



SNP Alliance

A National Nonprofit Leadership Organization

The National Voice for Special Needs and Medicare-Medicaid Plans

VIA ELECTRONIC SUBMISSION: <http://www.regulations.gov>

March 5, 2018

The Honorable Seema Verma
Administrator
Department of Health and Human Services (HHS)
Centers for Medicare & Medicaid Services (CMS)
Attention: **CMS-2017-0163 -007**
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Part II: Advance Notice on Methodological Changes for Calendar Year 2019 for MA Capitation Rates, Part C and D Payment Policies and 2019 Draft Call Letter.

SNP Alliance Comments

The Special Needs Plan Alliance (SNPA) is pleased to offer our comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2019 Draft Call Letter*. The SNPA represents 24 organizations of special needs plans and Medicare/Medicaid plans serving 1.6 million SNP enrollees. Since the SNP Alliance did not comment on each section of this Part II Advance Notice and Call Letter, we have identified the sections where we did comment with page numbers and section titles.

For the entire sections--which refer to frailty adjustment, to the Star ratings, measures, proposed measurement changes, and Quality Measurement System, and to the Health Risk Assessment-- the SNP Alliance provides a very brief summary comment in the body of this letter, and then requests that the agency review the more extensive analysis presented in the **Appendix**. This **Appendix** should be considered equivalent in importance to comments and recommendations in the main body of this letter. We have done this to group like issues together, and therefore offer CMS reviewers who focus on quality measurement, adjustment, methods, and related issues—easier navigation within

our remarks and additional information that we hope is useful to them in understanding our analysis and moving ahead to discern needed refinements.

Pg 30 – 34: Sections H and I address the CMS –HCC risk adjustment model and ESRD risk adjustment Models for CY 2019

SNP Alliance Comments and Recommendations

For the CMS-HCC Risk Adjustment model and ESRD Risk Adjustment Models for 2019, the SNP Alliance refers CMS to our comments for Part 1 of the Advance Notice (published Dec 287, 2017)

Pg 34 -35: Section J – Frailty Adjustment for PACE organizations and FIDE SNPs. Table II-4 outlines the Frailty Factors for FIDE SNPs for Non-Medicaid and Medicaid beneficiaries based on ADL needs. These range from -0.078 for non-Medicaid with 0 ADL support needs to 0.371 frailty adjustment for Medicaid beneficiaries with 5-6 ADL needs.

SNP Alliance Brief Comment (see Appendix for full analysis and recommendations)

The SNP Alliance appreciates the recognition by CMS of the importance of frailty and the effect on costs which are not captured by the HCC model. This has made an important difference for several health plans in adjusting payment more appropriately. However, we have several concerns and offer possible solutions for adjusting to make the application of the frailty adjustment more equitable. See Appendix for full comments

Pg 35 – 36: Section K. Medicare Advantage Coding Pattern Adjustments for 2019 - CMS proposes to apply the statutory minimum MA coding pattern adjustment of 5.90%. They are also considering 3 methodologies for final decisions regarding PY 2019 and seek comment on these methodologies. The 3 options are:

- The methodology discussed in the Payment Year 2010 Advance Notice and Rate Announcement.
- The methodology discussed in the Payment Year 2016 Advance Notice and Rate Announcement.
- The methodology discussed in MedPAC’s March 2017 Report to Congress: Medicare

SNP Alliance Comments and Recommendations

The SNP Alliance urges CMS to retain the current methodology for the Coding Pattern Adjustment at the statutory minimum adjustment of 5.90 percent until 2020. We question the validity and the appropriateness of the alternative methodologies noted in the Advance Notice. If CMS decides to adopt a methodology at some point in the future, CMS should include stakeholders in a robust and transparent planning and development process with significant advance notice to plans prior to implementation. Additional information is needed in order for plans to provide meaningful input to CMS. The

current information available about proposed optional methodologies is not sufficient for making this change at this point, and may also be outdated. In addition, if CMS decides to explore the development of a different methodology in the future, CMS should carefully consider questions about how enrollment in MA plans, SNPs, and MMPs, and state initiatives for integrated care and passive enrollment may impact such adjustments and whether \$0 premiums for dual eligibles may affect MA and FFS member comparisons. Further, a fundamental flaw with the adoption of a uniform methodology is that it applies uniformly to MAOs regardless of the difference in their individual plans' coding methodologies. We believe this disadvantages smaller SNPs that are less likely to pursue comprehensive programs to capture omitted diagnoses.

Pg 36-41: Section L. Normalization Factors. Part I of the Advance Notice, published Dec 27, 2017 proposed to blend 75% of the risk score calculated with the CMS-HCC model used for payment in 2017 and 2018 with 25% of the risk score calculated with the proposed “Payment Condition Count” model. For PY 2019 CMS proposed to calculate two normalization factors for Part C, one for the CMS-HCC model used in PY 2017 and 2018, and one for the proposed “Payment Condition Count” model that would be blended with their respective risk scores in payment.

SNP Alliance Comments and Recommendations

SNP Alliance members continue to be concerned about the large and unexplained growth in FFS risk scores since 2015. CMS needs to provide additional information about underlying data and methodologies used for normalization updates. While some additional information was provided in the 2018 ANCL, this notice does not provide such detail and thus raises more questions about the data utilized and the resultant trend analyses and whether reimbursement to plans will be an accurate representation of current trends. We encourage CMS to seek involvement of plans in review of this process going forward.

Pg. 42: Section N. Encounter Data as a Diagnosis Source for 2019

For PY 2018, CMS calculated risk scores by adding 15% of the risk score calculated using encounter data and FFS diagnoses with 85% of the risk score calculated using RAPS and FFS diagnoses. For PY 2019, CMS proposes to calculate risk scores by adding 25% of the risk score calculated using diagnoses from encounter data and FFS diagnoses with 75% of the risk score calculated with diagnoses from RAPS and FFS diagnoses.

SNP Alliance Comments and Recommendations

The SNP Alliance appreciates the efforts that CMS has made to improve the accuracy of data provided through encounter data. However, we are still concerned about the potential adverse effects that may accrue for plans specializing in care of high-risk populations through greater use of encounter data in MA payment. We therefore

recommend that CMS further delay use of encounter data beyond the current 15/85 mix of encounter data and data based on RAPS/FFS diagnosis.

Pg 106: Enhancements to the 2019 Star Ratings and Future Measurement Concepts

SNP Alliance Brief Comment (see Appendix for full analysis and recommendations)

The SNP Alliance has surveyed plan members through calls, one-on-one discussions, and written communication as we analyzed this section of the Advance Notice and considered implications. We noted measure specifications, such as exclusions, which need adjustment as they are not being equally applied for like beneficiary characteristics. We also provide additional detail on considerations signaling changes in measure specifications prior to being put in use, and request considerations around cut points that will be determined later this year. We reflect our findings and analysis in detailed comments and recommendations which we include in the Appendix--particularly focusing on the Part C measures and proposed changes. For each area where we provide comment, this letter provides a brief summary statement. See Appendix for our full comments and recommendations.

Pg. 106. Technical Expert Panel - After the Call Letter is finalized, CMS Star Ratings Contractor – RAND Corp – will establish a Technical Expert Panel to obtain feedback on the Star Ratings framework, topic areas, methodology, and operation measures.

SNP Alliance Comments and Recommendations

The SNP Alliance has been a key stakeholder organization in the Stars and the QMS. We provide extensive analysis and comment throughout the year, working toward consensus among 24 organizations with over 250 plans, serving approximately 1.5 million beneficiaries. The SNP Alliance actively surveys special needs plans, conducts regular calls and meetings to promote shared learning and information exchange through multiple venues, reviews the literature and key studies on measurement issues, conducts expert policy and operational data analysis on measures, methods, and effect, and works collaboratively with national organizations, such as NCQA and NQF to advance understanding of special needs populations and the plans that serve them. As a key stakeholder organization, we welcome participation on this TEP and look forward to ensuring that Stars Rating and Quality Management System (QMS) work equitably and toward stated goals.

Pg. 107 New Measures for 2019 Star Ratings

Several SNP Alliance members have indicated their concern about the excessive attention to and measure specification differences across Part C and Part D, for example around Diabetes medication management measures. This proposed new measure “Statin Use in Persons with Diabetes” is one example. Given that there are other Diabetes medication

adherence measures (for example statin adherence is already measured in the existing adherence measures), how does this measure overlap or relate to that one? It would be helpful to examine all the Diabetes measures within Part C and Part D and consider them as a group as to their weight and comprehensiveness, and in proportion to the total Star measure set.

Pg. 108 Proposed Changes to Measures for 2019

Regarding proposed changes to Measures for 2019, the SNP Alliance offers comments on the following: (1) Calculation of Improvement Measures, (2) Members Choosing to Leave the Plan, and (3) Beneficiary Access and Performance Problems. See Appendix for full detail.

Pg. 113 Temporary Removal of Measures from Star Ratings - Reducing the Risk of Falling (Part C)

The SNP Alliance appreciates the attention to falls prevention as that is an important focus area for older adults. We reiterate our concern about the HOS instrument as the primary source of data to be used. See Appendix for full detail.

Pg 122. 2019 Star Ratings Program and Categorical Adjustment Index

CMS reiterates that they are committed to responding to work within the research community on both “identifying the impact of social risk factors on health outcomes and how to best address the impact on clinical quality measurement such that comparisons across contracts yield accurate representations of true differences in quality.” The agency notes that the final report of the two-year examination by the National Quality Forum includes a recommendation for another three-year initiative to further examine this issue and consider adjustment methods.

SNP Alliance Brief Comment (see Appendix for full analysis and recommendations)

The SNP Alliance fully supports the work of the research community (including experts involved in the National Quality Forum, National Committee for Quality Assurance, Assistant Secretary for Planning and Evaluation, and the National Academies of Sciences, Engineering, and Medicine) and by CMS to better understand and account for the effect of social risk factors in beneficiary populations which impact health outcomes. Toward moving forward in this important work, the SNP Alliance urges more interaction and collaboration between NCQA and PQA to examine not just each measure independently – but how measures on similar focus areas (e.g., Diabetes medication control/management) work together. This would involve attending to alignment between these Part C and Part D measures (NCQA and PQA working together) as they consider revisions to their measure specification as part of the examination of sensitivity to social risk factor characteristics. See Appendix for full detail.

