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Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
(HHS) Attention: CMS-4190-P

SUBJECT: Proposed Rule: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

The Special Needs Plan Alliance is pleased to offer our comments on this Proposed Rule.

The SNP Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent over 400 special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs), with over 2.2 million enrolled members—about two-thirds of all beneficiaries enrolled in these specialized managed care plans.. Our primary goals are to improve the quality of services and care outcomes for the complex populations served and to advance integration for those dually eligible for Medicare and Medicaid, and those with complex needs.

In our response, we first offer brief comments on the implications of COVID-19 on provisions of the Proposed Rule. We request additional flexibility, modifications, and waivers of enforcement around both current and proposed rules considering the observed impact of the national emergency on providers and beneficiaries. We are particularly concerned about how the emergency is disproportionately impacting special needs health plans given all their members are considered "high-risk." These additional comments were developed as the reality of the COVID-19 pandemic became clearer. They are offered for

consideration by CMS to help address near-term and longer-term implications facing SNPs, MMPs, beneficiaries, and providers. We then identify specific sections where we offer comments using page numbers and section titles.

Our comments on the Proposed Rule are divided into four parts:

1. **Specific COVID-19 Considerations for SNPs and MMPs**
2. **Summary of SNP Alliance Rule Recommendations**
3. **Detailed Rule Recommendations**
4. **Conclusion**

Please note that in addition to including our recommendations in our commentary, our recommendations are listed at the bottom of each section or subsection.

PART I. SPECIFIC COVID-19 CONSIDERATIONS FOR SNPS & MMPS

We recognize that this Proposed Rule was written prior to the COVID-19 pandemic and prior to the President declaring a national emergency. During the comment period we have seen events unfold that are upending lives and impacting our entire society. We have seen how all providers across the spectrum are needing to quickly re-work normal processes and standards of practice to respond to the virus. SNPs and MMPs have also been reporting how they have restrictions or simply cannot perform usual processes and practices around care coordination, preventive and wellness care, and follow-up support—given state mandates, clinical or organizational directives, and federal guidance that are designed to stop the spread of the virus and protect the public.

Most of these at-risk individuals cannot endure weeks of self-quarantine on their own. Their economic vulnerabilities exacerbate the negative effect of their ongoing medical conditions or behavioral health challenges. Many elderly and at-risk individuals do not have access to a smart phone or computer, and therefore virtual visual visits are not a viable solution. Providers and plans are working to reach individuals in any way possible, including making telephone calls. The frail elderly person who lives alone is especially vulnerable. These are but a few of the observed changes that are impacting special needs individuals and the plans and providers trying to serve them.

SNP and MMP enrollment are entirely comprised of individuals who are most at-risk of COVID-19 serious infections and its most severe complications. Most beneficiaries are dually eligible, with multiple underlying chronic and disabling conditions and high social determinant of health (SDOH) risk factors. The impact will fall disproportionately on these

people and on these types of plans.

We recognize the significant impact that this virus is having on beneficiaries, providers, and health plans. This is not business as usual, and—as much as we can forecast the rest of 2020 and into 2021 and beyond—the impact will continue to be felt. We have taken a second look at the proposed rule and identify where modifications will need to be made considering this national emergency. We offer these in the spirit of trying to address near-term and longer-term effects. Clearly the COVID-19 pandemic is a public health emergency that must be included in the definition of "extreme and uncontrollable circumstances."

Recognizing that the wave of societal impacts and burdens from this virus on providers and the delivery system will vary in timing and intensity, we recommend that CMS provide flexibility around when normal processes and operations must resume. The current timeframe listed in the Medicare Managed Care Manual regarding disasters is 30 days after declaration of the end to the national emergency. However, we are all observing in real time that the incidence and prevalence of COVID-19 is not uniform. The impact on the delivery system is likewise uneven. Hot spots have emerged, but new regions are being affected; it is hard to predict when or if the disease will overtake each state. Therefore, it's unlikely that all necessary components of the delivery system that are required by people with complex and varied conditions will be able to resume regular operations at the same time. This timeframe needs to be modified to take into account regional variation in impact and remaining capacity. We recommend that CMS revise the timeframe to conform to state or local public health emergency declarations, and when the "all clear" signal is issued, then the clock can begin. For an emergency of this scale and scope it is highly unlikely that operations will be up and running as normal in one month.

