



A National Nonprofit Leadership Organization

## SNP Alliance Comments

### 2020 Advance Notice and Draft Call Letter

Submitted via Federal e-Rulemaking Portal: <https://www.regulations.gov>

March 1, 2019

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Principal Deputy Administrator and Director  
Center for Medicare  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model, Medicare Advantage Capitation Rates, Part C and Part D Payment Policies, and 2020 Draft Call Letter**

Dear Mr. Kouzoukas:

The Special Needs Plan Alliance (SNP Alliance) is a nonprofit leadership organization of 24 managed care organizations providing special needs and Medicare-Medicaid plans representing 1.9 million enrolled individuals and 391 plans in 45 states. The SNP Alliance appreciates the leadership of the Centers for Medicare and Medicaid Services in developing regulations and guidance that take into account the needs of the dually-eligible, low-income, disabled populations with high care complexity, social determinant of health risk factors, and diverse demographic characteristics. These complex population groups are our primary focus.

The SNP Alliance appreciates the opportunity to provide comments in response to the Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Advance Notice of Methodological Changes for CY 2020 for MA Capitation Rates, Part C and Part D Payment Policies (Advance Notice) and 2020 Draft Call Letter (Draft Call Letter).

***Attachment II. Changes in the Part C Payment Methodology for CY 2020.....9***

**Section A. MA Benchmark Cap, Quality Bonus Payments and Rebate .....14**  
*CMS shares the concerns stakeholders have raised about any rate-setting mechanism that diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries, and agrees that a primary goal of the Star Rating system for MA is to encourage plans to continuously improve the quality of the care provided to their enrollees. However, while we appreciate the concerns stakeholders have raised in connection with the cap on benchmarks, CMS believes that section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation.*

**SNP Alliance Comments:** The SNP Alliance continues to point out the problems related to the benchmark cap resulting in reducing bonus payments earned through the hard work of high performing plans in certain counties which undermines intended incentives of the Star Ratings system and is unfair to both plans and beneficiaries in those counties. This result disadvantages beneficiaries by further reducing their access to the potential supplemental benefits such bonus payments would provide. We request CMS carefully re-consider its determination that it lacks authority to address this issue in any way, particularly in light of its authority to implement demonstrations to achieve public policy objectives. The SNP Alliance intends to work with other interested parties to remove the cap by seeking statutory changes including consideration of potential demonstration authority. If CMS cannot address this issue through existing authorities, we request CMS support for these legislative efforts.

#### **Section G. CMS-HCC Risk Adjustment Model for CY 2020 .....28**

*On December 20, 2018, CMS published for public comment the proposed Part C risk adjustment model in Part I of the Advance Notice. The 21st Century Cures Act included a goal to “improve risk adjustment.” The goal of the CMS-HCC risk adjustment model is to accurately differentiate between beneficiaries who have annual costs that are higher or lower than the average annual cost of providing Medicare Parts A and B benefits in the original Medicare program. CMS interpreted the statute’s directive to improve risk adjustment to mean improving the accuracy of the cost predicted by the risk adjustment model across subgroups of beneficiaries in the program.*

*By law, CMS is required to implement a model in 2020 that takes into account the number of conditions a beneficiary may have, in order to be able to complete the phase in of the model by 2022. In the current CMS-HCC model specification, the incremental predicted expenditures of a given condition category (i.e., an HCC) is unaffected by the presence of other conditions (unless that specific HCC is part of a disease interaction). The proposed PCC model includes a separate factor for the count of conditions and the incremental predicted expenditure for a given HCC is dependent on the number of conditions the beneficiary may have, regardless of what those conditions may be. Adding a count of payment conditions, as constructed for the new proposed PCC model, improves the risk adjustment model by improving accuracy across deciles of predicted risk, by either decreasing over-prediction observed in some deciles or decreasing under-prediction in other deciles.*

*The model proposed for PY2020 includes the additional conditions for mental health, substance use disorder, and CKD. Coefficients are determined by 2014 diagnoses predicting 2015 cost. PCCs are capped at 10 to avoid instability. CMS also presents for consideration a PCC model that is similar to the proposed PCC model except that it has additional HCCs for Dementia and Pressure Ulcers. CMS research found that some beneficiaries with multiple chronic conditions were under predicted by the CMS-HCC model. CMS found that the addition of these HCCs improved the model for community enrollees, however it did not add value for the institutional population where costs are less variable.*

**SNP Alliance Comments:** The SNP Alliance generally favors additional model specificities that better capture and reflect frailty and complexity of plan enrollees. We support the three criteria CMS cites in developing the Alternative PCC model: that the model should be clinically meaningful, should predict medical expenditures, and should not comprise discretionary diagnoses. The SNP Alliance appreciates and supports the inclusion of HCC 159 (Pressure Ulcer of Skin with Partial Thickness Skin Loss), HCC 51 (Dementia with Complications), and HCC 52 (Dementia without Complication) in the proposed model for CY 2020. These conditions impact the beneficiary and ongoing care management in significant ways and should be considered as indicators of complexity. The inclusion of these conditions signals recognition of their significance in managing care. This is particularly relevant for plans with a high proportion of members of advanced age and who are deemed to be at an institutional level of care. Therefore, at least in theory, we prefer the Alternative PCC model that includes the additional dementia and pressure ulcer conditions which have not been directly recognized in past models. We also understand

that the impact of the model will be highly dependent on the distribution and mix of enrollees included in each plan.

However, we have serious concerns as to whether the model(s) have been adequately tested and modified to reflect the costs of significant subpopulations and whether it will truly meet the statutory intent for improving risk adjustment for the targeted population segments or whether the model actually masks/inhibits some important differences for key complex groups. For example, some testing we have seen indicates that at 0-3 HCCs, risk scores stay the same, while risk scores for the 4-5 HCC levels actually decrease, this seems both clinically and financially illogical. While risk scores for those beyond 8 HCCs may increase more substantially, there are relatively few enrollees in that level.

More specifically we understand that the new PCC model could result in significant decreases in risk scores for the disabled dually eligible population segment. According to a study conducted by Avalere on a large group of plans and enrollees, mean risk scores for most plans will not change significantly overall. However, members who qualify for HCC 55 under the old definition will decrease slightly, and those members who meet the expanded criteria for HCC 55 had mean risk scores nearly three times higher, indicating a much higher illness burden. Yet the new HCC 55 did not increase factor weights, leading to a -2.19% decrease in the full dual-disabled population and an even larger decrease of nearly 4% for disabled non-duals. The burden of this reduction is likely to be borne by medium size or smaller D-SNPs who are serving disabled populations with behavioral health and substance abuse needs, which are likely to have larger proportions of those groups due to their Medicaid contracts with states. This is exactly the opposite of the kind of incentives CMS should be encouraging given the new proposed integration rules and requirements for FIDE and D-SNPs to provide and integrate behavioral health services. <https://avalere.com/insights/impact-of-cms-changes-to-the-medicare-advantage-risk-adjustment-models>.

We are very concerned about unintended or unexpected consequences of these results. This issue should be addressed by CMS prior to implementation of this model. For example, CMS could consider making beneficiaries with the added diagnoses a separate HCC or make modifications that better reflect the highly specific needs and complexities of beneficiaries with complex condition combinations of alcohol and/or drug abuse and behavioral health needs.

We appreciate CMS efforts to develop a payment method that is responsive to Congressional direction. However, we are very concerned that the existing PCC model may be inconsistent with the intent of Congress. As a result, we recommend that CMS explore a variety of options for addressing the payment issues identified and work with Congress to advance the best of the alternatives, consistent with Congressional intent, including advancing refinements in legislation where necessary.

One such option that we would strongly recommend is that CMS establish a Technical Expert Panel (TEP), similar to the one CMS created for Star Ratings. This TEP would work to ensure ongoing improvements to achieve a model that appropriately adjusts payment for high acuity patients while not causing unintended or counterintuitive impacts on payment. A TEP would allow for a faster and more efficient exchange of ideas and a review of the model refinements that would facilitate selection of model that more closely achieves Congress' underlying objectives in establishing the risk adjustment methodology. The SNP Alliance and its members would welcome the opportunity to participate on such a TEP.

#### **Section H. ESRD Risk Adjustment Model for CY 2020 .....29**

*CMS proposes to use the proposed CPT/HCPCS filtering-based ESRD model for the encounter data-based portion of the CY2020 ESRD risk score and the 2019 ESRD model for the RAPS-based portion of the risk score. The change in the filtering approach for the recalibration of the ESRD model is the same*

*change CMS made for the 2019 CMS-HCC risk adjustment model. CMS is proposing a national average of End-Stage Renal Disease (ESRD) Dialysis Payment rate increase of 1.48% for 2020.*

**SNP Alliance Comments:**

The SNP Alliance is concerned that this update—in combination with the ESRD FFS normalization factor—results in another reduction in plan payments for a small, high-need beneficiary population. MA plans that serve ESRD patients have experienced significant swings in payment rates over the last several years that have a direct impact on beneficiaries and making it challenging to design stable benefit packages that limit year-to-year changes.

The ESRD Dialysis Payment rate trend of 1.48% is significantly lower than the non-ESRD FFS cost trends of 4.52%. The SNP Alliance requests that the CMS Office of the Actuary publish the underlying Part A and Part B cost data for the ESRD population, similar to the information released for the non-ESRD population, as included in the 2020 Advance Notice, Table I-3 (Comparison of Current & Previous Estimates of the Total US PCC – Non-ESRD on page 7). This level of data disclosure would be helpful as MA plans take on a greater share of the ESRD population in the coming years.

We also request that CMS take steps to provide year-over-year stability for the ESRD population. In addition, future updates to the ESRD risk adjustment model should be communicated under a similar timeline as the CMS-HCC model. CMS should allow stakeholders at least 60 days to review and submit comments on all risk adjustment model proposals in order to give plans enough time to properly analyze any contemplated updates. This is particularly important for ESRD model changes, given the fact that ESRD patients will be able to choose MA as an option in 2021.

**Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs .....35**

*For 2020, CMS is changing the overall risk score model for PACE to the 2017 HCC 6 segment model along with the proposed PCC or APCC changes. (While no diagnoses of dementia or ADLs, those associated costs are included.) Consistent with CMS's proposal to blend the risk scores calculated for enrollees in MA plans, they also propose to blend the frailty score that is applied in FIDE SNP's payment. CMS proposes to blend 50 percent of the frailty score calculated from the proposed PCC model frailty factors with 50 percent of the frailty score calculated from the 2017 CMS-HCC model frailty factors. The blended frailty score will be compared with the PACE level of frailty in the same manner as CY 2019 to determine whether that FIDE SNP has a similar average level of frailty as PACE.*

**SNP Alliance Comments:**

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 FIDE SNPs, adjusting payment to more appropriately match beneficiary characteristics.