Pg. 122 PQA Adjustment and NCQA Stratification

CMS notes that PQA has draft recommendations for three measures: Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension, and Medication Adherence for Cholesterol. These measures are to be adjusted for social risk factors, age, gender, dual/LIS/disability status. Furthermore, the measure results will be stratified these beneficiary-level characteristics so that plans can identify how their enrollment mix may be affecting their measure scores. Similarly, NCQA has received approval from the Committee on Performance Measurement to implement stratified reporting of 4 measures used in Star Ratings: Breast Cancer Screening, Colorectal Cancer Screen, Comprehensive Diabetes Care – Eye Exam, and Plan All-cause Readmissions. They will be stratified in 5 subgroups: both LIS/DE and disabled, not LIS/DE and not disabled, LIS/DE and not disabled, and not LIS/DE and disabled, and “other”.

SNP Alliance Brief Comment (see Appendix for full analysis and recommendations)

The SNP Alliance supports the proposed stratified reporting as it offers the potential for greater understanding of population-level differences. It is important to compare similar populations to each other in order to use measurement results and compare plans accurately. Stratification has been endorsed by the National Institutes of Sciences Engineering and Medicine as one method for adjusting for population level differences which arise independent of plan or provider performance. See Appendix for full detail.

Pg. 122. Categorical Adjustment Index

For 2019 Star Ratings Program, CMS is proposing to continue the use of the interim analytical adjustment, the CAI. The overall methodology would remain unchanged for 2019.

SNP Alliance Brief Comment (see Appendix for full analysis and recommendations)

The SNP Alliance appreciates the work by CMS to address social risk issues affecting health outcomes in beneficiary populations and their work to make adjustments in some measures. As stated previously, there has been very limited effect of the CAI on plans with high-risk beneficiary populations in terms of Star measure ratings and request additional attention to improving this or other methods for recognizing beneficiary and community characteristics on measure results. There is work to be done. See Appendix for full detail.

Rules Codified

With regard to the process for updating measures in the future, CMS refers to the proposed rule published 11/28/2017 which indicated intent to codify all of the Star Ratings and Quality Management System (QMS) into regulation.

SNP Alliance Comment

The SNP Alliance appreciates CMS's interest in codifying sections of the current rules to provide stability in the system. We agree that transparency and predictability is important for organizations to anticipate measure elements and respond, invest, and learn from accurate quality measurement results. However, we hope that CMS will test alternatives and make substantive modifications to the current measures, methods, factors for adjustments, cut point methods, scoring, rating, and reporting as part of this rule codification, or through subsequent action in the near term. The SNP Alliance provided extensive comment on this in our response to the Proposed Rule.

Pg. 140 Display Measures – CMS outlines display measures including **Hospitalizations for Potentially Preventable Complications** (Part C).

SNP Alliance Comment

The SNP Alliance has heard from several member health plans about potential difficulties with including observation stays as a possible negative signal. They note that some clinicians are using observation stays for positive condition management, rather than signaling a poor practice, particularly in rural areas where distance to the hospital and Emergency Room can mean long drives which can be even more precarious in bad/snowy weather. The individual who presents himself/herself to the ER given symptoms can be kept in an observation unit for the clinician to take more time to evaluate the individual's condition to ensure medical stability and adequate self-management capability. Further development is needed to allow for positive uses of observations stays, such as in rural areas, before the measure is ready for display.

Pg. 145 Potential Changes to Measures - CMS outlines changes to existing measures, including **Controlling High Blood Pressure, Plan All-Cause Readmissions, Initiation and Engagement in Alcohol or Drug Dependence Treatment, Telehealth and Remote Access Technologies, Cross-Cutting Exclusions for Advanced Illness** (all Part C measures), and **MTM Program Completion Rate for CMR** (Part D).

SNP Alliance Brief Comment (see Appendix for full analysis and recommendations)

*The SNP Alliance appreciates the ongoing measure development work. We provide overall recommendations and key considerations regarding the inclusion of telehealth/remote access technologies, and the cross-cutting exclusion for advanced illness. Please see **Appendix** for full detail. We also request more immediate action on an exclusion provision that needs correction, as discussed briefly below and more fully in the Appendix.*

Important Immediate Fix Needed on Measure Exclusions for Institutional Level of Care Beneficiaries

Special Needs Plan Alliance Brief Comment:

Related to this issue of measure exclusion and in anticipation of further work to be done on the Advance Illness exclusion, the SNP Alliance has been made aware of recent changes made to four Star measure specifications (additional exclusions made) following last year's Final Notice, via an update to the technical specifications manual issued by NCQA (October 2017). There were four measures where technical specifications updates were made to exclude persons who are at an institutional level of care (as specified by their state assessment and determination criteria) and who were living in the community or in an institutional setting and enrolled in an I-SNP. The four measures are: breast cancer screening, colorectal cancer screening, controlling high blood pressure, and osteoporosis management in women who had a fracture. We support these considerations not only for I-SNP enrollees, but also request that NCQA and CMS consider these exclusions for D-SNPs serving a high proportion of these same types of beneficiaries. Initial review suggests that this proportion is between 50-80% for other D-SNPs. This lack of additional measurement exclusion may have been an oversight. We bring it to the attention of CMS and NCQA to correct. Since this update was after the last Advanced Notice comment period, we request that some corrections be made – specifically in setting calculation of cut points and the application of Star ratings for these four measures. This would be needed to avoid unintended harm to other SNPs also serving a high proportion of these institutional level of care beneficiaries. See [Appendix](#) for full detail.

Pg. 148. Potential New Measures

There are 11 Part C potential new measures for 2020 and beyond, and 2 Part D potential new measures. Potential new measures include: **Transitions of Care, Follow-up after ED Visits for Patients with Multiple Chronic Conditions, Care Coordination Measures, Assessment of Care for People with Multiple High Risk Chronic Conditions, Depression Screening and Follow-up for Adolescents and Adults.**

Special Needs Plan Alliance Brief Comment:

We appreciate the work to focus on transitions of care, follow-up and other aspects of care with attention to persons with multiple chronic conditions and older adults. However, we find that many of these proposed measures have significant methodological, data constraint, and operational feasibility issues. In addition, some of the measures seem more suited to be applied to hospitals than managed care organizations. We provide more detail in the [Appendix](#).

Pg. 156. Measurement and Methodological Enhancements –

Special Needs Plan Alliance Brief Comment:

We appreciate CMS' commitment to continuing to improve the quality management system. The SNP Alliance has indicated in previous comments where/how specific

measures and methods used in the Star Ratings do not match with the special needs plans' beneficiary characteristics and thus may not provide adequate information for discerning quality performance or how to affect change toward quality improvement. Data which is not complete may lead to inaccurate conclusions and therefore inaccurate reporting on performance. See Appendix for detailed remarks.

Pg. 156. Exploring Additional Measurement Concepts, such as functional status

We strongly support CMS's interest in more fully recognizing the effect of persistent and ongoing functional limitations. We provide a full examination in the Appendix.

Pg. 166: Medicare Advantage Value-based Insurance Design Model Test

In 2018 CMS is testing the model in Alabama, Arizona, Indiana, Iowa, Massachusetts, Michigan, Oregon, Pennsylvania, Tennessee and Texas. Starting in 2019 CMS will also test MA- VBIID models in California, Colorado Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia.

SNP Alliance Comments and Recommendations

The SNP Alliance would like to see further innovations available under the VBIID demonstrations extended to Special Needs Plans. In particular, SNPs would like to be able to waive Part D drug co-pays, especially for low income beneficiaries. Such co-pays, while relatively low, still pose barriers for medication compliance for members with complex disabilities and medical conditions who may take large numbers of medications.

Pg 168: Special Needs Plan Legislative Sunset Provision

CMS recognizes that, as of the date of publication, Congress has not yet reauthorized the SNP program. CMS will continue to accept applications for SNPs, MOCs and other SNP-related material for new and renewing SNPs, based on a belief that Congress will likely act in 2018 to extent the SNP program.

SNP Alliance Comments and Recommendations

The SNP Alliance thanks CMS for this consideration, and is pleased and relieved that Congress has now provided permanency for all SNPs. We are looking forward to working with CMS on how permanency may impact opportunities for streamlining or improving operational deadlines and regulatory provisions in the future.

Pg 170: Plans with Low Enrollment

CMS will notify SNP plans that have fewer than 100 enrollees and have been in existence for three or more years that they will not be renewed. CMS does state they recognize certain factors, such as the specific populations served and geographic location of the plan that impacts the low enrollment. They provide an example of a SNP plan that

targets a subset of enrollees. CMS will take such information into considerations when evaluating whether a specific plan should be non-renewed because of low enrollment.

SNP Alliance Comments and Recommendations

The SNP Alliance supports CMS' continued flexibility to recognize legitimate circumstances where it is reasonable for a SNP to have enrollment of fewer than 100 members.

Pg 170: Meaningful difference

CMS proposed to eliminate the meaningful difference requirement beginning in CY 2019 as part of the Proposed Rule published Nov 29, 2017. They are reviewing comments regarding this proposal and will provide instruction in the final rule, in the CY 2019 Final Call Letter or a HPMS memo for CY 2019.

SNP Alliance Comments and Recommendations

The SNP Alliance supports the elimination of this provision.

Pg 182: Health Related Supplemental Benefits

CMS acknowledges the value of certain items and services that can diminish the impact of injuries or health conditions and reduce avoidable emergency and health care utilization. CMS has not previously allowed an item or service to be eligible as a supplemental benefit if the primary purpose is daily maintenance. CMS intends to expand the scope of the primarily health related supplemental benefit standard. They provided the example of fall prevention devices. Under their broader interpretation in order for a service or item to be “primarily health related” it must diagnose, prevent or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions or reduce avoidable emergency and health care utilization. Any supplemental health benefit proposed by an MA organization must be reasonably and rationally encompassed by this standard.

SNP Alliance Comments and Recommendations

As outlined in our comments to the recent Medicare NPRM submitted 1-16-2018, the SNP Alliance supports this additional flexibility. We would request CMS further define what this expansion encompasses, including additional potential examples. In this written Call Letter CMS provides the example of fall prevention devices, however on the recent technical assistance call, CMS also mentioned modifications like wheel chair ramps, non-skilled in-home support for ADLs and caregiver respite and support. Given the immense role family caregivers provide to many Medicare beneficiaries who are not eligible for such services under Medicaid, it is important that CMS clarify that these home-based care and services to enable family caregivers provide care to beneficiaries that helps to maintain health status are included. CMS may want to re-verify these latter examples discussed on the call, in writing in the final call letter for those were not on the call.