Recommendation: The SNP Alliance recommends that CMS revise its definition of extreme and unusual circumstances to include a broader set of events that go beyond natural disasters and that may not always be tied to federal declaration invoking FEMA.

The revised definition should recognize, federal, state, and local public health emergencies and apply uniform requirements or parameters to ensure that requirements are waived, exempted, or applied consistently across the country in situations that substantially impact beneficiaries, providers, and community resources.

Recommendation: The SNP Alliance recommends that CMS extend the timeline for when normal operations and processes must resume to at least 90 or 120 days following the resolution of the pandemic, per the Centers for Disease Control.

PART 2. SUMMARY OF RULE RECOMMENDATIONS

The SNP Alliance will be making recommendations on the following topics:

PART 3. DETAILED RULE COMMENTS

II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018 (page 9011)

A. Special Supplemental Benefits for the Chronically Ill (SSBCI) (§ 422.102) (pages 9011, 9041, 9103)

***Summary of Changes**:*
CMS has added a definition of "chronically-ill enrollee" in §422.102(f) to implement a congressional amendment to section 1852(a)(3) of the Act to authorize plans to provide additional supplemental benefits, defined the parameters around the purpose and eligibility of these benefits, and waived uniformity requirements.

SNP Alliance Comments:
SNP Alliance supports CMS' intention to provide plans with flexibility in the delivery of special supplemental benefits for the chronically ill. These benefits will offer additional opportunities to meet the needs of SNP and MMP populations. We appreciate CMS' intent to publish a non-exhaustive list of complex chronic conditions and the flexibility described for plans to identify those who can most benefit from their tailored SSBCI services. We applaud the focus on function of the beneficiary rather than medical or health status improvement alone. This provides the important opportunity to SNPs and MMPs to serve their populations—as most individuals enrolled have multiple chronic conditions that restrict functional ability. Having more options to address these functional issues is welcomed.

Additionally, we appreciate CMS' recognition that plans will incur a non-zero, non-administrative cost for these SSBCI and that these services can be included in the Medical Loss Ratio and other calculations.

We also ask that CMS devote resources and ensure consistent, timely, and accurate information to beneficiaries about these SSBCI to:

- Educate the public through a variety of media, including the Medicare Plan Finder, about these special supplemental benefits—but ensure that consumer information displayed makes it very clear what the criteria are (as set by the plan) for receiving these benefits and how/when they can be received;
- Include SSBCI beneficiary costs, if any, in the out of pocket costs estimates on the MPF and any other cost implication related to these benefits, so that it provides more accurate and complete information to the beneficiary

Recommendation: The SNP Alliance recommends CMS Allow plans to identify beneficiaries who could benefit from access to SSBCI beyond a list of chronic medical conditions to recognize chronic mental health and disability needs, as long as the statutory definition of "chronically ill" is met.

Recommendation: The SNP Alliance recommends CMS allow plans to target and tailor some services/benefits to address social risk factors—issues such as homelessness and food insecurity drastically impact the ability to maintain or improve health and function, and to follow-through on treatment recommendations for chronic conditions.

B. Improvements to Care Management Requirements for Special Needs Plans (SNPs) (§ 422.101) (page 9013)

Summary of Changes:
CMS has added five new requirements to SNPs pertaining to their Model of Care and care management processes. Though statute mandates some of this for C-SNPs but does not address other SNP types, CMS is proposing to apply additional requirements to all SNP types.

SNP Alliance Comments:
We **do not** recommend that CMS proceed with applying the new Model of Care (MOC) and care management requirements to D-SNPs or I-SNPs. This action is not required by statute, does not take into account the robust guidelines already in place specifying expectations for MOC

processes by plans, and would be burdensome with uncertain added value, even without the current crises. Furthermore, given the challenges of the COVID-19 pandemic, we propose that such is not an appropriate time to add new requirements that are not mandated by statute.