Further in this letter we describe our concerns about the Health Outcomes Survey. We know the frailty adjustment can utilize the HOS or the HOS-M instrument, with the items included to compare to a PACE population focusing on functional status questions. We note there are several important domains or characteristics of frailty that are not fully addressed through the ADL/functional status items within HOS or HOS-M. Furthermore, it is based on self-report from the beneficiary. We discuss several challenges with this method later in our letter. For now, the use of the HOS-M instrument for considering frailty adjustment is expedient and we understand the practical reasons to continue its use for CY2020. This could be uncoupled from the use of the instrument for Star measures. However, as efforts move ahead, we offer a few considerations for crafting a frailty 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) Ensure sampling methods are robust and result in a sufficient representative sample of beneficiaries that to tie back/match the full enrolled plan population.
- (3) Ensure that the methods do not place unreasonable or undue administrative burden on beneficiaries, providers, or plans.
- (4) Conduct robust modeling, and provide full transparency of results from testing around various functional status adjustment approaches.

Given the importance of frailty adjustment to special need populations, we request CMS conduct additional modeling or offer clarification on the impact of the PCC or APCC model and proposed blending, to ensure there are not unintended consequences on specific high need/complex populations.

We also request clarification and consider modification on whether CMS can calculate the frailty adjustment at the individual level—including only those individuals who are nursing home level of care in the calculation.

The current methodology compares frailty scores for PACE members (all of whom must meet state requirements for institutional level of care) to the entire enrollment of FIDE SNPs. Though most FIDE SNPs have a very large proportion of beneficiaries meeting the institutional level of care definition, these plans often must also accept ALL dually-eligible beneficiaries given state contracting requirements where States mandate that the FIDE SNP cannot restrict enrollment only to dual individuals who meet an institutional level of care.

A convenience sample of SNP Alliance FIDE SNPs reported from 65-90% of their members met the definition. CMS could calculate the frailty profile of these members and compare to PACE scores, and then apply the adjustment proportionately to the FIDE SNP population that is at an institutional level of care. Modeling the effect of such an approach (e.g., test effect of this in 2020) would provide important information to CMS as to whether this is a rational approach for evening the frailty payment adjustment and making it more equitable--so that all beneficiaries in FIDE SNPs who are at an institutional level of care have access to enhanced services similar to those in PACE.

Finally, we request CMS consider a procedural change pertaining to the frailty adjustment process. SNP Alliance plans have pointed out that the CMS schedule (for informing plans that their population meets the frailty criteria akin to PACE) occurs too late in the bid process for plans to design and incorporate additional benefits that could enhance the services provided to beneficiaries. In other words, notification of the frailty adjustor revenue forthcoming comes too late in the year for the plans. FIDE SNPs may not receive these results until after their bids are already submitted or even well into the bid review process. This precludes significant changes in their proposed benefits. We request CMS move up timelines to make this calculation for comparison purposes to allow eligible plans to utilize the frailty adjustor revenue more expediently, toward the intended goal of additional payment to tailor services and meet expanded needs of these dually eligible, institutional level of care beneficiaries.

#### **Section L. Normalization Factors.....36**

*CMS proposes to maintain the same methodology as used in payment year 2019 for calculating the normalization factor. Based on the calculated average FFS risk scores from 2014 to 2018, CMS is proposing to set the average risk score to 1.0 to put MA bids and benchmarks on the same basis.*

*CMS' proposed 2020 normalization factors for Part C are 1.075 for the 2017 CMS-HCC model, 1.069 for the proposed "Payment Condition Count" model, and 1.059 for the ESRD dialysis model. In its Fact*

*Sheet, CMS states that normalization will result in a 3.08 percent payment reduction to MA plan payments. CMS proposes to use risk score data from 2014 to 2018 to estimate the normalization factor.*

*CMS explains the proposed reduction by suggesting large increases for the 2016-18 period are driving a substantial increase in the factor, which it attributes to changes in demographics, the reported health status in the Medicare FFS population and the implementation of ICD-10.*

### **SNP Alliance Comments:**

The SNP Alliance is concerned that the unusual growth in FFS risk scores is leading to higher normalization factors that result in fewer benefits, higher copays, and limited plan offerings for beneficiaries. Members have pointed to this issue as the most critical priority for these 2020 ANCL comments. We request CMS appropriately adjust the normalization factors down to account for the escalated FFS risk score trend to prevent cuts to benefits for MA enrollees.

This year, the higher normalization factors will translate to fewer benefits and support services for enrollees. Over time, if CMS continues to base the normalization factors on CMS data that seems to indicate inflated FFS risk scores, beneficiaries will experience more benefit cuts, increased costs, and limited plan offerings. It is critical that CMS adjust the normalization factors for the CMS-HCC model and the ESRD dialysis model to ensure beneficiaries are not unfairly penalized by artificially high normalization factors.

Based on available data, the increasing FFS normalization trend is driven by the introduction of ICD-10 codes that occurred in late 2015. Actuarial analyses conducted by members show the volatility in normalization factors—particularly starting in 2016—has led to FFS risk score inflation of 2-3 percent in the 5-year linear averaging methodology. We believe the 2016 through 2018 risk scores appear to be outliers, as compared to data from 2011 through 2015. We believe using the 2014 to 2018 data points incurs the risk of over normalizing for 2020 by setting the normalization factor too high.

To account for the anomaly in the risk scores resulting from the move to ICD-10 coding, we encourage CMS to appropriately adjust the 2020 normalization factors downward, and develop a more transparent and accurate normalization methodology moving forward. In preparation for plan year 2021, CMS should also determine whether recalibrating the risk score model using only years of data in which ICD-10 has been fully implemented increases the accuracy of the risk model. It is critical that CMS adjust the normalization factors for the CMS-HCC model and the end-stage renal disease (ESRD) dialysis model to ensure beneficiaries are not unfairly penalized by normalization factors that force cuts in benefits, premium increases and limit plan offerings for beneficiaries.

**Recommendations:** This artificial growth in FFS risk scores has elevated normalization factors, negatively impacting beneficiaries through the reduction of benefits and increased costs. The growth in FFS risk scores—particularly starting in 2016—are unusual and negatively correlated with FFS costs. Based on available data, the FFS normalization trend is driven by the introduction of ICD-10 codes that occurred on October 1, 2015. Actuarial analysis shows 2-3 percent FFS risk score inflation as a result of the move to ICD-10 has led to volatility in the FFS normalization factors. To account for this anomaly in FFS risk scores, the SNP Alliance recommends that CMS:

- Appropriately reduce 2020 normalization factors to account for artificially high average FFS risk score growth following the introduction of ICD-10 codes;
- Develop a more transparent and accurate normalization methodology;
- For 2021, release the impact of recalibrating the risk score model using only years of data in which ICD-10 has been fully implemented (i.e. 2016 and later).

**Additional Details:** The growth in FFS risk scores—particularly starting in 2016—are unusually high. The FFS normalization trend is driven by the introduction of ICD-10 codes that occurred on October 1, 2015. The ICD-10 code set is much larger than the ICD-9 code set, suggesting that the higher than expected normalization factors are due to the inflationary effect of the difference between ICD-10 and ICD-9 mapping to HCCs.

The growth in FFS risk scores has not corresponded with increased FFS costs. In fact, since 2015, projected FFS cost and FFS risk score trends have been negatively correlated. CMS data indicates FFS risk scores are moving in different directions than FFS cost, which means a population-driven change is unlikely. Instead, we believe there is an unaccounted-for coding trend in FFS data driven by the move to ICD-10 codes that has not been captured in the normalization methodology.

The 5-year linear averaging methodology for normalization has failed to capture the FFS coding trend that has emerged following the introduction of ICD-10 codes. Therefore, we recommend an explicit adjustment to 2020 normalization factors due to the artificially high FFS risk scores that member actuarial analysis shows are inflated by 2-3 percent. For 2020, CMS could also consider using 2012 to 2018 or 2013 to 2018 data to determine the normalization factor, the risk score increases appear to be most driven by the use of ICD-10 codes and, as a general policy principle, the agency may use additional data points to ensure stability in its estimates of normalization. CMS should appropriately adjust normalization factors this year, while developing a more transparent and accurate normalization methodology for stakeholders to consider for future years.

In preparation for plan year 2021, CMS should work with the Office of the Actuary to develop, review, and determine the appropriateness of the FFS normalization factors in relation to the FFS growth rate. In addition, CMS should release the results showing the impact of recalibrating the risk score model using a full year of data that reflects ICD-10 coding. It is critical that CMS accurately account for the impact of the transition to ICD-10, ensure the accuracy of the normalization methodology, and release the impact of recalibrating the model using more recent data to ensure plans are accurately reimbursed in 2020 and beyond.

#### **Section N. Encounter Data as a Diagnosis Source for 2020 .....42**

*For CY2019, CMS calculated risk scores by adding 25% of the risk score calculated with diagnoses from encounter data (supplemented with RAPS inpatient data) and FFS with 75% of the risk score calculated using RAPS and FFS diagnoses.*

*For CY2020, CMS proposes to calculate risk scores by adding 50% of the risk score calculated with diagnoses from encounter data (supplemented with RAPS inpatient data) and FFS with 50% of the risk score calculated using RAPS and FFS diagnoses.*

*Specifically, CMS proposes to calculate the encounter data-based risk scores as follows:*

- *With the proposed PCC CMS-HCC model,*
- *Using diagnoses from encounter data, FFS claims, and RAPS inpatient records.*

*RAPS risk scores would be calculated as follows:*

- *With the 2017 CMS-HCC model,*
- *Using diagnoses from all RAPS records and FFS claims.*

*Thus, as proposed, encounter data-based risk scores would only be calculated with the PCC model proposed in this Notice.*

**SNP Alliance Comments:**

The SNP Alliance continues to be concerned about the transition to use larger proportions of encounter data because of continuing operational challenges and inaccuracies in the Encounter Data Processing System (EPDS) which CMS has acknowledged. As a result of a wide variety of data intake, processing, and errors, beneficiary risk scores calculated using Encounter Data System (EDS) submissions are lower than risk scores calculated using RAPS.

These ongoing problems have been well documented by a January 2017 GAO report entitled “Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments) and a more recent 2018 OIG report entitled "Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed" as well as findings from Milliman which showed that 50% of MA plans have EDPS scores more than 5% below RAPS risk scores.

While we appreciate CMS efforts to resolve these challenges and increase transparency, many issues that are out of a plan’s control remain unsolved. By increasing its reliance on encounter data without resolving acknowledged issues, CMS is enabling expanded use of inaccurate data, and adversely impacting adequate plan payments required to provide robust beneficiary access to care. The negative consequences of these operational issues are likely to fall disproportionately on smaller plans and plans serving a high proportion of people with multiple, complex condition, such as SNPs.