We also request clarification as to how this provision impacts, overlaps with or interfaces with current flexibilities provided to certain high performing D-SNPs and FIDE-SNPs. As discussed in our comments on the recent CMS Medicare NPRM, CMS should also provide clarification on how the additional benefit flexibility as outlined in the Medicare Managed Care Manual Chapter 16b for highly integrated D-SNPs interacts or is modified under these provisions and under any new provisions that may be allowed under revised regulations as proposed. The current flexibility for highly integrated D-SNPs originated in the April 2012 MA regulatory amendments to §422.202, which allowed fully integrated dual eligible SNPs that meet certain additional quality-related requirements certain flexibility in providing certain supplemental benefits that CMS concluded were a “means of furthering this goal of better integrating care for dual eligible beneficiaries.” Current provisions as outlined in Chapter 16b allow highly integrated D-SNPs to provide additional flexible benefits to dually eligible beneficiaries including those with IADL and ADL needs. We suggest that CMS clarify in its guidance that this provision is distinct from the proposed modification of the uniformity of benefits provision.

Specifically, in light of this new proposed broader flexibility for all MA plans, the SNP Alliance recommends that CMS also revise current guidance implementing §422.202 in order to allow more flexibility in the specific services listed in Chapter 16b to assure that these benefits could include additional items not currently listed there, including those tailored to populations with defined needs for long term supports and services or other supports needed to maintain health status. Some of the benefits now allowed only for highly integrated D-SNPs were mentioned by CMS on the recent Technical Assistance call as examples of supplemental benefits now allowed to all MA plans. If this is the case, CMS needs to clarify distinctions between regular MA plans and highly integrated D-SNPs. In addition, the current criteria and list of supplemental benefits for highly integrated D-SNPs would need to be revised.

There are many other potential supplemental benefits other than those currently listed that would be useful to plans serving highly complex and MLTSS populations and would assist in maintaining health status. Besides the items already mentioned by CMS (non-skilled in-home support for ADLs, caregiver respite and support, home modifications for wheel chair ramps) these include extended nutritional assistance beyond the current limited scope for home delivered meals, assistance with grocery shopping and meal preparation, transportation to adult day care facilities (now allowed under PACE) and medication management and set up, an item often not available under Medicaid. Confusion and poor administration of medications is responsible for many hospitalizations. According to the Agency for Healthcare Research and Quality (AHRQ), nearly half of preventable hospitalizations are due to medication problems. The Centers

for Disease Control and Prevention (CDC) notes that older adults are seven times more likely to experience unintentional drug overdoses and other adverse drug events, and has called for increased attention to medication management for senior patients.

CMS should also consider how expanded benefit flexibility provisions interact with existing Medicaid benefits. Some benefits will overlap current Medicaid services so cannot be offered except to those not otherwise eligible. Other supplemental benefits may play an important role in providing assistance that Medicaid may not cover, such as dental, hearing and vision care. Highly integrated D-SNPs should be able to target the new benefit flexibility to work with states to meet local needs to assure that benefits do not duplicate Medicaid benefits or are those best targeted to members not eligible for them under Medicaid.

We recommend that CMS also clarify that under the change to the uniformity of benefits interpretation, CMS will allow D-SNPs to tailor supplemental benefits for defined population segments that are not driven by disease and will expand the current population segments (people with IADL and ADL needs) as suggested on the Technical Assistance Call. We note that the preamble language to the MA NRPM does allow plans to differentiate benefits based on health status as well as disease state. Consistent with this flexibility, we believe that CMS' new uniformity of benefits position can be interpreted to include subpopulations such as those with behavioral health problems or homelessness and partial versus full benefit dually populations. We are especially supportive of flexibility that would allow plans to provide certain supplemental benefits only to fully integrated dually eligible Special Needs Plan (FIDE-SNP) enrollees who do not meet nursing home level of care requirements that would otherwise make them eligible for home and community-based services under an HCBS waiver.

Further, currently the ability of a highly integrated D-SNP which meets FIDE SNP criteria to offer such flexible supplemental benefits may depend on their receipt of the frailty adjustor offered to FIDE-SNPs with similar frailty levels as PACE providers. D-SNPs seeking to qualify for this adjustment must submit HOS-M information to CMS for use in this comparison. As mentioned earlier, however, our members state that the schedule for informing plans that they meet these criteria occurs too late in the bid process for plans to design and propose the additional benefits that might be made possible by the receipt of the frailty adjustor revenue. FIDE SNPs report that they may not receive these results until after the bids are submitted and are well into the bid review process, which precludes significant changes in their proposed benefits. We request that CMS review timelines for this comparison process and make necessary adjustments that enable these plans to utilize the frailty adjustor revenue to provide this new benefit flexibility to members.

Pg 183: Enhanced Disease Management for D SNPs and I SNPs

Beginning in CY 2019 D and I SNPs may offer the EDM supplemental benefit that is currently available to non-SNP MA plans. The benefit may be proposed as a supplemental benefit in an MA plan’s bid and submitted plan benefit package.

SNP Alliance Comments and Recommendations

The SNP Alliance supports this provision.

Pg 184: Medicare Advantage Uniformity Flexibility

CMS has determined that they have the statutory and regulatory authority to permit MA organizations the ability to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees are treated the same and have the same access to these targeted benefits.

SNP Alliance Comments and Recommendations

The SNP Alliance supports this provision. However, we believe it is important for CMS to carefully consider how comparative information will be presented across plans, such as in Medicare Plan Finder, and how beneficiaries will be educated about them in order to give beneficiaries an objective and clear representation of the merits of different plan choices. These comparisons should also incorporate special programs offered by C-SNPs. We would also underscore the importance of transparency as a means to mitigate member confusion and facilitate appropriate enrollment decisions. It is critically important to make sure that beneficiaries are aware of these benefits as early as possible so that they can immediately take advantage of the improved benefits. This transparency will in turn, maximize the opportunity for improved outcomes.

Therefore, we request that CMS provide additional guidance on marketing and transparency for related information that can be provided to potential members and members as soon as possible. CMS should make necessary revisions in marketing guidance to make this comparative information fair for all plans and beneficiaries. We also request that CMS provide information on the envisioned impact on premiums, particularly in integrated D-SNPs and Medicare-Medicaid Plans.

Please see our comments to the MA NPRM submitted 1-16-2018 for similar concerns around transparency and marketing.

Pg. 185: Special Needs Plan Specific Networks Research and Development

After the 2018 Call letter in which CMS announced that it would explore SNP specific network changes, the SNP Alliance and many of our members provided considerable input into development of SNP-specific networks. We are concerned that CMS now “believes that the current network adequacy criteria and exception request process account for the unique healthcare needs and delivery patterns for Medicare Advantage

(MA) beneficiaries enrolled in SNPs, including chronic condition SNPs (C- SNPs), dual eligible SNPs (D-SNPs), and institutional SNPs (I-SNPs).” While they acknowledge the importance of the issue, CMS now states only that they “continue to examine the need for SNP-specific network adequacy evaluation and welcome continued stakeholder feedback”.

SNP Alliance Comments and Recommendations

The SNP Alliance believes that further clarification of network requirements for SNPs is warranted and continues to stand ready to work with CMS to improve tailoring of network requirements to the needs of SNP enrollees and to reduce unnecessary administrative burdens on plans. In the short term, consistent with CMS’ position stated above that the current criteria and exception review process addresses the unique characteristics of SNPs, we assume that CMS will make needed changes to its current network process, by modifying the current exceptions process to start to address changes that would accommodate many of the issues raised during our discussions. CMS could call upon experience from the modified exceptions process for MMPs as one basis for exercising this added and needed flexibility. At minimum, under the current process, CMS should address the following issues:

- *We are particularly concerned that application of current network requirements to ISNPs is highly inefficient and conflicts with current delivery patterns. CMS could use the exceptions process to allow bedside providers including primary care and specialists who focus on serving SNF and Assisted Living residents based on affiliations with SNFs (who may not serve the general population) to be counted and also make corresponding changes in provider directory requirements to reflect that such providers are available to I-SNP SNF and Assisted Living members.*
- *CMS should also extend the additional MMP exceptions process to DSNPs by embracing the inclusion of modern, now commonly used technological innovations such as mobile clinics, in home, e-visits and other telehealth modes to help address access issues such as shortages of behavioral health providers and other specialty types in rural areas, and to accommodate transportation limitations often experienced by dually eligible beneficiaries. Such changes are already being embraced in many Medicaid programs.*
- *CMS could also use the exceptions process to allow plans to document providers who have exclusive contracts or who consistently refuse to include refusal to serve dual population as an acceptable exception request. CMS could require state approval of such exceptions for integrated plans.*
- *CMS should also reduce confusion, reduce burden and improve efficiency of the process by communication of information to plans of which providers are causing a network denial, for example by including the NPI, provider name, and location in denial details.*

In the future, as CMS moves forward with broader changes in the network review process, we request that CMS consider additional changes in the standards to address SNP specific population network needs and to reduce administrative burden on plans. In particular, CMS should recognize the increasing role provider quality plays in network formations and that time and distance and supply based requirements may not always reflect quality. We request that CMS specifically consider the Principles for Consideration of SNP Specific Network Requirements as a framework, along with additional suggestions and ideas developed by our members and discussed in our network work group discussions with CMS as contained in the attached document “SNP Specific Network Problems and Solutions” and previously provided to CMS. (Attachment 1)

Pg.186: Rewards and Incentives for Completion of a Health Risk Assessment

Beginning in CY 2019 MY plans may include the completion of an HRA as a permitted health-related activity in an RI program. An RI program is not a benefit and it must be included in the bid as a non-benefit expense.

SNP Alliance Comments and Recommendations

The SNP Alliance thanks CMS for this change and supports this provision. We also suggest that HRA completion could be enhanced by allowing the HRA to be completed as an extension of the enrollment process. We understand CMS concerns about ensuring that enrollee health status does not impact choice enrollment. However, for SNPs, it is already necessary that enrollees meet additional enrollment criteria (specific diseases, dual status or institutional status). Allowing more immediate HRA administration would enhance the SNP’s ability to address immediate needs of highly complex members, thereby improving care, and eliminate common delays in understanding enrollee needs caused by scheduling difficulties, inability to reach enrollees after enrollment or enrollee lack of understanding of the process.