We have reviewed the complete set of statutory requirements around enhanced care management (now commonly referred to by CMS as *Model of Care* requirements) and the 2020 MOC scoring guidelines as issued by NCQA. These guidelines have been expanded and implemented for many years, and they apply to all SNPs already. SNPs of all types already have to provide extensive information on their MOCs and follow these care management processes throughout the year(s) for their SNP members. SNPs of all types have already developed processes and practices for all the areas mentioned in the Proposed Rule. The NCQA MOC, review, and scoring guidelines already comprehensively cover the coordination of care, provider, and quality requirements outlined. Furthermore, CMS audits include review of performance by SNPs on these processes.

Producing the MOC written document and enhanced care management processes involves extensive effort and multiple disciplines and staff expertise within the special needs health plan. The current benchmarks already in place clearly outline expectations for performance on each element and factor. Plans must meet 70% overall rating of performance to receive approval.

Frankly, we are unclear about the need for additional requirements—even for C-SNPs, though we recognize that statute mandates some action be taken for these types of plans. However, the current NCQA review process and MOC scoring guidelines represent extensive review and oversight of all SNPs. This is already well-established. There is no need to apply more requirements on these items and place additional burden on these plans that are trying to address the needs of our most vulnerable. As a reminder, none of these MOC requirements are placed on general Medicare Advantage (MA) plans.

Current requirements for all SNP types already include:

- four requirements regarding Health Risk Assessment (HRA),
- five requirements regarding Individualized Care Plan (ICP),
- four requirements regarding Interdisciplinary Care Team,
- six requirements regarding Care Transitions,
- four requirements regarding Provider Network,
- six requirements regarding use of Clinical Practice Guidelines and Care Transition Protocols,
- four requirements regarding MOC Training for Providers,
- four requirements regarding MOC Quality Performance Improvement Plan,
- five requirements regarding Health Outcomes and Measurable Goals,
- four requirements regarding Ongoing Performance Improvement Evaluation of the

MOC, **and**

- many additional requirements regarding staffing, providers, patient experience, identifying and stratifying individuals and sub-populations, dissemination of performance results.

Therefore, we recommend that these requirements be set aside for D-SNPS and I-SNPs entirely.

We understand that the statute requires new attention on specific elements and factors for C-SNPs as directed by Congress. However, many of the new requirements, such as face-to-face visits, additional access to specialty providers on IDTs, and fulfillment of the previous year's MOC goals will be challenging to meet in 2020 given the COVID-19 changes in healthcare delivery, access, and bandwidth of providers. Providers and plans appreciate CMS offering added flexibility around telehealth visits during this time, but capacity to conduct some activities such as preventive and wellness screenings will still be sorely limited. We see that the most vulnerable populations are most impacted—even access to a landline or track phone is difficult. Individuals who lack a permanent address may have moved in with friends or relatives and finding them is very difficult. We ask that CMS please take this into account and strive to reduce the burden on C-SNPs. Additional burdens placed on staff, providers, and beneficiaries at this time is counterproductive.

In the interim two years, **we recommend CMS provide clarification on how the new care management requirements differ from existing guidelines for C-SNPs** in 2022, recognizing that the current MOC factors and elements in NCQA guidelines and MOC review scoring factors *already provide detailed specifications for C-SNPs to comply with, which address HRA, IDT, ICP, and quality issues*. There is already a robust benchmark applied to performance as mentioned: 70% out of 100% compliance based on NCQA independent reviews is required. Clarification is needed to understand what would be different from what is followed now. We address each of the proposed requirements for C-SNPs below.

Interdisciplinary Care Team – C-SNP enrollees are diverse, have multiple chronic conditions in addition to a primary severe and disabling condition, as well as behavioral health, social support, and other medical needs. The exacerbation of one condition or disease impacts others. Their care management is not static and must evolve as needs changes. The types of providers, clinicians, case workers, community-based and home care support staff, varies throughout the year depending on need. An assessment and ICP, done even a few months ago, with a set of practitioners or service staff informed of the plan of care, may not be relevant today. In this fluid situation, particularly for the highest risk members, it is usually a care manager or coordinator who works with a principle provider that is most central to the current need and priority issue of the member. Plans already promote the identification of providers from disciplines and services

that are most relevant to the member's needs. The "new" requirement for C-SNPs around IDT and provider expertise seems to restate what already occurs and is outlined in the MOC existing guidelines. We ask CMS to clarify the difference.