Therefore, we continue to request that CMS delay increasing the reliance on encounter data beyond the current 25% until it can be documented that the completeness and accuracy of the data has improved and it can be certified as such. We also urge CMS to involve the industry in developing milestones for implementation and testing prior to bid submission as well as robust and relevant data monitoring standards as the system transitions to a system based on accurate and complete encounter data.

Finally, the SNP Alliance asks CMS to clarify whether encounter data would also be calculated using the Alternative PCC if approved.

***Attachment VI. Draft CY 2020 Call Letter.....98***

**Section I – Parts C and D.....101**

**Enhancements to the 2020 Star Ratings and Future Measurement Concepts.....107**

*CMS regularly reviews the measures and methodology (used to generate the ratings) to incentivize plans and provide information that is a true reflection of plan performance and enrollee experience. CMS states that it remains cognizant of the unique challenges of serving traditionally underserved subsets of the population such as dually eligible beneficiaries and disabled. CMS is working in collaboration with beneficiaries, stakeholders, measure developers, researchers and other HHS collaborators to improve the Star Ratings. A Technical Expert Panel (TEP) continues to provide feedback on the Star Ratings framework, topic areas, methodology, and operational measures. CMS is proposing enhancements to the 2020 Star Ratings, as well as soliciting feedback on possible future measure updates and concepts. CMS states that it strongly believes that although there are ways to enhance the current methodology, it is an accurate representation of industry performance.*

**SNP Alliance Comments:**

We applaud CMS for its ongoing efforts to stay abreast of research, listen to concerns, and work in collaboration with a variety of stakeholders. We appreciate the important work of the TEP and the opportunity to provide feedback to the RAND research team and CMS.

**Measure Updates*****Medication Adherence for Hypertension (D11)*.....109****SNP Alliance Comments:**

We support the removal of beneficiaries who elected to receive hospice care from this measure.

We have additional comments on the measure arising from the input of clinicians from plans serving complex populations. The clinicians note that this D11 measure does not recognize all types of hypertension medications, which therefore reduces the denominator artificially. In addition, they state the D11 measure would be improved by excluding discontinuation of a hypertension medication when it is determined that the medication is causing adverse effects that compromise the individual's health and quality of life. These events may be more common in populations with multiple chronic conditions and where frailty, advanced age, multiple medications, or other complexity characteristics complicate the medical management. We believe that special needs plans and MMPs may more frequently encounter members with these considerations.

***Controlling High Blood Pressure - CMS proposes a temporary removal from the 2020 Star Ratings of the Controlling High Blood Pressure (Part C) measure. ....111***

**SNP Alliance Comments:**

The SNP Alliance supports this action.

**2020 Star Ratings Program and the Categorical Adjustment Index .....111**

*CMS states that there is additional work on identifying impact of SDOH on health outcomes—the agency mentions the three-year NQF initiative to consider social risk adjustment in quality measurement, and ASPE reports published and forthcoming on impact of social risk factors on health outcomes. CMS states they contract with NCQA and PQA to review their measures for sensitivity to the composition of enrollees in a plan and whether measure specification modification is appropriate. CMS notes the four HEDIS measures that are included in Star Ratings where NCQA is now stratifying plans into groups according to beneficiary low-income/dually-eligible/and disabled status for reporting. CMS is considering how to implement the PQA and NCQA measure changes in the Star Ratings for 2021 and beyond and how to best incorporate stratified reporting in future years of the Star Ratings.*

**SNP Alliance Comments:**

***Attention to SDOH/SES*** - The SNP Alliance appreciates progress CMS has made to respond to evidence on effects of social determinants of health risk factors. The SNP Alliance supports the action by NCQA to recognize measures that are sensitive to effects of social determinant of health risk factors/socioeconomic status, beginning with Breast Cancer Screening, Colorectal Cancer Screening, Comprehensive Diabetes Care-Eye Exam, and Plan All-Cause Readmissions. We agree that this has potential value to facilitate fairer plan comparisons, provide a more complete picture, and increase the utility of measurement to guide quality improvement efforts. We suggest there are additional Star measures that should be examined further.

***Stratification*** - We are encouraged by the signal that CMS will conduct additional modeling to consider other Star measures which are impacted by DE/LIS and disability status, and its efforts to encourage

additional work by measure developers to recognize this and to define/address additional beneficiary complexity characteristics, such as advanced illness and frailty.

We support CMS' intent to test ways to incorporate stratified measure reporting in Star ratings. Special needs health plans are a natural group to provide insight and serve as field testing sites, given the characteristics of their enrollment. We hope that an interim step could be taken in CY2020 to test one or more approaches using data from a small sample of Medicare Advantage Organizations. This analysis would provide a foundation for considering how to incorporate stratification in Star measure calculation and reporting and provide insight for determining further changes needed in CY2021 or beyond.

We continue to be concerned that having one set of cut points for all Star measures masks important differences across plans that have vastly different beneficiary enrollment profiles, number of PBPs, and regional characteristics impacting health outcomes independent of plan action. We think this is an important area for additional testing—for example to calculate cut points by stratified plan groups (e.g. based on quintiles) for measures where there is evidence of effect on a measure arising from social determinant of health and DE/LIS/disability or other important risk factors. Additional stratified measurement, rating, and reporting has the potential to provide health plans and consumers with vital information so that they can more accurately benchmark performance and compare to plans with similar beneficiary enrollment characteristics and regional area coverage. We urge testing the feasibility and utility of stratified group cut points for at least a few measures that are sensitive to these factors in CY2020, or as soon as possible.

**Minimum Guidelines.** We also appreciate CMS' response to the work by ASPE and by NQF on the need for recognizing the effects of social risk issues and care complexity on health outcomes and considering how existing Star measures and quality performance evaluation needs to be modified. An important gap in guidance could be filled by CMS issuing minimum standards to measure developers and stewards for considering social determinant of health risk factors and other beneficiary characteristics that impact health outcomes independent of plan or provider action. Up to now, it has been up to each measure developer to examine effect of social risk factors, care complexity and other related factors and determine, on their own, that their measure is sufficiently valid and reliable for all populations to which it will be applied. We note that an expert panel on disparities from the National Quality Forum examined the current state of the art in measure testing and found that there was wide variation in the methods and rigor in how measure developers determined effects. If testing is not sufficiently rigorous, this could lead to faulty conclusions regarding the measure and its adequacy. Unadjusted measures or measures where necessary modifications have not been applied could yield inaccurate results about providers and plans who serve a disproportionate number of individuals with these characteristics. 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.

Creating one consistent set of standards with minimum parameters for sample size, variables, data definitions, data sources, and methods for testing the measures, would provide critical guidance. This would ensure the public and those in the field that the developers/stewards have performed their evaluation with due diligence and used a sound approach. We suggest that such standards for developers begin with guidance on oversampling vulnerable subpopulation groups—to ensure that the data adequately encompasses the diversity of the Medicare population. These individuals are often underrepresented in databases/samples.

Additional elements for minimum guidance would include: (1) minimum standards for methods (to demonstrate scientific rigor of the model/approach), (2) use of the smallest possible geographic unit of analysis to avoid large geo-units where important differences might be masked, (3) a minimum number of key variables in the model, (4) accommodation in methods where data is collected directly from the

beneficiary to attend to linguistic, health literacy, and other differences in beneficiary characteristics that are known to impact participation and understanding, and (5) transparency in reporting results by population subgroup, unit of analysis, or other category that provides sufficient detail to understand variations observed.

**Categorical Adjustment Index.....113**

*CMS is proposing to expand the adjusted measure set for the determination of the 2020 CAI values.*

**SNP Alliance Comments:**

The SNP Alliance greatly appreciates the work by CMS which has led to the decision to include more measures in the interim approach known as the Categorical Adjustment Index (CAI). Measurement specifications must also continue to be examined and adjusted to ensure appropriateness, validity, reliability, feasibility, and utility in application at the beneficiary level. We are hopeful the additional measures included and the proposed CAI values (based on proportion of a contract’s enrollment with LIS/DE and Disabled persons) will help rebalance the quality measurement system so that health plans with a high proportion of vulnerable beneficiaries are not harmed unintentionally. The combination of modifying measurement specifications (to take into account important beneficiary characteristics at the individual level), as well as application of CAI (to recognize differences in enrollment populations at the plan/contract level) is promising.

Even though CAI is an interim approach, which may be replaced following review of the ASPE report expected in October 2019, we hope CMS will continue to evaluate the effects of CAI and report these data and results with full transparency so that plans, researchers, and other stakeholders can understand more about the approach and its impact. We appreciate the continued work on the CAI method as understanding evolves. This work has the potential to further refine measurement and reporting to better reach intended goals and offer relevant, actionable information for both plan and consumer. We see continued need for tools and approaches to recognize the diversity of the Medicare population

**2020 Star Ratings Measures .....126**

**SNP Alliance Comments:**

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, documentation, constraints on appropriate clinical practice, and other special considerations for high need, complex populations with a high prevalence of social risk factors.

**Transitions of Care .....127**

*CMS is working with NCQA to expand efforts to better evaluate a plan’s success at effectively transitioning care from a clinical setting to home. The intent of the measure is to improve the quality of care transitions from an inpatient setting to home, as effective transitioning will help reduce hospital readmissions, costs, and adverse events.*

**SNP Alliance Comments:**

We agree transitions of care is an important focus. However, we have significant concerns around documentation, timeframes, and aspects of expected health data information exchange within this measure--over which the health plans do not have control. These issues will impact measure results. They will especially impact plans serving individuals with high numbers of chronic conditions including medical and behavioral health conditions—as these individuals are very likely to have more transitions given the complexity and multiplicity of their conditions and risk factors.

We strongly urge CMS to request additional testing of the Transitions of Care measure and obtain further input from the field around data collection, transmittal, and notification prior to the measure being put into use. The timelines and expectations are aspirational and favor certain types of organizations. The measure as defined will particularly impact non-integrated providers and health plans and favor large health delivery systems where the plan and hospital, home care, physicians and other providers are employed by the same parent organization sharing the same electronic health information database/system.

Unpacking the issues in more detail, we are encouraged of the progress being made in information exchange. In many areas of the country health plans recognize and work with hospitals and providers these settings of care/practitioners improve transmittal of information and set up triggers for expedient follow-up. Such structural components and processes are crucial foundational steps to support better transitions of care.