Pg 187 – 190: Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs

CMS has identified the following specific areas in which administrative alignment for integrated D-SNPs is current feasible within existing statutory, regulatory, and operational constraints and has been working on these with certain states such as MN and MA. CMS welcomes the opportunity to expand this work and to partner with additional states in which there are integrated D-SNP products available to Medicare-Medicaid enrollees:

- Oversight: Improving CMS-state communication and information sharing
- Integrated model materials:
 - Summary of Benefits (model language used in MN for 2018 and in MA for 2019)

- Annual Notice of Change / Evidence of Coverage, (model changes were announced for 2018)
- Provider and Pharmacy Directory (based on models used in MN and MA),
- Formulary (also based on MN and MA efforts)
- D-SNP non-renewals (state specific notice requirements with relevant Medicaid information for beneficiaries)
- Model of Care: Incorporation of information about the integration of Medicare and Medicaid Managed Long Term Services and Supports (MLTSS). “Based on work in MMPs and the MN Administrative Alignment demonstration, CMS offers interested states with integrated D-SNPs the opportunity to work with such contracted D-SNPs to include additional information in MOC submissions and to review the integrated MOC submissions concurrent with the review of the plans’ MOCs” by NCQA. These reviews and additions do not impact the NCQA reviews.

CMS welcomes comments on these or other areas and offers Technical Assistance to additional states to pursue similar efforts via State Medicaid contracts. They also want to hear from states interested in development of comprehensive administrative alignment work plans.

SNP Alliance Comments and Recommendations

The SNP Alliance appreciates that CMS is expanding these opportunities for enhanced integration outside of demonstration status. We encourage CMS and its partners to actively promote these opportunities with states, who are often deterred by the potential operational challenges involved in making such changes. We are particularly interested in CMS’ offer to work with states interested in development of comprehensive administrative alignment work plans. Promotion of such work plans, when developed collaboratively between D-SNPs, CMS and States and with consultation with stakeholders could provide an important vehicle and blue print for further expansion of integrated options outside demonstration status both now, and in the future.

In addition, now that D-SNPs have permanent status and Congress has passed additional requirements for further integration of Medicare and Medicaid, the SNP Alliance looks forward to continuing to work with CMS on implementation of new provisions that will further streamline and simplify administrative and operational issues related to integration of Medicare and Medicaid under both DSNPs and MMPs in order to improve services to dually eligible beneficiaries.

Building on the current MMPs and DSNP demonstration in Minnesota and requirements and opportunities under the recently passed legislation in HR 1892, the Bipartisan Budget Act of 2018, CMS and the Medicare-Medicaid Coordination Office (MMCO)

should extend administrative alignment and regulatory flexibilities features to additional FIDE-SNPs and D-SNPs in states that agree to participate by submitting the work plans mentioned above, in order to further develop and test a single set of standards for Medicare and Medicaid in areas such as a unified appeals and grievances processes, unified beneficiaries materials, , coordinated communications channels, a single coverage identification card, benefit flexibility, and other integrated elements.

- **Integrated Model Materials:** *We appreciate recent CMS changes that have made it easier to accurately describe both Medicaid and Medicare benefits and the interactions between them to dually eligible beneficiaries in model materials. In addition, we continue to believe that the MMP member handbook format is superior to the current EOC and we hope that CMS can find a way to extend the member handbook option to additional DSNPs outside of demonstration status. We also remain concerned that it is difficult for plans who serve members who are not enrolled in both Medicare and Medicaid to fully utilize these opportunities and we encourage CMS to continue to explore solutions and tools for states and plans that would improve enrollment alignment.*
- **Non-renewals:** *Streamlining the current process related to communications around pending non-renewals, service area reduction, and terminations is crucial as more DSNPs and states are encouraged to pursue integration. As referenced in the call letter, CMS would need to allow inclusions of state specific notices and Medicaid information for affected dually eligible beneficiaries in such a process. While CMS could develop some model notices that would be useful in this process CMS should allow for flexibility in these communications in order to allow plans to work with states to include the appropriate state specific information.*
- **Model of Care (MOC):** *CMS has explored state review of MOCs and inclusion of MLTSS requirements in MOCs in the MMPs and Minnesota's DSNP demonstration concurrent with NCQA's HPMS MOC reviews in order to avoid duplicative reviews by each program. The SNP Alliance has advocated for extending this process to other DSNPs outside demonstration status, so we support the CMS focus on this issue in this call letter. If this process is expanded it will be important to make sure plans have consistent and timely feedback and approval from both CMS and the state and to make distinctions in the MOC to recognize that plans may serve a variety of subpopulations including members who do not need MLTSS services.*

Additional areas for focus that our members believe CMS should consider as soon as possible include:

- **Appeals and Grievances.** *We look forward to participating in the required proposed rule making process. To the extent possible, we would encourage CMS*

to issue some preliminary information about the proposed process as part of this ANCL. In addition, it would be help if CMS could provide additional guidance to advise plans working toward integration on how they can better integrate without curtailing member rights.

- *Combined Member Material Reviews. In addition to developing combined materials, an integrated review and approval process to make the current multiple levels of state and federal review more efficient and coordinated should be prioritized as part of any oversight of integrated programs. While we understand there may be some HPMS and timing challenges involved in further coordination of the review and approval process, CMS has accomplished this under the demonstrations. CMS should explore extending this feature to other DSNPs and states who wish to pursue this additional level of integration through clarification of current authorities or pursuit of new authority where needed.*

Pg 191: Encounter Data Listening Forum, Monitoring and Compliance Activities
SNP Alliance Comments and Recommendations

We commend CMS for providing these opportunities. Please see additional comments related to encounter data on page 3 above.

Pg 222-223: Section IV – Medicare-Medicaid Plans

This section of the Call Letter reminds MMPs of Medicare requirements and timeframes for renewal of MMP contracts. CMS will also provide guidance shortly after the issuance of the CY 2019 Final Call Letter about the applicability of the provisions in other sections of the Call Letter to MMPs. CMS will also release additional guidance on the Network submission process, including how MMPs will be able to submit exception requests, in the summer of 2018. CMS has reviewed networks and provider directories in two states and remains committed to working with MMPs to improve their directories to ensure that enrollees and prospective enrollees have the information they need to make informed decisions about their healthcare choices. CMS will continue to provide assistance in this area and collaborate with states and MMPs to make additional improvements to MMP directories in CY 2019.

SNP Alliance Comments and Recommendations

The SNP Alliance appreciates provision of information for MMPs as part of this ANCL.

Conclusion

The SNP Alliance, again, appreciates the opportunity to provide comments. We applaud the work and commitment by CMS to address these many important issues to improve

access and care for the beneficiaries served. We are happy to answer any questions and to provide additional information, if needed.

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SNP ALLIANCE APPENDIX

FULL COMMENTS AND RECOMMENDATIONS to CMS ON: FRAILTY ADJUSTMENT QUALITY MEASUREMENT, MEASURES, METHODS, ADJUSTMENT, AND HEALTH RISK ASSESSMENT

Pertains to the Part II:

Advance Notice of Methodological Changes for Calendar Year 2019 for MA Capitation Rates, Part C and D Payment Policies and 2019 Draft Call Letter

[published February 1, 2018]

SNP Alliance Comments and Recommendations

We have substantial comments and recommendations pertaining to the following sections of the Advance Call Notice:

PP. 34-35; **Frailty Adjustment for PACE organizations and FIDE-SNPs**

PP. 106-157; **Enhancements to the 2019 Star Ratings and Future Measurement Concepts**

PP. 186; **Rewards and Incentives for Completion of a Health Risk Assessment (HRA)**

Pg 34 -35: Section J – Frailty Adjustment for PACE organizations and FIDE SNPs

The SNP Alliance appreciates the recognition by CMS of the importance of frailty and the effect on costs which are not captured by the HCC model. This has made an important difference for several health plans in adjusting payment more appropriately. However, we have several concerns and offer possible solutions for adjusting to make the application of the frailty adjustment more equitable.

The SNP Alliance continues to be concerned about the methodologies CMS utilizes in comparing FIDE SNPs to PACE levels of frailty. The current methodology compares frailty scores for PACE members, all of whom must be assessed to meet state set requirements for institutional levels of care. FIDE SNPs, too, serve many beneficiaries meet this level of care. However, because of state contract requirements to serve ALL dually eligible subpopulations, not all dually individuals have to meet an institutional level of care if they choose to enroll in a FIDE-SNP. We know that the proportion of persons enrolled in FIDE-SNPs who meet the nursing home institutional level of care criteria can be very high (a convenience sample of SNPA members indicated this is from 50% to 80+% of their total FIDE-SNP enrolled population), the fact that FIDE-SNPs

must also enroll persons who have complex chronic conditions and other limitations but DO NOT meet the state's definition of institutional level of care—results in a skewed comparison of populations that are not equivalent. This enrollment requirement placed on FIDE-SNPs then has the unintended consequence of denying many of these SNPs the opportunity to reach similar frailty levels as the PACE programs within their enrollment. They cannot turn others away.

A potential solution to this inequity would be to assess the proportion of enrolled FIDE-SNP population meeting the nursing home/institutional level of care criteria, and apply the frailty adjustment accordingly in that same proportion. The SNP Alliance believes such a policy would be within statutory authority for CMS and is in keeping with the principle of equal treatment for beneficiaries at a similar level of care. The legislative directive states that the FIDE SNP enrolled population have “similar levels of frailty (as determined by the Secretary)” as the PACE program. Indeed, many FIDE-SNP enrolled individuals do have similar levels of frailty to PACE program beneficiaries--and plans/providers serving them should receive similar resources and be able to offer comparable services/level of care. A proportional adjustment which ties back to the proportion meeting the level of care criteria would be a straightforward way to accommodate state requirements and still meet the intent of the law.

Another challenge with the frailty adjustment is that FIDE-SNPs seeking to qualify for this adjustment must submit HOS-M or HOS information to CMS for calculating frailty levels to use in making the comparison between FIDE-SNP and PACE. However, SNPA health plans have noted that the schedule for informing them about the determination (whether they do or do not meet the target comparison criteria) occurs too late in the bid process for plans to design and propose any additional benefits that might be made possible by the receipt of the frailty adjustor revenue. FIDE SNPs report that they may not receive these results until after the bids are submitted and are well into the bid review process by the time CMS notifies them. Such late notice precludes significant changes in their proposed benefits. This reduces the ability to offer beneficiaries the enhanced services that they could utilize to maintain or improve physical or mental health in the community. Therefore, we request that CMS review timelines for this comparison process and make necessary adjustments to ensure earlier/timely notification of FIDE-SNPs. This earlier notification will enable eligible plans to access the frailty adjustor revenue in order to provide additional benefits of value to members.

Pg. 106. Enhancements to the 2019 Star Ratings and Future Measurement Concepts
CMS notes that the agency regularly reviews the Star measures and methodology to “incentivize plans and provide information that is a true reflection of plan performance and enrollee experience.” With regard to assigning a numeric measure score to each plan

and determining cut points and clustering to determine the numeric range associated with a star value for each measure—the agency says it will review data quality across all measures, variation among organizations and sponsors, and measures’ accuracy and validity before making a final determination about inclusion of measures in the Star Ratings.

