTSS and behavioral health services. The SNP Alliance has concerns that this particular policy will pose additional challenges to integration of Medicare and Medicaid because it is likely to overlap and duplicate many care coordination functions already required for dual eligibles served under Medicaid MLTSS programs offered by D-SNPs.

As Medicare starts to define overlapping but separate criteria for home visits, assessment and care coordination, functions that were once integrated may have to be disintegrated resulting in higher administrative costs and duplication, as well as more burdens for beneficiaries who have to undergo additional assessments. Similar to comments made on the standardized HRA, this also raises concern about medicalization of in home visits and which personnel should conduct such visits.

Home visits are a key component of MLTSS programs. CMS' definition of best practice now assigns traditional functions performed in MLTSS to medical personnel conducting annual wellness visits, requiring a level of personnel that would increase costs while duplicating many functions now performed under Medicaid MLTSS and resulting in separate assessments and in home visits for MLTSS purposes.

For example, in MLTSS programs such in home assessments and care coordination are typically provided by RNs, public health nurses and social workers and in some cases nurse practitioners. MLTSS care coordinators conducting in home visits are required to perform all items mentioned in CMS' best practice list of functions except the annual wellness visit and the final medication reconciliation (usually referred to a pharmacist or physician). These functions are not a matter of best practice but are typically required MLTSS requirements per CMS Medicaid guidance. In integrated D-SNP programs the in-home visit also often incorporates the HRA because it overlaps with requirements for MLTSS assessments. MLTSS home visits are not usually used to determine new diagnoses, however, they are meant to capture all of what is known, including existing diagnoses, to identify need for follow up on new indications and to develop a plan of care to support the beneficiary to remain in the community. This includes making sure that physical, social, and mental health needs are being met and that appropriate follow up appointments are made. Physicians may make home visits as well, but they do not typically perform all of the functions outlined above, most of which are the traditional role of the MLTSS care coordinator. It would be too costly to have physicians and nurse practitioners or physician assistants perform these functions for MLTSS purposes, plus, they may not meet state qualifications to conduct portions of the assessment related to social and behavioral health needs. If both assessments have to be performed separately, it could lead to different or conflicting recommendations in the plan

of care which would be confusing for all involved.

In addition, as also noted below, CMS should ensure that such processes do not cause additional burdens for enrollees of I-SNPs, IE-SNPs or C-SNPs, who also serve high numbers of members eligible for MLTSS and may need to coordinate with or follow state requirements or utilize home visits tailored to the populations they serve.