However, the state of practice is such that hospitals still do not immediately communicate discharge information to the beneficiary's health plan, nor to the beneficiary's primary care physician. If the health plan is not even aware that the individual is hospitalized or discharged, it is impossible to impact the further distribution and exchange of health information nor monitor for expedient follow-up.

The exchange of information may be slower in regions where there are not highly integrated providers or where health information exchanges are not complete—do not have all relevant providers participating. Particularly when the patient/beneficiary utilizes various providers for multiple chronic care and behavioral health issues—often moving across organizations with different health information systems—data is not immediately transferred from one organization to another. Furthermore, 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 from 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.

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. This must be taken into account when setting forth a measure. 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—particularly concerning mental health inpatient visits. 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.

As discussed, information exchange and notification timeframes vary for reasons outside of a plan's control. Furthermore, documentation is unlikely to be in a **single medical record**. We urge attention to these issues prior to bringing the measure forward, and particularly before applying it to health plans where they do not have control over the transmission of information within these short timeframes.

We are especially concerned that this measure will inherently favor more resource-rich environments, and managed care organizations where their enrollment does not include many beneficiaries with complex care needs that cross disciplines, settings, and types of care. The measure may have an inherent bias against plans with beneficiaries who have complex care needs—including special needs plans. We urge CMS to consider these issues and recommend that the measure be further developed or modified prior to being deployed.

One idea that has been offered to us is that the measure be re-focused on two of the four components—the component focused on **patient engagement after inpatient discharge**, and the component focused on **medication reconciliation post-discharge** (removing the notification and receipt components). This re-focus together with adjusted timeframes for flow of information and expansion of the definition on where the information is housed would bring attention to core aspects of quality improvement while incorporating flexibility in the guideline or expectations for how and where information is processed. This adjusts the measure attention to focus on patient engagement and ongoing care management across providers, rather than on processes which are problematic, administratively burdensome, or currently unattainable.

Finally, we do not agree that the definition should only focus on the primary care practitioner or ongoing care provider who is managing the patient’s care—with people who have multiple chronic conditions crossing medical, behavioral health, rehabilitative, and skilled nursing care, and other domains—there are often multiple providers involved. Who is to decide who is the principle provider? It may depend on the reason for the hospitalization. For example, a person who has congestive heart failure, diabetes, and mental illness and was hospitalized for a psychotic episode, the principle provider for handling the transition may be the psychiatrist and behavioral health counselor. For a person who has these same three primary conditions--congestive heart failure, diabetes and mental illness--who was hospitalized for a myocardial infarction, the principle provider may be the cardiologist. For the person who has these same diseases and suffered a fall, the principle provider may be the nurse practitioner and the rehabilitation clinicians. If the fall is associated with multiple medications, the principle provider may be the pharmacist. In some cases, the clinical care manager working within an Interdisciplinary Care Team will be the “primary ongoing care provider.” These examples demonstrate that a broader definition of what constitutes follow-up and who provides it is needed.

#### **Follow-up After ED Visit for Patients with Multiple Chronic Conditions.....128**

*CMS is proposing a new HEDIS measure to focus on patients with multiple chronic conditions who have an emergency department visit. CMS provides a list of eligible chronic condition diagnoses. Members must have two or more conditions. The measure focuses on follow-up service within 7 days of the ED visit.*

#### **SNP Alliance Comments:**

The SNP Alliance agrees with the broader definition of follow-up. We request CMS confirm that this follow-up would include flexibility in type/location as well as who conducts the follow-up. In other words, follow-up includes telehealth, telephone, web/online, face-to-face, office visits, etc. and the accepted individual(s) who conducts the follow-up can include a broad range of personnel/providers—not only the person’s primary care provider. Some clarification is needed, as the intent is to provide necessary follow-up in a timely manner and there are many individuals who can effectively do that.

In addition, we recommend the issue of documentation and how this follow-up will be recorded, audited and confirmed, be flexible. The definition needs to fully incorporate the multiple possible service settings and personnel who will be doing this follow-up and allow for this wide flexibility.

Additional flexibility may also be needed to recognize barriers to follow-up. If an individual is not home or available within the 7 days (e.g., unable to be reached after multiple attempts, refuses follow-up, moves, goes on vacation or leaves the area, is admitted to an inpatient setting, rehabilitation, post-acute care, etc.), the timeframe should be extended and/or the documentation of this should allow for the exclusion of this individual from the measure. We recommend some flexibility beyond seven days for the accepted timeframe in certain circumstances. Where providers are not part of a fully integrated health delivery network and not part of a single electronic health information system, tracking down the individual may require extended and substantial effort.

Our biggest concern, as with some of the other measures proposed, is that the administrative burden on health plans with a high proportion of members having two or more chronic conditions will predictably be higher than general Medicare Advantage plans with general enrollment. The administrative burden involved in tracing events and follow-up across multiple providers may be quite high and we ask for attention to this issue. Since special needs plans are enrolling and serving almost exclusively people with multiple chronic conditions, we anticipate that this measure will impact SNPs more than plans with a non-dually eligible, general Medicare population. This is on top of requiring work to calculate and produce data on four extra SNP-specific measures they already must report—where general Medicare Advantage plans are exempt. This increasing measurement and reporting burden should be recognized in some way. Otherwise it has the potential to divert resources from managing and supporting care needed by the vulnerable beneficiary populations to documentation and reporting. This could jeopardize the ability of special needs plans to continue serving these individuals.

**Health Outcomes Survey .....132**  
*CMS proposes to exclude beneficiaries enrolled in I-SNPs at the plan benefit package (PBP) level from HOS baseline.*

#### **SNP Alliance Comments:**

Over the last two+ years, the SNP Alliance has been surveying health plans, analyzing peer-reviewed literature, and gathering information from researchers and experts to better understand the strengths and limitations around the use of the Medicare Health Outcome Survey (HOS) in the Medicare Stars rating and quality measurement system for Medicare Advantage plans. There is compelling evidence indicating need for improvement. The challenges are particularly pronounced for special needs plans as they serve diverse, low-income, disabled, and chronic care, complex, or advanced illness populations. These populations and plans are more likely to be negatively impacted by the limitations in HOS instrument, methods, and scoring.

We have developed and disseminated a White Paper, entitled *Special Needs Plans under Medicare Advantage Quality Measurement: A Focused Look at the Medicare Health Outcomes Survey (HOS)* <http://www.snalliance.org/media/1277/snpa-paone-hos-white-paper-final-dec-2018.pdf> The White Paper describes the observed limitations with HOS and offers recommendations for improvement. The following observed limitations are discussed in this report:

- Diversity of Medicare Population not fully Considered
- Instrument Limitations as Applied to People with Special Needs
- Inadequate Methods and Administration
- Information Decay, Time Lag
- Proxy Bias
- Results May be Affected by Underlying Characteristics of Enrollment
- Attribution, Context Issues
- Inadequate Models and Adjustments
- Cautions Regarding Analysis, Interpretation, and Reporting

The following options for improvement are discussed:

1. Level the measurement field
2. Use additional exceptions and exclusions
3. Discontinue the longitudinal design
4. Use better predictive models and data sources
5. Use alternative instrument(s)
6. Re-test HOS with disabled and diverse groups
7. Improve methods of administration and accommodation
8. Conduct analysis at a finer level and report on results
9. Provide greater transparency and consumer education
10. Convene ongoing stakeholder and expert panels

Given the evidence from the field and our analysis, we strongly support removal of HOS measures for I-SNPs and would recommend this be extended to all special needs plan types, at least as an interim step while the noted limitations are addressed.

The same rationale for excluding I-SNP populations can be extended to FIDE SNP and other special needs enrolled populations. Moreover, the issues and challenges found around the: two-year longitudinal design, sampling and surveying methods, lack of accommodation of linguistically diverse Medicare beneficiaries and those with significant social determinant of health risk factors, and predictive modeling—are also present with other SNP and MMP populations. We urge attention to these issues. We are concerned that the limitations found in HOS-derived measures, particularly the Maintaining Physical Health Component Score (PCS) and Maintaining Mental Health Component Score (MCS), have substantial negative implications pertaining to validity, reliability, accuracy, and utility principles and disproportionately affect special needs plans. These measures should be re-examined for use in the Star Ratings.

#### **Potential Changes to Existing Star Ratings and Display Measures .....132-134**

*CMS proposes five Part C measures for potential changes:*

*Plan All-Cause Readmissions (Part C)*

*Medication Reconciliation (Part C)*

*Osteoporosis Measure (Part C)*

*Care for Older Adults – Functional Status Assessment Indicator (Part C)*

*Hospitalization for Potentially Preventable Complications (Part C)*

#### **SNP Alliance Comments:**

The SNP Alliance supports the re-examination of these measures.

**Osteoporosis Measure (Part C)** – The SNP Alliance is concerned that the measure relies on self-report—especially if this self-report is derived from the Health Outcomes Survey. There are many methodological problems with HOS which we have already described. This would introduce subjectivity and call into question the validity of the data and measure result. We believe that there are more objective ways to gather information about this issue, and strongly urge additional measure development.

**Care for Older Adults-Functional State Assessment** - We appreciate the importance of comprehensive functional assessment and believe that special needs plans have incorporated such assessment into their care processes in a number of ways. However, the proposed measure changes as specified are not simple/non-substantive changes. Several plans have reported these changes could require substantial new work, and therefore request that the measure be subject to formal rulemaking. This is particularly important for health plans that generate the data needed from extensive chart review—a laborious and

time-consuming process. We agree this would be considered a substantive change which could lead to significant changes in adherence rates and measure results. We request that these concerns be further attended through additional field work to trace the processes for obtaining data needed for this measure. We also request formal rulemaking be pursued allowing for public comment since there is evidence this measure change is a substantive change for some health plans.

### **Potential New Measure Concepts .....138**

*CMS offers eight new measure concepts for consideration:*

*Cross-Cutting Topic – Measure Digitalization (Part C)*

*Cross-Cutting Topic – Exclusions for Advanced Illness (Part C)*

*Physician/Plan Interactions (Part C & D)*

*Interoperability Measures (Part C & D)*

*Patient Reported Outcome Measures (Part C)*

*Pain Management (Part C)*

*Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Part C)*

*Antibiotic Utilization Measures (Part C)*

*Diabetes Overtreatment (Part C)*

### **SNP Alliance Comments:**

The SNP Alliance has the following comments on these measure concepts.

**Cross-Cutting Topic – Measure Digitalization (Part C)** – We support the progress toward digitization of measures as long as the measure developer and CMS work closely with providers and plans to recognize and support infrastructure and capacity development and titrate the expectations and timelines so that the implementation is as seamless as possible.

**Cross-Cutting Topic – Exclusions for Advanced Illness (Part C)** – We welcome and appreciate the work by NCQA and stakeholders as well as CMS to recognize the need for exclusions for people with advanced illness. We are very encouraged that NCQA is recognizing not only persons with advanced illness, but also those who have substantial frailty characteristics.