SNP Alliance Comments and Recommendations

The SNP Alliance has surveyed plan members through calls, one-on-one discussions, and written communication as we analyzed this section of the Advance Notice and considered implications. We noted measure specifications, such as exclusions, which need adjustment as they are not being equally applied for like beneficiary characteristics. We also provide additional detail on considerations signaling changes in measure specifications prior to being put in use, and request considerations around cut points that will be determined later this year. We reflect our findings and analysis in detailed comments and recommendations --particularly focusing on the Part C measures and proposed changes.

As new measures, changes to measures, and measure specification updates are made, we ask for more collaboration and better synergy between related Part C and Part D measures—and for NCQA and PCA to work more closely to avoid having disparate measure specifications between the two agencies for related focus areas. Where measure focus areas overlap, each measure developer is asked to consult with the other to ensure that measure specifications are consistent. Even small variations, for example in exclusion criteria, can have a substantial impact resulting in burden without meaningful value. We are able to provide additional information and comment and would welcome the opportunity to do so.

Pg. 107 New Measures for 2019 Star Ratings – *Several SNP Alliance members have indicated their concern about the excessive attention to Statin Use in Persons with Diabetes, given that there are other Diabetes measures—for example statin adherence is already measured in the existing adherence measures. It would be helpful to examine all the Diabetes measures in concert and consider them as a group and in proportion to the total Star measure set.*

Pg. 108 Proposed Changes to Measures for 2019 - *Regarding proposed changes to Measures for 2019, the SNP Alliance offers comments on the following: (1) Calculation of Improvement Measures, (2) Members Choosing to Leave the Plan, and (3) Beneficiary Access and Performance Problems.*

1) Calculation of improvement measures – *We appreciate the focus on improvement from one measurement period to another. The current methodology, however, has*

inequities that seem to favor general Medicare Advantage plans vs. SNPs and larger plans vs. plans with smaller enrollment. There is potential disadvantage for SNPs and Medicare/Medicaid plans who serve special needs populations that tend to have smaller plan enrollment in application of improvement measure calculations in Star ratings. This may particularly come into play when measure application requires sampling to gather data from a subset of the enrolled population (such as in HOS or CAHPS). Given the sampling methodology used with these self-report surveys, the sample sizes can be quite small and therefore the measure results are considered not statistically valid. This effectively reduces the number of measures available from that plan to be considered for improvement in the summary rating calculation. Thus, this methodological design favors larger plans. As the process is currently set, the improvement measure score is only calculated for contracts that have numeric measure scores for both years for at least half of the measures identified for use in the improvement measure. We also note that the HOS and CAHPS self-report survey derived measures in Stars have other challenges. We suggest that these may need to be removed from the set of measures considered for improvement score calculation because of these methodological issues.

As CMS considers additional factors that affect plan performance using the Star measures and current methods for calculating summary ratings (such as in considering social determinant of health, community characteristics, and dual/LIS, and disabled proportions within the enrollment of plans factors)—we encourage the consideration of an additional index that recognizes high quality performance by special needs plans as a separate cohort—comparing performance of each plan over time (to its past performance)—independent of shifting cut point levels. We further urge two calculations be done—one with general Medicare Advantage plans and one with a SNP-specific cohort where like populations are compared more accurately. Since individuals with extensive social risk factors and care complexity issues make up a much larger proportion of the enrolled population in a SNP vs. general Medicare Advantage plan, these two plan types represent significantly different beneficiary populations. Therefore we urge CMS to consider methods that address these social risk and care complexity characteristics which affect how, what, and when care and support is provided tailored to these populations, and which do not penalize special needs plans that have demonstrated performance improvement over time.

- 2) Members Choosing to Leave the Plan (C and D) - The agency proposes to expand exclusions for this measure to include plan benefit package service area reductions – including when the area reduced is part of the SNP PBP and there are no non-SNP

PBPs or another SNP PBP within the contract of the same SNP type that covers the area. The SNP Alliance supports the rationale for this measure exclusion expansion.

- 3) *Beneficiary Access and Performance Problems – The SNP Alliance supports the rationale for the removal of this measure to replace it with a revised BAPP measure on the Display Page through 2020.*

Pg. 113 Temporary Removal of Measures from Star Ratings - Reducing the Risk of Falling (Part C) - *The SNP Alliance appreciates the attention to falls prevention as that is an important focus area for older adults. We reiterate our concern about the HOS instrument as the primary source of data to be used in this section and regarding making measurement and methodological enhancements (P. 156).*

The Health Outcomes Survey (HOS) has drawbacks in design, methodology, administration, and reporting that we believe disproportionately affect SNPs who have high dual and high social risk enrolled populations. Our overall recommendation is to re-examine and modify the HOS and its design and methods of administration and analysis, or replace the instrument with another method toward securing reliable and accurate beneficiary feedback and to specifically include diverse, low income, dually-eligible, disabled, non-English speaking persons and those with complex chronic conditions, cognitive impairment, and other special needs populations in the re-testing.

Pg 122: 2019 Star Ratings Program and Categorical Adjustment Index

CMS reiterates that they are committed to responding to work within the research community on both “identifying the impact of social risk factors on health outcomes and how to best address the impact on clinical quality measurement such that comparisons across contracts yield accurate representations of true differences in quality.” The agency notes that the final report of the two-year examination by the National Quality Forum includes a recommendation for another three-year initiative to further examine this issue and consider adjustment methods.

SNP Alliance Comments and Recommendations

The SNP Alliance fully supports the work of the research community (including experts involved in the National Quality Forum, National Committee for Quality Assurance, Assistant Secretary for Planning and Evaluation, and the National Academies of Sciences, Engineering, and Medicine) and of CMS to better understand and account for the effect of social risk factors in beneficiary populations which impact health outcomes.

We further support attention to specific beneficiary population groups to better understand the unique characteristics of these individuals and how their characteristics affect care seeking, health behavior, and service/care preferences—including those who are dually-eligible, low-income, disabled, those of advanced age, those with advanced

severe chronic conditions, and individuals who are ethnically/culturally diverse, non-English speaking, and living in communities that have high social deprivation index scores. Such beneficiary and community characteristics have a great influence and impact on health, health care, and health outcomes.

The SNP Alliance believes that special needs plans, serving a high proportion of individuals with these characteristics, are an important stakeholder with unique perspectives and field experience, together with safety net providers, such as federally qualified health centers and public community hospitals, public health, and consumer groups representing these beneficiaries.

Toward moving forward in this important work, the SNP Alliance urges more interaction and collaboration between NCQA and PQA to examine not just each measure independently – but how measures on similar focus areas (e.g., Diabetes medication control/management) work together. This would involve attending to alignment between these Part C and Part D measures (NCQA and PQA working together) as they consider revisions to their measure specification as part of the examination of sensitivity to social risk factor characteristics. This is very important. We underscore the need to jointly consider options and methods for review and adjustment. The resulting measure specifications, exclusions, and adjustments, then, would be in concert across the Part C and Part D measure set for calculation and scoring and there would be a consistent rationale and methodology. The opposite of this—for each measure developer to consider adjustments, exclusions, or specifications separately on similar areas substantially increases the likelihood of duplication, mismatch, conflict, overlap and wasted resources—as well as confusion in the field. Such a scenario does not support quality improvement.

Even if the measures under Part C and Part D are different, held by NCQA and PQA respectively, there is great value in collaborating across the two measure sets on considerations for refining specifications and making recommendations on risk adjustment methods which are consistent and based on the same scientific principles and thorough data analysis. This is the value of evidence-based science and the scientific method—to build on what is known and share across disciplines and over time in a structured and systematic way. We urge for such collaboration and consistency here.

Pg. 122 PQA Adjustment and NCQA Stratification – CMS notes that PQA has draft recommendations for three measures: Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension, and Medication Adherence for Cholesterol. These measures are to be adjusted for social risk factors, age, gender, dual/LIS/disability status. Furthermore, the measure results will be stratified these beneficiary-level characteristics so that plans can identify how their enrollment mix may be affecting their

measure scores. Similarly, NCQA has received approval from the Committee on Performance Measurement to implement stratified reporting of 4 measures used in Star Ratings: Breast Cancer Screening, Colorectal Cancer Screen, Comprehensive Diabetes Care – Eye Exam, and Plan All-cause Readmissions. They will be stratified in 5 subgroups: both LIS/DE and disabled, not LIS/DE and not disabled, LIS/DE and not disabled, and not LIS/DE and disabled, and “other”.

SNP Alliance Comments and Recommendations

The SNP Alliance supports the proposed adjustments and stratified reporting as it offers the potential for greater understanding of population-level differences that affect care seeking behavior, follow-up, adherence, etc., and impact health outcomes and outcome measurement. In keeping with this purpose, the SNP Alliance would appreciate stratified reporting at the plan/contract level for these and additional Star measures— grouping by plan cohort, based on the proportion of their enrollment which have these beneficiary characteristics, including low income, dually eligible, disabled, and social risk factors. For example, the plans could be separated by the proportion of enrollment in their plans into quintiles. This would provide the reporting and transparency necessary for greater understanding and would allow for relevant plan comparisons for greater accuracy and more meaningful analysis. It is important to provide the necessary information for consumers to compare, plans to benchmark, and equitable scoring to occur. Stratification has been endorsed by the National Institutes of Sciences Engineering and Medicine as one method for adjusting for population level differences which arise independent of plan or provider performance.

Pg 122. Categorical Adjustment Index

SNP Alliance Comments and Recommendations

The SNP Alliance appreciates the work by CMS to address social risk issues affecting health outcomes in beneficiary populations and their work to make adjustments in some measures.

The CAI is a method that was implemented following action requiring that socioeconomic status (SES) and other beneficiary characteristics that affect health outcomes independent of plan performance be taken into account. While we appreciate the initial and interim step, this has now been in use for two+ years, and it is clear that the method has not been effective in addressing this issue. Only 6 out of 47 Part C Star measures are included in the CAI formula. We note that some research requires the inclusion of many more measures (18+) to appropriately capture and adjust for the effects of low income, dually eligible, or disabled status.

We continue to be concerned that unadjusted measures used in the Star ratings are yielding inaccurate conclusions about providers and plans who serve a disproportionate

number of individuals with these characteristics. These quality ratings can influence consumer behavior and are tied to payment. This may inadvertently negatively impact providers and plans serving the most vulnerable population subgroups. As stated previously, there has been a very limited effect of the CAI on plans with high-risk beneficiary populations in terms of Star measure ratings.