However, the definitions and criteria for frailty and advanced illness and the methodology for identifying qualifying individuals needs additional work. Conditions such as advanced cancer, late stage ALS, MS, Stage 4 congestive heart failure, Stage 5 chronic kidney disease, advanced COPD requiring oxygen, late-stage or advanced Alzheimer’s Disease and Related Dementia Disorders, and other neuromuscular or brain conditions which are at later stages in the disease process, are all candidates and should be considered. Factors to consider as the criteria for qualifying a member is considered include: (1) the disease /condition characteristics and pathway of progression, the stage of disease, presence of co-morbidities which impact treatment options substantially, and beneficiary preferences around their own end-of-life. These elements should be considered singly and in combination with one another. Special needs plans, some with a substantial proportion of members who have advanced illness or frailty characteristics, are a natural group who could offer rich insight to further develop and define the specifications.

**Physician/Plan Interactions (Part C & D)** – The SNP Alliance supports CMS’ decision not to introduce a new survey of physicians around interaction with health plans. The administrative burden, confusion, and potential bias are all sound reasons not to proceed. Plans have suggested that a process measure may help address a key area of focus/interest regarding interactions with the health plans by the provider. For example, claims processing timeline when there are clean and complete claims submitted by a provider could be a process measure that begins to develop a better understanding of one aspect (timeliness) across Medicare Advantage plans that is important to providers.

**Interoperability Measures (Part C & D)** – The SNP Alliance appreciates the extensive and ongoing work nationally by States, providers, plans, consumers, system experts, and other stakeholders to develop Health Information Exchanges (HIE) and work toward a data repository which can accept information and produce real-time reports from many disparate electronic medical record (EMR) systems in a given geographic area. Plans are eager to participate in this work and contribute to these discussions. Special needs plans encourage interoperability across all types of providers to share health information in a timely and accurate way as an aspirational goal.

However, the current state of infrastructure and development of these HIEs and EMRs is widely varied and very dependent on the resources available in that state, as well as the capacity of the health care community in each region. There are several states where there are multiple HIEs not connected or only partially connected with each other. Several provider types, such as community-based providers of Long-Term Services and Supports (LTSS), small rural providers, and other entities are often not included for a variety of reasons—lack of capacity or infrastructure within the entity is a common one. Systems are not standardized, and legacy health information systems often require significant reprogramming, financial resources, and testing to bring them to the level where interoperability and health information exchange is possible. Smaller providers and those in low-income, resource-scarce geographic areas, are particularly challenged.

Setting interoperability guidelines, while building capacity nationwide and providing technical support (including financial resources) to accomplish a national infrastructure is the step most needed. States will need to be heavily involved. This is where resources should be directed, not measuring the widely different levels of HIE and EMR data integration and utility. Health plans cannot drive or create these systems independent of the states and providers or other stakeholders.

**Patient Reported Outcome Measures (Part C)** – The SNP Alliance supports development of Patient-Reported Outcome Measures done in a rigorous way to ensure the measures are relevant, valid, reliable, feasibility and have utility and are appropriately measuring an element of care or experience which can be impacted by health plan action. As discussed in the White Paper referenced above, we have found substantial limitations in the use of the HOS instrument and the PCS and MCS measures and find it fails in some of these important areas, particularly for diverse, low-income, chronically ill, and dually-eligible or disabled individuals.

Alternate physical and mental health status self-report items, currently in use and validated, could be used as substitute questions to the HOS 12 items used in the PCS and MCS. We urge CMS to work with consumers, health plans, providers of all types, and other stakeholder to consider what should be measured, how to do it accurately and fairly, and to whom the observed outcome or result can be attributed.

Any alternative chosen to HOS would have to be piloted within a representative group of MAOs and their beneficiary populations to fully understand the feasibility, utility, and accuracy of the alternate instrument and methods tested, the means for population difference case mix adjustments that the alternative instrument/method would support, and how superior the alternative would be to HOS.

We know substantial work in the field would need to be done. On the face of it, such effort could have significant value for individuals, practitioners, and plans. Integrating a standard self-report into practice nationwide (that is, setting expectations that clinical, behavioral health and long-term care services providers utilize such a standard self-report) could have real value to incorporate the person's voice. By assessing the individual's perception of his/her health in a consistent way over time and across settings,

the care management practices may evolve as well. We recognize this is aspirational, but it seems to be an important step toward being able to measure self-report of health status and connect it to provider or plan actions.

As an interim step, we strongly suggest HOS PCS and MCS measures be discontinued for special needs plans, as it appears they will be for I-SNPs. These composite measures of self-report, particularly collected longitudinally, does not provide useful information for pursuing quality improvement. There are too many variables, no contextual information, and the information is not timely, thus it is not actionable.

Going forward, we suggest that specific targeted areas for PROMs be developed and tested, such as Assistance With and Results Experienced in Managing Pain, or Assistance With and Results Experienced in Performing Activities of Daily Living. Single focused items that are relevant will be much more useful. SNP Alliance health plan members have indicated they would welcome the opportunity to explore the possibilities for more relevant and targeted self-report health outcomes. We would like to work in partnership with others under CMS' direction to explore alternatives to HOS in targeted focus areas where there are interventions or actions by providers and plans which can impact results demonstrably. Suggestions include:

- Pain
- Fatigue
- Depression
- Mobility/Balance

When utilizing patient self-report with any measurement instrument and methods chosen, the issues of *context, attribution, accuracy, validity, feasibility, adjustment, and comparison or predictive modeling* (i.e., scientific soundness in comparing responses across time periods for all individuals, need to exclude certain individuals based on specified criteria, or how observed and predicted results should be compared) would still need to be addressed.

**Pain Management** – For special needs populations, pain management is often an important element of care. We would like to be involved in helping to identify targeted areas for assessing performance and working with beneficiaries around pain management.

#### **Removal of Measures from the 2022 Star Ratings .....141**

*CMS proposes the removal of two measures from 2022 Star Ratings:*

*Adult BMI Assessment (Part C)*

*Appeals Auto-Forward; Appeals Upheld (part D)*

#### **SNP Alliance Comments:**

The SNP Alliance appreciates and agrees with removal of the Adult BMI measure.

#### **Measurement and Methodological Enhancements Under Consideration.....143**

*CMS is exploring the feasibility of testing web options for existing beneficiary surveys and wants feedback. CMS wants feedback on completeness and accuracy of plan data on member email addresses, and regular updates.*

#### **SNP Alliance Comments:**

The SNP Alliance appreciates CMS' continued commitment to search for ways to reach out to all beneficiaries to offer them multiple ways to provide feedback. The utility and viability of web-based surveys or surveys via smart phones or other technology will be less robust or possible for persons who

are low-income, do not speak English or Spanish, and have low education or health literacy levels. We have read studies that report the completion rate and response rate of web-based surveys, particularly among low-income, diverse, and elderly individuals is quite low. Access to and understanding of the technology is also tenuous among some beneficiary groups—given social determinant of health risk factors. We suggest for these populations greater attention to one-on-one, face-to-face, or assisted telephone or even virtual visits with a person (interviewer) who is of the same culture, language, and ethnic background as the individual would be efforts well spent. Perhaps independent agencies not currently serving the individual and under contract with CMS, such as social service agencies within the beneficiary community could be deployed as survey supports. The interviewer who is of the same culture, language, ethnicity, and even age may help guide the individual through a paper or graphic image-formatted survey form. We recommend some work on more targeted and “hands on” tailored approaches for these Medicare special population groups. There is already deep concern they are largely left out or not appropriately accommodated in current surveys.

## **Innovations in Health Plan Design .....146**

### **Value-Based Insurance Design (VBID) Model Test**

*The CMS Innovation Center is responsible for developing and testing new payment and service delivery models intended to lower costs while preserving or enhancing quality of care for Medicare, Medicaid, and CHIP beneficiaries. In the 2016 Call Letter, CMS indicated its intention to partner with private payers to test innovations in health plan design for CMS beneficiaries.*

*Section 50321 of the Bipartisan Budget Act of 2018, “Adapting Benefits to Meet the Needs of the Chronically Ill Medicare Advantage Enrollees,” amends section 1859 of the Social Security Act to require the Secretary to “revise the testing of the [VBID] model ... to cover, effective not later than January 1, 2020, all States.” For CY 2020, MA plans that meet model eligibility criteria may apply for participation in the VBID model for one or more VBID component(s).*

<https://innovation.cms.gov/initiatives/vbid>

*CMS is taking applications for projects in 2020 in four categories: Value-Based Insurance Design by Condition, Socioeconomic Status, or both; Medicare Advantage and Part D Rewards and Incentives Programs; Telehealth Networks; and Wellness and Health Care Planning. Beginning in CY 2021, the VBID model will also test including the Medicare hospice benefit in Medicare Advantage. CMS will release additional information and guidance on this intervention for interested stakeholders in the coming months.*

### **SNP Alliance Comments:**

The SNP Alliance was pleased to see the interest stated by CMS to explore the integrated of Hospice into Medicare Advantage and for Special Needs Plans to be considered for VBID participation.

Because our members, all of whom are special needs plans and Medicare-Medicaid demonstration plans, are already committed to serving complex care needs populations we believe our members are a natural laboratory to explore such a Hospice pilot and help inform CMS of critical issues related to benefit design, payment models, UM and quality measures, concurrent care, adequate sample size and appropriate risk adjustment. However, we believe many of these critical design issues must be addressed prior to the launch of a successful pilot, and that the defined time frame for 2021 implementation is far too short to resolve these. The SNP Alliance would recommend CMMI to form an advisory group to

better articulate the scope and design of an integrated Hospice-MA pilot and would be very willing to be part of such work.

**Section II – Part C.....147**

**Total Beneficiary Cost.....149**

*CMS will exercise its authority to deny MA organizations bids if the Agency determines the bid proposes too significant of an increase in cost sharing or a decrease in benefits from one plan year to the next through the TBC standard. CMS proposes using the same methodology as last year for the 2020 OOPC model.*

**SNP Alliance Comments:**

There is growing recognition among policymakers, that the conditions in which people live, work, and age impact their health. Therefore, improving health care outcomes and lowering costs requires the coordination of resources to attend to social determinants of health. CMS has granted health plans additional flexibility to offer supplemental benefits that can enhance quality of life and improve health outcomes. By redefining health-related supplemental benefits, CMS has allowed plans to more holistically address the social, economic, and environmental factors that impact the availability of resources to address the health care needs of Medicare consumers, which can lead to improved outcomes, reduced out-of-pocket costs, and decreased system-wide costs.

As CMS makes significant changes in supplemental benefits, it is even more important than ever that beneficiaries have the information they need to identify a plan that will provide the highest-quality care and most desired benefits based on their unique needs, at the lowest cost. Unfortunately, the OOPC calculated for MA plans with robust supplemental benefit offerings—designed to improve health and address social determinants of health—places these plans artificially low on the list on the Medicare Plan Finder (MPF), at a disadvantage among the many options from which beneficiaries from can choose. The current TBC test only compares a plan to itself year-over-year, and fails to capture many supplemental benefit offerings. The expansion of allowable supplemental benefits will result in unintended operational consequences that should be addressed, particularly as additional guidance that could improve social barriers to care is expected to re-define supplemental benefits in 2020 and beyond.

Under the current approach, Medicare plans are sorted by lowest estimated annual health and drug costs based on OOPC data calculations that only account for some dental, vision, and hearing supplemental benefits, and fail to account for newly allowable supplemental benefits. Therefore, plans that invest in supplemental benefits designed to address SDOH have been ranked lower in the MFP OOPC calculation, putting them at a placement disadvantage and making it less likely beneficiaries will obtain flexible, high-value supplemental benefit offerings that address social risk factors and provide the most robust benefits to improve their health outcomes and lower out-of-pocket costs. Weighting comprehensive dental supplemental benefits, while failing to capture the value of transportation to incentivize preventive care, assistive devices such as grab bars to prevent falls, and in-home health to help avoid hospital readmissions is a methodological limitation of the OOPC estimates.

The SNP Alliance requests that CMS improve the resources available for beneficiaries to more fully and accurately compare plans by incorporating the value of the new allowed benefits in its OOPC model including data calculations that accurately account for these additional supplemental benefits and redesigning MPF comparisons to ensure beneficiaries can consider the full spectrum of plans available to them. At a minimum, as CMS makes improvements in Medicare Coverage and decision support tools, CMS should accurately display newly allowable supplemental benefits on the MPF.

### **Special Supplemental Benefits for the Chronically Ill (SSBCI).....161**

*Beginning CY 2020, the BBA, section 1852(a)(3)(D), does not require supplemental benefits to be primarily health related when they are provided to chronically ill enrollees if certain conditions are met. MA plans will have the ability to offer a “non-primarily health related” item or service to chronically ill enrollees if the SSBCI has a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease.*

*CMS solicits comment on whether plans should have flexibility to determine what is a chronic condition that meets the statutory standard (“is life threatening or significantly limits the overall health or function of the enrollee”) and if CMS should consider alternative approaches to determining what meets this criterion. By CY 2021, CMS will convene a technical advisory panel to periodically update the list of chronic conditions for MA plans to use when determining if an enrollee is chronically ill for purposes of section 1852(a)(3)(D)(iii).*

#### **SNP Alliance Comments:**

The SNP Alliance commends CMS for continuing to implement supplemental benefit flexibilities to improve the health and quality of life of MA beneficiaries, and thanks CMS for the new flexibility for supplemental benefits tailored to the chronically ill and the related provision allowing plans to waive the uniformity requirements with respect to SSBCI. We appreciate the new flexibility granted by Congress in expanding the scope of supplemental benefits to include non-health related benefits and in determining qualifications for chronic conditions for this purpose.

While we support flexibility to allow plan sponsors to develop definitions for chronically ill enrollee to address evolving medical conditions and to develop interventions that may slow or prevent disease progression, we believe CMS will find that it needs to provide additional guidance and parameters for these determinations to assure some consistency and fairness across the marketplace in meeting the new statutory requirements. We also urge CMS to provide clear guidance around which services can be provided through SSBCIs and how plans can best communicate SSBCI information with providers and beneficiaries. The SNP Alliance welcomes the use of a technical advisory panel to ensure a broad array of plan expertise and experience are considered when updating the list of chronic conditions for MA plans to use when determining if an enrollee is chronically ill and we request to be included in this panel.

We appreciate the opportunity to comment on whether CMS should consider alternative approaches to determining what is a chronic condition that meets the statutory standard (“is life threatening or significantly limits the overall health or function of the enrollee”.) Thus far, we have been concerned that CMS’ approach to determining which chronic conditions should be considered emphasizes only the clinical diagnoses without enough attention to functional limitations. The SNP Alliance supports and recommends a more holistic determination process that takes into account a “whole person care/patient centered care” model including both medical and social determinants of health and functional status information, where available. Identification of this population could include multiple data points for areas such as health risk assessment, case management, care transitions, and enrollee’s self-assessment of health.

In addition, CMS should take into consideration the multiple codes used by providers to report social determinants and the same conditions in various programs. For example, physicians may participate in several quality initiatives and must use different coding to report similar conditions. Physicians and their staffs may have difficulty remembering which code applies to which program, leading to coding errors.

We suggest that CMS ensure that different quality programs harmonize the same codes, whenever possible.

We have some concerns about how these new flexibilities will be implemented in relation to transparency and to a fair playing field with regard to potential differences in processes and related requirements for C-SNPs and general MA plans targeting the same population segment. For example, it appears that general MA plans “do not have to submit the processes by which they identify chronically ill individuals that meet this definition.” Yet, C-SNPs must follow very specific processes for verifying eligibility for the chronically ill members they enroll. This indicates the potential for general MA plans to have more flexibility than C-SNPs for targeting and serving targeted population segments, which could in turn create a competitive market advantage for general MA plans. If CMS is going to provide this flexibility for general MA plans, it should also be provided to C-SNPs. This should apply to other provisions as well, any flexibility provided to general MA plans should also apply to SNPs.

A similar set of concerns exists in the application of the waiver of the uniformity requirements. As MA plans are now allowed “to offer chronically ill enrollees supplemental benefits that are not uniform, either for all enrollees or for all chronically ill enrollees it will pose competitive challenges for SNP. SNPs are required to implement extensive Models of Care (MOC) including reporting requirements to CMS in order to be able to serve chronically ill enrollees, while general MA plans do not have to comply with these additional provisions. This gives rise to new concerns about confusion in the marketplace about what consumers can obtain and expect from general MA plans versus SNPs. CMS should look carefully at the need for transparency and consumer education about the differences in plan requirements, including possible changes in marketing procedures. CMS should assure that SNPs, who are specifically designed and permitted by Congress to specialize in serving chronically ill beneficiaries are not placed at additional disadvantage because of these changes.

While the SNP Alliance supports greater flexibility for general MA plans in developing specialized benefits and services for various subgroups, plans that seek to go beyond the norm in serving a comparable group should not be placed at a disadvantage. In fact, CMS should consider helping beneficiaries access programs with superior care arrangements as well as provide additional flexibility, incentives and supports for plans that seek to go beyond the norm of general MA plan arrangements.

Members also have questions about how these new supplemental benefits will be communicated to enrollees. We understand that they must be included in the EOC but they also need to be appropriately, clearly and fairly represented in Medicare Coverage Tools such as the Medicare Plan Finder. (See previous comments on TBC calculations.)

The SNP Alliance also notes the new benefit flexibility for the chronically ill overlaps benefit flexibility previously allowed only to FIDE and HIDE-SNPs as outlined in the MCCM Chapter 16b, Section 20.2.6. We renew our request for clarification of how the new flexibilities intersect with that previous flexibility. We also request that FIDE and HIDE SNPs continue to be provided additional flexibility around services related to Social Determinants of Health, including those targeted to low income and dually eligible members. We look forward to additional clarification of these issues as Chapter 16b is updated.

**Physical Exam Supplemental Benefit for Special Needs Plans (SNPs) .....164**

*Beginning CY 2020, SNPs may offer the Physical Exam supplemental benefit that is currently available to Non-SNP MA plans. As discussed in section 30.1 of the Medicare Managed Care Manual, a supplemental physical exam benefit would provide services beyond those services required to be provided in the Annual Wellness Visit and beyond what is required as part of the SNP’s regular care coordination and disease*

*management responsibilities components of their Model of Care. To qualify, these exams would be provided by a qualified physician or qualified non-physician practitioner.*

**SNP Alliance Comments:**

The SNP Alliance supports this change. However, CMS should note some FIDE SNP plans already provide coverage for physical exams beyond those required in an annual wellness visit so would not offer it as a supplemental benefit. We also recommend CMS provide additional clarification on whether the proposal is meant to allow for a supplemental physical exam *in addition to* the Annual Wellness Visit, or whether this would be provided through a more comprehensive Annual Wellness Visit. In addition, CMS should further clarify this supplemental benefit option applies to all SNPs types (C-SNP, D-SNP and I-SNPs).

**D-SNP Administrative Alignment Opportunities.....165**

*CMS outlines initiatives to promote administrative alignment of Medicare and Medicaid through D-SNPs including final rules (CMS-4182-F, Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program) codifying authority to permit default enrollment of newly Medicare- eligible individuals into integrated D-SNPs at 42 C.F.R. §422.66(c)(2) and, at 42 C.F.R. §422.60(g)(1)(iii), to allow passive enrollment to preserve continuity of care and integrated care related to D-SNP non-renewals or state Medicaid managed care organization procurements.*

*In addition, CMS cites the flexibility to integrate the description of Medicare and Medicaid benefits into the Summary of Benefits and other member materials cites for D-SNPs with exclusively aligned Medicare and Medicaid enrollment, and for D-SNPs enrolling only dually eligible beneficiaries who are exempt from Medicare cost sharing (zero dollar cost sharing D-SNPs) the opportunity for plan materials and the Medicare Plan Finder on Medicare.gov to reflect the \$0 for all benefits covered by Medicare Parts A and B.*

*Through the MMCO, designated as the dedicated point of contact for states regarding D-SNP Medicare Medicaid integration, CMS continues to provide state Medicaid agencies with technical assistance and information on plan performance and audit results of their contracted D-SNPs so that the quality of Medicare services delivered by those D-SNPs can inform state contracting strategies. We have also provided states the opportunity to ensure that state expectations for the delivery of managed long-term services and supports and behavioral health services are integrated into the model of care employed by the D-SNPs that deliver those benefits. CMS invites states to contact the MMCO and to utilize resources provided through the Integrated Care Resource Center*

**SNP Alliance Comments:**

The SNP Alliance appreciates MMCO's work to advance integration through the additional flexibilities outlined in the Call Letter. We continue to point out that the degree to which D-SNPs are able to integrate Medicare and Medicaid services depends largely on state interests and policies related to integration.