Options for improvement in this interim phase while CMS awaits more study results could include: (1) applying an additional population-level quality adjustment to plans achieving at least 3 Stars where their enrollment profile characteristics indicate high social determinant of health risk issues, and/or (2) adding more social risk adjustment factors to the CAI model, and/or (3) including more measures in the CAI. Another footnote to the CAI interim adjustment methods—is to ensure that persons who became eligible for Medicare due to a disability prior to age 65 are able to retain their “disabled” status even when reaching their 65th birthday—as their disability surely continues and switching them to Medicare “aged” reduces validity and suppresses appropriate application of adjustments.

We understand that CMS is awaiting further study results including the final ASPE report, but there are several steps that the agency could take right now that are not dependent on further research or final decisions on an approach.

For example, CMS could conduct modeling of options presented in the first December 2016 ASPE report and in the five NASEM reports that examined the effects of social determinant of health characteristics on Stars and health outcomes. Using the data CMS already has access to, connected to community-level data, the agency could model two or more methods for adjustment. This modeling would help us all learn and would inform the field and CMS as it begins to set up more robust methods. Engaging key stakeholders in the analysis helps to ensure a fully-vetted approach. We believe that there are health plans that would be willing to participate as volunteers in such modeling, and/or to interpret results.

There is also critically important work to be done to help coalesce and/or build social risk health data and datasets with consistent and meaningful definitions. Likewise work is needed to bring all measure developer’ social risk modeling methods up to a reasonable standard and consistency. For example, the NQF recent report on health equity, disparities and implications for risk adjustment pointed to the critical need for standardization in both data definitions/data sets, and attention to minimum standards for measure adjustment analysis by developers.

These actions will be needed in any risk adjustment method that is eventually chosen. CMS leadership and guidance is also needed now to build the foundation for action. There is likely inequity and resource maldistribution happening now in the current system. We urge attention to these foundational steps—that they be undertaken now while additional study, and full development of potential solutions to the problem is still in the future.

Pg. 140 Display Measures – CMS outlines display measures including **Hospitalizations for Potentially Preventable Complications** (Part C). *The SNP Alliance has heard from several member health plans about potential difficulties with interpreting all observation stays as a possible negative signal. They note that clinicians sometimes use observation stays for positive condition management, rather than signaling a poor practice, particularly in rural areas where distance to the hospital and Emergency Room can mean long drives which can be even more precarious in bad/snowy weather. The individual who presents himself/herself to the ER given symptoms can be kept in an observation unit for the clinician to take more time to evaluate the individual’s condition to ensure medical stability and adequate self-management capability. Further development in examining these appropriate practices may be needed before the measure is ready for display.*

Pg. 145 Potential Changes to Measures - CMS outlines changes to display measures and potential changes to existing measures, including **Controlling High Blood Pressure, Plan All-Cause Readmissions, Initiation and Engagement in Alcohol or Drug Dependence Treatment, Telehealth and Remote Access Technologies, Cross-Cutting Exclusions for Advanced Illness** (all Part C measures), and **MTM Program Completion Rate for CMR** (Part D).

SNP Alliance Comment and Recommendations

The SNP Alliance appreciates the ongoing measure development work. We provide overall recommendations to continue to take into account these key considerations:

- *Small special needs plans – considering the effect on these plans; where measure specifications, instruments, and methods for data collection/reporting may preclude or inhibit their participation and thus hamper their ability to demonstrate measure/condition improvement and therefore affect their ability to participate in the Star ratings system, potentially affecting consumer confidence, choice, benchmark and improvement options, and payment*
- *Measure testing consistency - Consistent scientific methods robustly applied across measure developers to test and refine for social determinant of health factors, LIS/DE, disability, and to accommodate diversity of culture, ethnicity, and language in beneficiaries (particularly in terms of self-report surveys),*

- ensuring that the tools used appropriately accommodate all individuals and are valid and reliable*
- *Weights on Measures - Caution on weighting measures without full analysis of the effects of plan beneficiary enrollment characteristics where these characteristics influence measure results independent of plan or provider actions.*

Inclusion of Telehealth and Remote Access - *Regarding inclusion of telehealth and remote access technologies, the SNPA supports this recognition, where there is sound evidence that such technologies work effectively for individuals—and that these technologies can be tailored or are appropriately utilized for individuals with ethnic, linguistic, and other diverse characteristics. A thorough examination is necessary with expert and stakeholder input.*

Advanced Illness Exclusion - *Regarding the proposed Cross-cutting Exclusion for Advanced Illness, we strongly support this examination. The SNPA and its special needs plans have long recognized the need for re-evaluating the clinical appropriateness for excluding individuals with advanced illness from selected HEDIS measures. We welcome this change by NCQA and their interest in examining this issue and in moving ahead. We believe SNPs are key stakeholders and welcome the opportunity to provide expertise and field experience. As a caution, we urge attention to two key considerations for defining and specifying the conditions for such exclusions:*

- 1) *Thorough vetting through stakeholder input on carefully defining the conditions for measure application, exclusion, and specification modifications to ensure equal/even application across plan types and attend to unintended consequences that arises from uneven application (see current example below), and*
- 2) *Need for greater collaboration and joint analysis between Part C (NCQA) and Part D (PQA) measure developers and stewards to ensure alignment, synergy, and positive, intended effect that promotes quality improvement—particularly where measure focus overlaps.*

Immediate Fix Needed on New Updates to Measure Exclusions for Institutional Level of Care Beneficiaries

Related to the development of Advanced Illness Exclusions, the SNP Alliance has been made aware of recent changes made to four Star measure specifications (additional exclusions specified) following last year's Final Notice, via an update to the technical specifications manual issued by NCQA (October 2017). There were four measures where technical specifications updates were made to exclude persons who are at an institutional level of care (as specified by their state assessment and determination criteria) and who were living in the community or in an institutional setting and enrolled in an I-SNP. We

agree with this but request that D-SNPs with similar institutional level of care beneficiary populations also be excluded.

The four measures are: breast cancer screening, colorectal cancer screening, controlling high blood pressure, and osteoporosis management in women who had a fracture. NCQA recently specified additional measure exclusions for these four measures, removing persons enrolled in I-SNPs from the measure specifications because of the potential for harm related to testing and treatment (related to actions specified in these four measures) of persons who are assessed to be at an institutional level of care.

We agree with the need to consider the potential harmful effects of, in effect, promoting testing or treatment that may not have value for beneficiaries with specific illness and advanced condition criteria. We note the great importance for maintaining the primacy of the authority of the beneficiary's clinician to determine what he/she needs or does not need in terms of treatment, screening, and testing.

If, however, expert clinicians and panels have determined that there are reasons to consider the potential for harm in applying these measures across the board to persons who are at an institutional level of care (whether living in an institution or in the community) then we support these considerations not only for I-SNP enrollees, but also request that NCQA and CMS consider these exclusions for D-SNPs serving a high proportion of these same types of beneficiaries. Initial review suggests that this proportion is between 50-80% for other D-SNPs.

Corresponding measure exclusion needs to be specified to address the same measurement application concerns for beneficiaries served by FIDE-SNPs and D-SNPs who meet the institutional level of care as determined by the state in which they reside. Some states have had a substantial focus on returning these individuals to the community and managing them through significant support at home. Though at home, they remain "institutional eligible and certified at a nursing home level of care." Such screenings and preventive treatment can still be ordered by their providers as they deem fit, but the same reasoning for excluding beneficiaries who are nursing home certified and living in a facility or other residence enrolled in an I-SNP also applies to beneficiaries who are nursing home certified and living in a facility or another residence enrolled in a D-SNP or FIDE-SNP.

Given the appropriate exclusion of beneficiaries at an institutional level of care enrolled in I-SNPs, the same reasoning applies to D-SNPs serving a high proportion of beneficiaries at an institutional level of care. Otherwise plans who have a high proportion of these beneficiaries face unintended negative consequences in Star measure score results arising from applying the measures in an unequal way.

Therefore, we suggest that cut points should not be adjusted upwards or otherwise changed (as a result of the I-SNP population measure data being removed) for these four measures in the current year. Otherwise, by removing the I-SNP scores, the resulting distribution of measure scores for these four measures is likely to be skewed upwards. Thus, an unintended consequence of not also excluding D-SNPs that have a heavy enrollment of these institutional level of care beneficiaries—the same as those individuals enrolled in I-SNPs—will be to inequitably apply measures and cut point levels which should not now be applied to SNPs with similar beneficiary composition.

It is reasonable to believe that cut points would rise, and by applying the measure to these D-SNPs it is likely to drive down star performance ratings on these four measures and may even negatively impact their overall Star rating performance. This is so given that these four measures are also in the improvement calculation. This would double the negative effect—particularly when considering that the improvement scores are highly weighted.

Since this update was after the comment period, we request that method adjustment be made; at a minimum in the calculation of cut points and application of Star ratings for these four measures to avoid unintended harm to other SNPs also serving a high proportion of these institutional level of care beneficiaries. This correction would be for the current year. We assume additional corrections would appear in future technical specification updates made by NCQA and in concert with their development of the Advanced Illness exclusion(s).

Pg. 148. Potential New Measures for 2020 and Beyond - There are 11 Part C potential new measures for 2020 and beyond, and 2 Part D potential new measures. Potential new measures include: **Transitions of Care, Follow-up after ED Visits for Patients with Multiple Chronic Conditions, Care Coordination Measures, Assessment of Care for People with Multiple High Risk Chronic Conditions, Depression Screening and Follow-up for Adolescents and Adults.**

SNP Alliance Comments and Recommendations

The SNP Alliance appreciates the ongoing measure development work. We appreciate the work to focus on transitions of care, follow-up and other aspects of care with attention to persons with multiple chronic conditions and older adults. However, we find that many of these proposed measures have significant methodological, data constraint, and operational feasibility issues. In addition, some of the measures seem more suited to be applied to hospitals than managed care organizations. Since SNPs are very likely to have a high proportion of persons with multiple chronic conditions and who match the other measure eligibility criteria these new measures will most certainly disproportionately

affect these types of plans. Special needs plans already have four extra measures that pertain to assessment and care of older adults.

We therefore urge attention to the existing measures already applied to SNPs, and request that there not be duplicative and overlapping focus. We would not support additional measures to be applied to SNPs on top of the four extra measures already applied. This would be unfair and an unequal administrative burden on SNPs compared to general MAOs.

The SNP Alliance provided comment previously to Mathematica and NCQA on some of these measures when they were first offered by the developer. Some of our concerns persist, particularly on timing, data sources, constraints on appropriate clinical practice, special considerations for high need, complex populations with a high prevalence of social risk factors, and questionable application and the MAO measure set. We restate some of these concerns and offer additional analysis. Again, we urge particular attention to SNPs and to working with the SNP Alliance and our member plans as integral stakeholders. It is reasonable to assume that these measures apply to a much greater proportion of their enrolled beneficiary populations than to general MAO enrollment populations.

Transitions of Care - We agree Transitions of Care is an important focus. However, there are methodological and operational feasibility concerns in addition to considering if this measure is appropriate for health plans.

This measure may be more appropriate as a hospital measure rather than applied to plans. Hospitals have been working on their transitions of care and readmissions and transmittal of information and follow-up, but they do not immediately communicate this information to the beneficiary's health plan. The exchange of information may also be slower particularly so in regions where provider structures and practice patterns do not have highly structured or clearly defined medical home clinics and/or primary care to hospital linkages. In addition, the patient/beneficiary may utilize various provider systems—clinics, hospitals, urgent care centers—that are independent of each other and not linked electronically. These disparate providers are unlikely to provide immediate information to the health plan until they submit claims. It is important for CMS to consider that any information required by providers to be submitted to health plans sooner than the time-period for submitting claims (90 days) is very challenging for providers. This particularly affects small and rural providers where capacity and resources are more constrained. This must be taken into account when setting forth measure specifications and exclusions/exceptions.

Beyond the issue of notifying the health plan, practice capacity, internal structures, information systems, and interoperability issues come into play when considering the feasibility of a one-day notification timeframe for providers. There should be some leeway on the documentation timeframe regarding transitions, taking into account differences in information exchange capacity and systems capabilities and other resource/capacity limitations of providers. Recognition that transitions of care for SNP populations are complex and can involve multiple providers and settings of care—important for follow-up—is also warranted.

A related issue is securing documentation of receipt. Even if a provider in fact received a notification from a hospital within the specified time period--the documentation in a PCP clinic is dependent on the internal processes, workflow, and other constraints of the provider realizing the notification came in and documenting that in the medical record. This timeframe for documentation seems an excessive additional burden on the provider.

It is well understood that information system and health information exchange capabilities, systems and structures vary widely across the country. There are many examples where a primary care provider and hospital do not operate on the same data platform. Some primary care clinics are connected to specific hospital systems with shared information systems, and some are not. In addition, state health privacy and data exchange standards or state contracts may dictate timeframe and methods for notification. Resource constraints and capacity differ as well. For example, federally qualified health centers (FQHCs) that serve low-income and vulnerable populations do not often have additional resources to apply to added documentation requirements.

Other important considerations include the need to expand the measure specifications to allow “notification” and “receipt of discharge information” to include other key providers who are the principle clinician required and necessary to handle follow-up care relevant to the admission/discharge and the transition, given the beneficiary primary medical and behavioral health needs (not only the reason for admission, but underlying chronic care needs and conditions).

There are serious and persistent mental illnesses, high-risk, high-cost conditions, and complex medication regimens needing post-acute management and reconciliation--which PCPs may not feel are under their purview or level of expertise. Note that for mental health, behavioral health, some neurological conditions, and other high-medical intensity conditions, the most appropriate provider(s) needed to work with and engage patients following an acute episode may not be limited to PCPs. Others should be recognized as appropriately providing follow-up and appropriately handling medication reconciliation—such that if these individuals were involved, the requirement is met. The standard should be flexible enough to encompass this. We agree that the PCP should be included and notified on the follow-up and patient engagement. We trust that if the other

provider completes their work within 30 days of discharge and notifies the PCP within 30 days as well (same 30 days), that this would meet the intent of the measure.

As discussed, notification timeframes vary for reasons outside of a plan's control and the intent and application of this measure to assessing an aspect of quality over which the organization has some control—seems more relevant for hospital providers than plans.

Follow-up after ED Visits for Patients with Multiple Chronic Conditions - We agree that follow-up is important for all persons (those with multiple chronic conditions and others) after an ED visit. Again, there are challenges in operationalizing this measure as a plan-specific measure of quality. To comment fully, we would need additional background information and testing results showing the utility of this measure and how plans have been able to influence this behavior. This is another measure where more field experience and operational insight is needed.

With respect to the type and timeframe for follow-up, we believe a patient's needs and the severity of their medical or behavioral conditions should guide subsequent action. Access, accommodation, and amenability issues for persons with complex medical, behavioral, and social risk factors should be taken into account.

We wonder about the multiple possible data sources for this information – those who will need to document in their record systems that there was follow-up within the 7-day timeframe, and then appropriately transmit this to the health plan. Again, the issue of requiring transmittal to the health plan any sooner than the 90-day window for when claims must be submitted is potentially problematic.

In particular, this kind of follow-up is more complicated with persons with multiple chronic conditions, as there may be a number of clinical/medical and behavioral health providers who could provide appropriate follow-up after an ED visit. The individual's principle clinician may be a specialist pertaining to the reason for the ED visit. In addition, the necessary follow-up might include a designated care coordinator, telehealth visits, or a skilled home care nurse who is working within a clinical team. These types of follow-up should be taken into account, in addition to the other issues raised—as the measure specifications are developed. Therefore a more expansive/inclusive definition and statement of follow-up (e.g., office/clinic visit, mobile unit visit, video/telehealth visit, telephone visit, web visit, home visit, etc.) is needed. To trace this complex pathway could require extensive time. Finally, there is a time lag between when the ED visit occurs and when the health plan is notified and can connect with the beneficiary. For all of these reasons, clarification and development on the purpose, feasibility, and utility of this measure is warranted.

Care Coordination Measures - SNPA supports the focus on care coordination across settings and over time as especially important for those with complex care needs. However, we request more work be done to clarify measure specificity, application, and consider duplication/overlap with existing measures.

There are real challenges in defining measures and evaluating methods of care coordination that take into account unique issues and concerns of persons with multiple chronic conditions, behavioral and physical health challenges and social risk factors which affect care outcomes—such as in characterized by SNP populations. The SNPA stands ready to provide additional information and analysis as the details about what is being considered come to light. We request that the SNPA be contacted and serve in some kind of advisory way or as part of a technical expert panel, as we represent key stakeholders that may be unduly affected or who may offer important and unique perspectives on these care management and measurement issues.

CMS notes that there are four additional measures applied to SNPs but not applied to all MAOs serving older adults. These include: Older Adult Care Management, Care of Older Adults-Medication Review, Functional Status, and Pain Assessment). Plans have said that these are useful and relevant measures. While challenging to collect and report, they can offer important information that is specific to older adult care management and priority focus areas. However, because they are only required by SNPs to collect and report and are not required of general Medicare Advantage plans also serving older adults with chronic conditions, and given that these are therefore not taken into account in the overall Star Ratings for plan comparisons, there is unequal burden on SNPs under the Star measurement process.

SNPs are already reporting on the Older Adult Care Management measure which has some of the same focus areas as these proposed Care Coordination measures. Understandably, special needs plans are concerned that the focus for these new measures will be duplicative of existing measures and would represent additional measurement burden without demonstrated value toward quality improvement. The SNP Alliance recommends that the fairness in measurement burden be considered as an important principle of the QMS. Therefore, in considering these two measures (Care Coordination and Assessment of Care), SNPs might be allowed to substitute and continue their existing SNP-specific measures for these two measures.

We would not support additional measures to be applied to SNPs on top of the four extra measures already applied. This would be unfair and an unequal administrative burden on SNPs compared to general MAOs. In addition, because the measures are likely to apply to more of the SNP enrolled population than the general MAOs, the operational,

administrative, provider, and reporting burden will be higher on these SNP organizations. This increases the inequity.

Assessment of Care for People with Multiple High-Risk Chronic Conditions - The SNPA supports assessment of care for people with multiple chronic conditions—this is an important part of good care management.

However, it is difficult to imagine having access to data that would allow for accurate and consistent measurement, particularly for persons with multiple chronic conditions. The methods and processes that would go into producing data for this measure seem excessive. Member SNPs have cautioned that the measure as described would require extensive chart review to discern the beneficiaries to whom this should be applied and how/when care assessment occurred.

In addition, the more narrowly defined/applied, the smaller the denominator. This affects the statistical validity and accuracy of the result, given that sampling a small number of people can result in a biased subgroup. Since SNPs are very likely to have a high proportion of persons with multiple chronic conditions, this (and the other proposed measures) will disproportionately affect these types of plans.

Again, we note that special needs plans already have four extra measures that pertain to assessment and care of older adults. We therefore urge attention to the existing measures already applied to SNPs, and request that there not be duplicative and overlapping focus. We would not support additional measures to be applied to SNPs on top of the four extra measures already applied. This would be unfair and an unequal administrative burden on SNPs compared to general MAOs.

Depression Screening and Follow-up for Adolescents and Adults - We agree that depression screening and follow-up are important—underlying and untreated depression can affect care management, treatment and self-care for other conditions.

With regard to this proposed measure, however, there are a number of methodological and practical challenges with the measure specification developed to date. We have previously offered these to the developer in an early version of measure exploration. Some of our concerns persist, which we re-state here.

First, we are concerned that the measure specifications may not fully accommodate or recognize the practices of depression screening and follow-up which are taking place. We note that providers and plans serving populations such as Duals and other low income groups with significant social determinants of health vulnerabilities may be

disproportionately negatively impacted by this measure based on its specifications-- particularly as transient, low-income, dual, and other beneficiaries with high social risk factors may not be utilizing their primary care clinic effectively, either because of housing, transportation, or other challenges—choosing to obtain services from urgent care centers, or switching providers intermittently. This behavior (using multiple primary care clinics in a given area) is more prevalent among specific beneficiary populations. This behavior, then, reduces the proportion of attributed patients who have been screened at the primary care setting. This, in turn, limits the denominator for gauging depression follow-up and remission—if the person is screened by another provider than where he/she normally gets care—then the attributed clinic will not have this individual in the denominator for follow-up.

We note that that special needs plans and safety net primary care providers (e.g., federally qualified health centers) serving a disproportionate share of low SES and vulnerable beneficiaries are more likely to score poorly on the measure of depression screening and follow-up because of characteristics of the population with high social risk challenges and their care seeking behavior and difficulties with responding to clinic outreach for preventive screening and follow-up.

Related to this, people can and do refuse such screening questions for a number of reasons related to their beliefs around this condition. There is evidence that certain ethnic minority groups, such as Hispanic, Hmong, and Somalian groups may have heightened concerns about this condition and will resist participating in any screening given their health beliefs. The measure may need to allow for patient refusals of the screening items—perhaps through indication by the provider after repeated attempts.