CMS must continue to work toward incentives and operational pathways that make it easier for states and plans to support and engage in integrated programs including those building on the D-SNP platform. We understand that the characteristics of individual states can lead to unique processes with respect to operations, documentation, and consumer outreach for dual eligible beneficiaries. However, while some differences may be appropriate, there are others that can lead to significant obstacles and financial and operational burdens that present unnecessary challenges. These concerns are particularly acute for application, beneficiary communication, and state reporting requirements for plans that operate across states. Some of the more serious obstacles and challenges could be mitigated through a greater

standardization of common processes and operational elements across states through development of up to two or three streamlined pre-approved and predictable operational options from which states and plans choose, and agree to follow. These could be outlined in something like a state plan preprint so that all parties can plan ahead for them.

Areas of additional continuing concern include:

**Coordinated review of member materials:** While CMS has stated it does not have authority to follow an integrated member materials process for D-SNPs such as that used in the Financial Alignment Demonstration (FAI) demonstration, based on experience with that demo as well as with D-SNP states such as Massachusetts, Minnesota, and New Jersey, CMS could update or develop new, state-specific FIDE or D-SNP model documents with greater commonality and uniformity between them and improve coordination of timelines between state and federal reviews to reduce process inefficiencies and backlogs for materials approvals. The current state and federal model review processes can lead to contradictory recommendations and duplicative filings and negotiations between the state and federal review agencies. For example, modifications may currently have to be made to the CMS model language in order to ensure the material is accurately explaining both benefits, but this creates the possibility that CMS would question the change (in which case, plans must notify the state, who would then need to follow-up with CMS to confirm the change was at the state's direction).

**Clarification of FIDE SNP status under the new proposed integration rule:** D-SNPs and states have been concerned about the change in the FIDE SNP definition under the new proposed integration rule that now requires that FIDE SNPs must include behavioral health services. While we understand that both the statute and the rule allow for some discretion to CMS to consider carve outs of services "consistent with state policy" but it is not clear what that means for existing FIDE SNPs. We ask CMS to clarify that existing FIDE SNPs will not lose FIDE status, if states are not willing to include behavioral health services in their contracts.

In addition, we ask CMS to clarify the following change in the FIDE SNP definition. The new proposed rule defines a FIDE SNP as a dual eligible special needs plan "that provides dual eligible individuals access to Medicare and Medicaid benefits *under a single entity*". The old definition defines FIDE SNPs as a dual eligible special needs plan that "Provides dual eligible beneficiaries access to Medicare and Medicaid benefits *under a single managed care organization*". The SNP Alliance notes there are some existing FIDE SNPs that operate a fully integrated plan as if it is a single entity but may technically be separate legal entities owned by the same parent organization. We strongly recommend that CMS continue to allow this under the new definition since it does not negatively impact integration.

**Application of Demo Features to D-SNPs:** The aforementioned standardized pathways could include state/plan options application of demo features to integrated D-SNP programs such as addition of MMLTSS features to the Model of Care, use of FAI dual specific network standards and utilization of the FAI model handbook format outside of demonstration status.

**Passive enrollment modifications:** Enrollment alignment is critical to the advancement of integration as CMS acknowledges in its proposed integration rule. D-SNPs cannot achieve FIDE and HIDE SNP status without state assistance and cooperation. While there are some tools for enrollment alignment through Medicaid managed care, despite CMS expansion of enrollment options like default enrollment for new duals and passive enrollment for transitions to other integrated plans when an integrated plan leaves the market, passive enrollment opportunities in Medicare are still minimal. CMS should extend passive enrollment opportunities (with opt out) to states, based on best practices from the most successful FAI initiatives in order to facilitate enrollment into integrated/affiliated D-SNP/Medicaid plan(s) and help D-SNPs to achieve further enrollment alignment and FIDE and HIDE status.

**Special Election Period Modifications:** New rules restricting those dual eligible to quarterly SEPs changes may stabilize enrollment in some D-SNPs but also may provide a barrier to timely enrollment of dually eligibles into integrated D-SNPs from free standing PDPs. We recommend that this restriction be lifted to allow dually eligibles to enroll into an integrated D-SNP in any month.

**Continue to deepen ICRC education for states and plans:** As outlined in the next section on lookalike plans, additional education efforts to outline the benefits of integration for states is needed, as well as to help states understand related market consequences of their policies, design and purchasing decisions. In addition, more education to further the understanding of FIDE and HIDE SNP status, requirements and expectations on what is involved in that for both states and plans is necessary.

**Streamlined information and data sharing between CMS and states, Medicaid and Medicare payers and providers:** Successful implementation of integration requirements in the new proposed standards for D-SNPs is going to be dependent on sharing of information and data between Medicare D-SNPs and Medicaid plans, particularly when members are not aligned. D-SNPs often do not know into what Medicaid plan their members have enrolled. Best practices such as the reported system in Virginia where the state shares Medicare enrollment information with their Medicaid plans should be considered as a starting point.

#### **D-SNP “Look-alikes” .....166**

*In its June 2018 report to Congress, the Medicare Payment Advisory Commission (MedPAC) described the recent emergence of MA D-SNP “look-alike” plans with high proportions of dually eligible enrollees.<sup>32</sup> MedPAC found that D-SNP look-alike plan benefit packages, which are approved by CMS as conventional MA products, are characterized by high cost sharing for Medicare Parts A and B benefits that most dually eligible beneficiaries are not required to pay, and Part D premiums and deductibles that are covered by the Part D Low Income Subsidy. Such benefit designs are unappealing to non-dually eligible Medicare beneficiaries who would have to pay these costs out-of-pocket.*

*CMS states that marketing of such D-SNP look-alike plans to full benefit dually eligible beneficiaries may undermine state efforts to integrate Medicare and Medicaid benefits through their contracted D-SNPs or MMPs and notes additional requirements under the Medicare Improvements for Patients and Providers Act (MIPPA) and implementing regulations for D-SNPs to provide periodic health risk assessments (HRAs) and develop individualized care plans (ICPs) for their members, to develop and seek CMS approval for their model of care, and to enter into contracts with states to provide or arrange for Medicaid benefits along with new D-SNP integration requirements in the Bipartisan Budget Act beginning in CY2020.*

*CMS seeks comment on the impacts of D-SNP look-alike plans for Medicare beneficiaries, including dually eligible individuals; the MMPs, D-SNPs, and other healthcare providers who serve such beneficiaries; state Medicaid agencies; and the coordination of Medicare and Medicaid coverage, in particular the extent to which the proliferation of D-SNP look-alike plans affects:*

- *Informed consumer choice by Medicare beneficiaries;*
- *Competition and innovation among Medicare Advantage plans;*
- *The provision of high-quality coordinated care that addresses the full spectrum of dual eligible individuals’ care and service needs;*
- *State Medicaid policy and operations;*
- *Financial incentives for providers and plans across Medicare and Medicaid;*
- *The potential to reduce provider burden in billing for Medicaid payment of Medicare cost sharing; and*
- *Development and sustainability of integrated care products for dually eligible beneficiaries, through which an enrollee can receive all Medicare and Medicaid services from one organization.*

*Comments will inform future policy development. To the extent that D-SNP look-alike plans impede CMS or state policy priorities in these and other areas, we would consider future rulemaking.*

**SNP Alliance Comments:**

The SNP Alliance goal is to advance integration for those dually eligible for Medicare and Medicaid by providing access to high quality health plans, and a transparent process by which beneficiaries can select plans that truly best meet their needs. We are not seeking to move the bar *lower* for standards of Medicare-Medicaid integration (i.e. not seeking the “lowest common denominator”). At the same time, we wish to be sensitive to the market issues impacting health plans – while remaining clear to our agenda to advance integration.

The SNP Alliance is committed to integration, quality and transparency. If CMS is to make current and proposed integration requirements meaningful for people with dual eligibility and fair to D-SNPs that comply with existing and additional standards to meet the special needs of dual eligible individuals, we believe CMS, plans and states must further address complex market factors that are arising and undermining integration. As a result, MA plans that are not required to meet these additional standards are tailoring products to attract dually eligible members.

We recognize there are many factors contributing to the growth of these look-alike plans with some having higher impact than others. Some of these impact factors are byproducts of state efforts to further integrate the two programs: High impact factors include:

- Agent Commissions that drive enrollment into selected products
- State Bid engagement – requiring DSNPs to buy down cost share or provide specific supplemental benefits, making these less competitive than look-alikes
- DSNPs limited to MCO – MIPPA contracts with states /procurement
- Lack of education for consumers and states on the benefits of integrated plans
- DSNPs enrollment limited to MCO membership

Medium impact factors include:

- Impact on Star ratings – incenting plans to move duals into smaller contracts
- No DSNP program in state or county
- MA rates higher than MMP (quality withhold for MMPs)

Lower impact factors include:

- No partial duals allowed in DSNP
- Provider rates higher in non-MMP and or D SNP products

In order to better understand the dynamics of these factors, the SNP Alliance recommends that CMS conduct an in-depth study to identify the drivers for enrollment of duals into various MA product options, including patterns and volume of enrollments across all of the products, what factors (such as supplemental benefits, broker activity, presence or absence of joint state marketing) drive enrollment into regular MA plans vs other plan options, how state design and purchasing patterns in Medicaid managed care impact duals’ enrollment and plan design choices, and what features or plan characteristics or activities are pushing enrollment into each type of plan. This sort of study would help all parties identify and gain important insights into the most important drivers for duals’ enrollment choices. This would involve interviews with duals to understand those patterns.

In the meantime, the SNP Alliance has some specific suggested recommendations for addressing these issues as follows:

1. Address marketing / broker commission incentives that drive enrollment selectively into these plans when other integrated plans are available and would better suit the individual.
2. Allow D SNP marketing year-round for those plans meeting a quality threshold.
  - In creating the 5-star SEP CMS exercised flexibility under Section 1851(e)(4)(D) of the Social Security Act. Similar discretion could be exercised to create an "integrated high-quality SEP" or similar name.
  - It could then be addressed in the Marketing Guidelines in 40.6 (it could become 40.6.3) and be constructed similar to 5-Star plans.
  - There would need to be agreement of what would be the star threshold - i.e., integrated plans with at least a 4-star rating would be given an "integrated High-quality SEP".
3. Loosen Special Enrollment Periods (SEPs) for FIDE/HIDE SNPs and allow beneficiaries to get out of Part D quarterly lock-ins in order to enroll in integrated SNPs in any month.
4. Clarify the impacts of integration and non-integration and provide educational resources.
  - While many materials have been developed for states – what is needed is information specifically addressing not only benefits of integration, but to identify unintended consequences of state policies that impede integration
  - Other Stakeholders:
    - Develop 101 education for providers and beneficiaries (or groups working on their behalf such as AAAs and SHIPs) on the advantage of integration.
5. Consider frailty adjustment to be applied at the individual level for integrated products (FIDE/HIDE). Although we address this elsewhere in this Advance Notice, this could be included as an incentive for integrated plans.
6. Develop a comprehensive marketing strategy, including addressing changes to PlanFinder
  - a. Require explicit product info for consumers in marketing materials.
  - b. CMS to develop slip-sheets on the value of integrated care for the states to use, and sharable with SHIPs and AAAs – to include a focus on the state, the beneficiary and providers – and how to better counsel beneficiaries about choice and selecting plans that best fit their needs.
  - c. Require brokers to disclose the full menu of options and products available in a given market.
  - d. Require outbound calls to verify enrollment of duals into non-integrated products. The call would inform the dual that the plan they are enrolling in does not coordinate with Medicaid, explain the benefits of coordination, and provide information about other options in the region that do.
  - e. Refine Plan Finder to more easily display DSNPs/FIDE SNPs:
    - i. Even when an individual identifies they have Medicaid, no D SNP plans show.
    - ii. The order of plans should show integrated options at the top of the list.
    - iii. If an individual selects a D SNPs without also stating they have Medicaid – there should be a disclaimer.
    - iv. If a dually eligible individual selects a non-integrated MA plan, when an integrated option is available, there should be an out-bound (pop-up) notice that an integrated option is available.
  - f. Develop new standardized language to add to model LIS riders sent by non-SNPs to LIS dual members, with an educational section informing dually eligible members of SNP options designed for their needs.