We also urge consideration and flexibility around how and where and when the person is screened-- this may be one way to begin to address this complicated issue. For example, Community health workers who are embedded in an ethnic community and see individuals in their homes may have greater success administering a depression screen (may be the PHQ-2 or PHQ-9 or alternative valid screens) than clinicians in an office setting. However as CHWs may not be able to bill for their services, this screening may not be as easily captured as when conducted by a Medicare-certified provider where visit and other codes are captured onsite and these are submitted to the plan for billing. Depression screening and follow-up may be occurring but this activity is not often effectively communicated to the health plan in a timely way.

We note the variety of professionals who may follow-up on the depression screen when the score triggers follow-up—appropriate follow-up may include behavioral health counseling/therapy, medication, and other modalities, but various certified providers. We

are also concerned about the timing specifications for follow-up care. In the integrated behavioral health/primary care models, of which there are many and are growing—some screens and follow-up are done in the medical visit and some by behavioral health—via co-located or integrated providers—so that the care is targeted and timely and so that the individual does not have to be rescheduled, take time off of work, deal with transportation issues, and perhaps neglect the follow-up visit entirely.

Another important issue is the data sources for this measure. While it is certainly desired practice to have an electronic clinical data system that includes the depression screening tool, the health plan cannot dictate or require this. Since most clinics do not have shared medical records across the entire health plan's network of providers—it is not possible for the health plan to require their use nor the health data exchange of the depression screening information. The information exchange structures and processes across independent health care provider organizations will have to continue to advance—with state health exchange requirements also being considered—before such a free flow of this kind of information is the norm. Since depression is considered a behavioral health condition, the restrictions on information sharing across disparate providers and with plans may be even more narrow.

We strongly urge the developer to hear from/listen to behavioral health and primary care providers who predominately serve low income and ethnically diverse populations with high social risk issues. Their insight on depression screening and follow-up will offer guidance on where to allow for flexibility. This is especially important to accommodate beneficiaries with high social risk factors and cultural/language diversity as these individuals learn, understand, and accept depression as a condition they have and can accept, so that they can move toward activation or readiness in following through on recommended actions which are tailored to their beliefs and preferences. We particularly urge attention to take into account where accessibility and accommodation may be particularly difficult for specific populations and to consider the regional, capacity, and information exchange differences across providers.

When these issues have been sufficiently studied, the testing of the measure should include attention to how and when and in what form such data can be effectively transmitted to the health plan. In summary, measures cannot, of themselves, create capacity in the field or change information exchange policy. Measures of quality which are required by health plans should be those where data exists, where the data accurately reflects provision of care, and where the data can be transmitted in a timely way to the plan using the technology available/in use.

Pg. 156. Measurement and Methodological Enhancements

Special Needs Plan Alliance Comments and Recommendations:

We appreciate CMS' commitment to continuing to improve the quality management system. The SNP Alliance has indicated in previous comments where/how specific measures and methods used in the Star Ratings do not match with the special needs plans' beneficiary characteristics and thus may not provide adequate information for discerning quality performance or how to affect change toward quality improvement. Data which is not complete may lead to inaccurate conclusions and therefore inaccurate reporting on performance.

We believe CMS has the statutory authority to consider accommodation and tailoring of quality measures and the quality management system for special needs populations—as evidenced by the legislation enacting this particular form of Medicare Advantage Organization, and by the recognition through subsequent legislative action. We would appreciate the opportunity to participate in this work.

As stated earlier, a very important area for examination is the Health Outcomes Survey (HOS), which has been found to have drawbacks in design, methodology, administration, and reporting that may disproportionately affect SNPs who have high dual and high SDOH enrolled populations. This is a key instrument in calculating some HEDIS measures which are heavily weighted in Stars. The SNP Alliance provided extensive comments on the problem areas with HOS in our response to the Proposed Rule. Briefly, we find methodological problems in: design and administration, sampling, validity and reliability pertaining to specific diverse population subgroups, accommodation, and attribution. Re-design of HOS content, methods of administration, case mix adjustment, analysis, and reporting toward effectively capturing beneficiary vulnerable groups, such as linguistically diverse, low income, dually-eligible, disabled, and those with complex chronic conditions, or cognitive impairment is warranted.

Pg. 156. Exploring Additional Measurement Concepts, such as functional status

Special Needs Plan Alliance Comments and Recommendations:

The SNP Alliance strongly support CMS's interest in more fully recognizing the effect of persistent and ongoing functional limitations. We are eager to be part of the development of this work. We note that the General Accounting Office is also conducting work on examining functional status adjustment, which we have provided input into at their request.

More than twenty years of evidence supports the need to take functional status into account. We know that medical expenditures for a similar condition can be widely different based on functional status and frailty. There is strong evidence that functional status limitations are linked to higher costs. Studies show that functional limitations impact acute care and post-acute Medicare covered expenditures. A longitudinal study (12 years) of a nationally representative sample of over 8,500 community dwelling older adults found that functional impairment was an important marker of higher Medicare and potentially higher long-term care costs. The most severely impaired cost 77% more than Medicare beneficiaries with no functional impairment. Other studies show that when dementia/moderate to severe cognitive impairment is present, preventive and maintenance health care as well as acute care episode management is more difficult and resource-intensive.

Persistent and significant functional limitations, for example in ambulation, cognition, eating, may greatly complicate or challenge the individual when seeking to follow medical treatment and practice good self-care for chronic conditions. Such limitations (for example) could impact the ability to conduct daily testing of insulin and eating at the right times and the right foods, following exercise regimens to manage heart disease or Diabetes self-care at home practices, or checking on weight gain/loss and tracking changes in fluid retention. Therefore, a similar diagnosis in persons of a similar age, weight, gender, and race may play out—in terms of managing at home—very differently based on the individual’s functional abilities and level or type of limitations. Likewise, the ability of the individual to achieve Diabetes self-care management targets for health improvement, for example, may require significantly greater resource support.

Currently, functional status limitations characteristics that affect treatment and self-care capability as well as care management strategies and resource inputs, are not taken into account in measurement adjustment and dis-similar beneficiary population groups are considered the same. Assuming there is consensus on the importance of taking functional status into account, we collectively turn to the issue of how to do this in a valid, accurate, reliable, and equitable way.

We recognize that there could be several methods for incorporating risk adjustment—including (1) application of a “frailty/functional status” adjuster to be applied at the health plan level (as is currently allowed for some FIDE-SNPs) through sampling a portion of the enrolled population and calculating functional status as compared to another reference group—such as PACE, (2) use of functional status assessment data from States on dual populations (Medicaid comprehensive eligibility assessments), or (3) use of a validated, standardized, reliable functional status assessment instrument—not currently required by Medicare—to derive a dataset for all Medicare beneficiaries. These three options are not exhaustive of possibilities but are offered as illustration.

We have discussed some of the current limitations in the HOS and HOS-M instrument (Health Outcomes Survey-Medicare).

Currently, as stated earlier in discussing the frailty factor adjustment, the HOS-M instrument is used as part of the methods to calculate and apply a frailty adjustment to FIDE-SNPs that have a similar population to PACE programs. The HOS-M instrument includes functional status questions, although this ADL/functional status information is very limited. Furthermore, it is based on self-report and we have already discussed challenges with this in terms of accuracy, accommodation, and validity and reliability for diverse, language diverse, and low-income populations.

However, it is useful to review the experience of this method which uses a sample of beneficiary HOS-M survey data as the source data for potentially applying a functional status adjustment to quality measures as well as payment adjustment to FIDE-SNPs. These are two different issues, but some of the challenges or considerations in methods are similar. Therefore, as efforts move ahead, we offer a few recommendations for crafting the functional status adjustment:

- (1) If self-report is utilized, ensure the validity and reliability and accuracy of the instrument for all beneficiary groups, particularly for ethnic, language, culturally diverse individuals and those who are LIS/DE/disabled—and ensure there is accommodation in the methodology and format,*
- (2) The sampling methods must be sufficient to result in a representative sample of beneficiaries for validity to tie back to the full enrolled plan population,*
- (3) Ensure that the methods do not place unreasonable or undue administrative burden on beneficiaries, providers, or plans,*
- (4) There is stakeholder involvement, robust modeling, and full transparency of results/finding to pilot or test various functional status adjustment approaches,*
- (5) In terms of quality measure scoring and reporting, the underlying functional status limitations present within the plan enrolled beneficiary population are taken into account and effects are reported clearly,*
- (6) There is timely notification by CMS on functional status enrollment profile. This relates to the lack of timeliness of notification on the frailty profile for FIDE-SNP adjustment in payment (that is, currently there is not sufficient time to include in the bid process/submission). The timeliness of notification may also be important here, particularly if plans are expected to adjust and enhance care management, provide additional supplemental support, or conduct other work with providers and beneficiaries to address issues arising from this level of functional status limitations*

In conclusion, we are encouraged by the interest of Congress and CMS to explore the necessity and methods for examining the effects of functional status limitations including a functional status quality measurement adjustment for Star ratings and/or a functional status risk adjuster for payment. We know that functional status limitations are particularly high in dually-eligible beneficiary populations.

Pg.186: Rewards and Incentives for Completion of a Health Risk Assessment
Beginning in CY 2019 plans may include the completion of an HRA as a permitted health-related activity in a Rewards and Incentives program.

Special Needs Plan Alliance Comment:

The SNP Alliance thanks CMS for this change and strongly supports this provision. Though health risk assessments alone do not improve health status or drive behavior change of an individual, they are very important in establishing a more complete and accurate picture of member needs, preferences, living situation, social supports, self-care practices, activities of daily living, and other non-medical characteristics which are just as important as clinical/medical/physical conditions. Offering incentives to members for HRA completion may help to increase willingness of individuals to spend the time with plan care managers and/or participate over the phone and help them to see the value in sharing this information. It also signals an awareness that the individual's time is valuable and respected.

We also suggest that HRA completion could be enhanced by allowing the HRA to be completed as an extension of the enrollment process for SNPs. We understand CMS concerns about ensuring that enrollee health status does not impact choice enrollment. However, for SNPs, it is already necessary that enrollees meet additional enrollment criteria (specific diseases, dual status or institutional status). Allowing more immediate HRA administration would enhance the SNP's ability to address immediate needs of highly complex members, thereby improving care, and eliminate common delays in understanding enrollee needs caused by scheduling difficulties, inability to reach enrollees after enrollment or enrollee lack of understanding of the process.