*For most dually eligible individuals, Medicaid is responsible for Medicare deductibles and coinsurance for services under Parts A and B, within certain limits. This is true regardless of whether the individual is in Medicare Fee or Service (FFS) or a MA plan. Since 2001, CMS automatically forwards claims under Medicare FFS to state Medicaid agencies and other secondary payers to process for covering cost sharing. Under this automatic claims crossover process, providers do not need to submit separate claims to both Medicare and the state Medicaid agency, which greatly reduces provider burden.*

*A growing number of dually eligible individuals receive Medicaid benefits through Medicaid managed care plans, which may include the coverage of Medicare cost sharing. In 2016, we modified regulations at 42 C.F.R. §438.3(t) to require that certain Medicaid managed care plans, including Medicaid managed care organizations and prepaid health plans, responsible for Medicare cost sharing for dually eligible individuals enroll in Medicare's automated crossover process. In the recently published Notice of Proposed Rulemaking (see 83 FR 57264), we propose to modify the requirement so that the state's contract with a Medicaid managed care plan must ensure the plan receives Medicare crossover claims, but provides states the flexibility to determine on how to do so. We believe the proposed changes enhance state flexibility while continuing to reduce administrative burden on providers.*

*For providers serving dually eligible individuals in MA, however, there is no guarantee of an automated crossover process. This means the providers must directly bill Medicaid in addition to billing the MA plan. In areas in which a state Medicaid agency has delegated coverage of Medicare cost sharing to a Medicaid managed care plan, the provider has to take the extra step of identifying whether a state Medicaid agency or Medicaid managed care plan is responsible for covering the Medicare cost-sharing for dually eligible individuals, and then directly bill that state Medicaid agency or managed care plan.*

*We are seeking to identify ways to extend the benefits of the crossover process for cost-sharing claims for dually eligible individuals in MA plans. To that end, we seek comments on ways to promote MA plans automatically crossing over cost-sharing claims to state Medicaid agencies and Medicaid managed care plans for dually eligible individuals.*

*We welcome comments on the scope of the following issues related to MA plans crossing cost-sharing claims to Medicaid for dually eligible individuals:*

- Challenges or opportunities faced by providers who are directly filing these claims with each secondary payer under the current system;*
- Impact on providers and plans if MA plans were to implement an automated crossover process to the appropriate Medicaid secondary payer;*
- Impact on the state when MA cost-sharing claims are not included with the existing Medicare FFS claims crossover process;*
- Obstacles to implementing a standardized process to crossover cost-sharing claims; and*
- Other prevalent challenges to aligning the cost-sharing claims between MA plans and state Medicaid agencies or Medicaid managed care plans.*

*Please include specific examples when possible while avoiding the transmission of protected information. Please also include a point of contact who can provide additional information upon request.*

#### **SNP Alliance Comments:**

The SNP Alliance supports CMS efforts to address the need for additional information sharing between D-SNPs, Medicaid plans and providers for crossover claims and other claims related to services for dually eligible D-SNP members as well as to achieve better coordination between payers, plans and providers providing services to those members. We agree with CMS that facilitating cross-over claims is important and that processes should be improved. We also appreciate CMS recognition that resolving this issue involves significant complexity.

The SNP Alliance acknowledges crossover issues should be ultimately addressed through more comprehensive reform of this now outdated and artificial split between Medicare and Medicaid responsibility for what are primarily Medicare services for dually eligible populations, but we know this would require major federal legislative change that is probably unrealistic at this point. However, it is notable that under the FAI demonstration, crossover claims were able to be eliminated due to the integrated financial model.

In the meantime, sharing of crossover claim information should be considered as part of a comprehensive reform of what is considered necessary and relevant data sharing between payers, plans and providers to improve health information exchange, particularly for dually eligible enrollees where payment and service responsibility remains a joint responsibility between CMS and state Medicaid programs. We are looking forward to addressing this issue in more detail in comments on the new proposed interoperability rule when it is published.

In addition, as part of implementation of the new proposed integration rule, it is going to be necessary for CMS to consider development of new or modifications of existing system wide data collection and file exchanges, shared portals, or secure applications and other streamlined technological solutions to sharing of information between CMS, D-SNPs, Medicaid providers and states in order to implement the proposed requirements for D-SNPs to coordinate with all Medicaid services, including those outside of their direct provision and to assist members with Medicaid Grievance and Appeals and to share data on hospital and NF admissions.

Rather than have each state reinvent the wheel, the SNP Alliance suggests CMS needs to develop a comprehensive plan for standardized system wide approaches to broader sharing of information including Medicaid eligibility status, Medicaid and Medicare plan enrollments and disenrollment, responsibility for claims payment including crossovers, and care coordination. This system has to consider how to collect and disseminate information among shared providers and plans more efficiently both on a broader level for policy analysis and for use in point of contact in care coordination. We suggest CMS consider building on existing data exchange mechanisms such as the state MMA files, by adding fields such as Medicaid and Medicare plan enrollment information to those files and developing additional mechanisms for sharing some of that information with plans and providers. Ideally, there would be at minimum, one comprehensive source for enrollment and eligibility information for all parties. This could also start with a CMS information source using joint formats to which all states could add Medicaid enrollment data. In addition, CMS could explore other avenues through application programming interface (API) technology solutions related to interoperability proposals.

As we have recommended for other complex issues, we suggest CMS might set up a Technical Advisory Group across both Medicare and Medicaid to map out the scenarios and possible pathways for data sources, processes and technological solutions. If CMS considers this the SNP Alliance requests to participate.

Specifically, regarding crossover claims, we find it helpful to outline multiple scenarios with interacting factors that must be considered such as the following:

- D-SNPs with an aligned Medicaid product commonly have access to cross-over claim information as secondary payers when they are also responsible for payment of crossovers, so they have the potential to offer streamlined claims processing (one combined payment including any crossovers) to their providers. This is an efficient scenario though there may be certain service or population carve outs that still require providers to submit claims directly to the state or to other payers, and some D-SNPs and states do not take advantage of this opportunity even when

there is alignment. Further, providers still may complain about the number of payers with whom they have to interact.

- For these and other reasons, a number of states choose to retain responsibility for payment of all crossovers for duals, including for those in aligned Medicaid plans. Encouraging states to capitate crossovers amounts as part of the Medicaid benefit for aligned plans could resolve some of this issue for D-SNPs and providers under their Medicaid contracts, and we understand CMS continues to encourage and facilitate this approach through rule making.
- However, when there is a lack of aligned enrollment between D-SNPs and Medicaid managed care plans where D-SNPs serve members also enrolled in multiple Medicaid managed care plans, there is less opportunity for single billing systems and states may believe it is simpler for all concerned to retain direct payment to prevent additional confusion.
- Further, D-SNPs without Medicaid contracts for service provision would generally not have direct responsibility for payment of any Medicaid crossover claims. They may have members who are also enrolled in multiple Medicaid plans and/or fee for service so may not typically enroll in any automatic crossover process. In these cases, neither providers nor D-SNPs may have enough information to direct providers to the proper entity for billing crossovers, unless the state retains responsibility for processing all crossovers meaning that providers would have to continue to bill two different places.

Additional specific comments and questions from plan experience and concerns with crossovers are outlined below.

- It would be helpful to know whether CMS is somehow prohibited from sharing the cross over files with D-SNPs for informational and care coordination purposes for their enrolled dual members or whether there are HIPPA barriers that prevent exchange of this information (i.e. plan enrollment in receipt of automatic crossovers) in cases where the D-SNP is not actually responsible for payment.
- CMS should consider potential challenges to providers and payers including any increased administrative burden for providers who directly file these claims with secondary payers under the current system, as well as opportunities for provider cost reductions through reduced billing and reconciliation efforts.
- CMS should consider that MA plans would need to develop processes to support issuance of bi-directional payment and remittance advice information to both providers and Medicaid payers which would take significant effort and require sufficient implementation time. Accurate information relating to the member's dual eligible status and Medicaid payer would be required to support this process. New processes and systems would need to be developed to forward claim details along with payment information to the secondary payer.
- Medicaid payers would need the ability to accept a standardized claim and remittance advice format. Customized formats by Medicaid payers would present significant challenges to MA plans and processes would need to be in place to address claims that are misdirected from MA plans to the incorrect Medicaid payer.
- Further, currently there can be significant claims management challenges when a member receives emergency services out of area. These situations frequently require out-of-state providers to bill systems and entities with which they are unfamiliar. While plans strive to help facilitate billing and payment under these circumstances, operational challenges, coupled with uncertainty, complicate the process and can lead to significant burdens on managed care entities. For example,

some plans experience cases for out-of-state emergency claims where the out-of-state entity requests payment at a higher rate than the state is willing to pay. In some of these situations, the managed care plan is put in the middle of such disagreements and may be forced to assume higher costs to remedy the situation—costs that are not reimbursed to the managed care plan.

- CMS should provide states and managed care entities with greater clarity on the procedures for payment of claims and cost-sharing, especially for beneficiaries receiving emergency care in other states. States and CMS must work together on a uniform process to handle these cross-over claims and any cost-sharing that may be due related to the service.

We appreciate the opportunity to provide comments and are available for follow-up questions, should they be needed.

Respectfully,

A handwritten signature in black ink that reads "Cheryl Phillips, MD". The signature is written in a cursive, flowing style.

Cheryl Phillips, M.D.  
President and CEO  
Special Needs Plan Alliance