Face to Face Encounters – Many plans already work to conduct annual face-to-face encounters with members around the HRA. As we understand the Proposed Rule, any face-to-face encounter during the course of the year would be sufficient to meet the new requirement, even if it did not involve conducting the HRA. The PR provides examples, such as the annual wellness visit, home health care visits, etc. These visits involve different diagnostic and therapeutic processes and focus on specific conditions or have specific purposes. They may not involve assessment of functional status, cognitive status, emotional status or other domains—even if this would be desirable. Therefore, we are wondering if the additional requirement simply asks the plan to document that someone from the provider or plan has seen the individual in person or through a telehealth encounter within the previous year. We further understand that any clinician, therapist, health care worker, health educator, or paid caregiver could be considered part of the IDT and their documented encounter with the member meets this requirement. If this is the intent, it would help to clarify that. This would then indicate that the plan is expected to set up tracking and documentation requests of all types of providers of service to each member—some services which may be outside of the network or lack sufficient reporting capability. From the examples, it seems clear this is not specific to HRA completion—but in any case, CMS should specify expected actions when members refuse, cannot be reached or are unable to participate via remote technology given lack of a smart phone, computer, or other device. We assume that the definition of a face-to-face encounter would now include a simple telephone call—CMS has indicated wide flexibility to the provider community in accepting telephone visits as meeting requirements. Furthermore, during this time of COVID-19 many face-to-face in-person encounters are prohibited, such as when care managers need to access the individual in a skilled nursing or assisted living facility.

Looking ahead into 2020 and possibly 2021, we anticipate that beneficiary resistance to meeting face-to-face (in-person) will increase for the foreseeable future as a result of lingering concerns around disease spread. We hope that one outcome of this national disaster will be to help the most vulnerable stay connected, perhaps by equipping individuals' homes with technology or remote access that does not place them in harms' way, and offering training on technology not currently available to them.

HRA/ICP – As discussed above, the needs of the member—whether they are the same as when the HRA was conducted, or whether they have changed—always drive the care management approach. In addition, while the health risk assessment may be comprehensive (a good thing), it has two limitations: (1) it is a point of time, static picture, and (2) it may reveal conditions,

vulnerabilities, or deficits in the individual which cannot be addressed all at once. Therefore, the creation of an ICP must focus on specific priorities. It cannot set forth plans or goals within defined parameters for every deficit discovered. Because the information and relevancy of the HRA will may diminish over time, additional data sources and information must be used to tailor care. It would be harmful to the individual to stick with the HRA and an ICP that is static, ignoring changes in member priorities, preferences, needs, condition status, etc. Furthermore, the plan recognizes that different providers serving the same individual have different clinical and treatment or care management purposes. The individual's behavioral health counselor's care plan will be different from the cardiologist's care plan for managing the individual's congestive heart failure. The C-SNP's care manager should not be trying to enter into or impede the therapeutic relationship between an individual and his/her provider to recommend different clinical practice. The ICP created with the individual by the health plan's care coordinator is not written to require specific actions by every provider involved in the person's care. It presents the current assessment and the person's priority goals. It is a useful snapshot of the person at a point in time, which is transmitted to the individual's providers who are invited to use it to tailor their approaches and take into account the more complete picture of the individual as that provider creates his/her own patient recommendations and treatment regimen. This is already outlined in the MOC factors and requirements that exist for C-SNPs. We wonder what is new here.

Due to observed challenges around the HRA, IDT, and ICP for the past several years, **we also recommend to CMS that CMS auditors receive the same training around MOC, HRA, IDT, and ICP as NCQA reviewers**. We have heard many examples of auditors reviewing an ICP and not finding specific action steps for every deficit, condition, or risk issue identified in the HRA and then citing the plan, or that auditors look for evidence of a complete IDT meeting of all involved providers (in-person or virtually). It is very unlikely that there will be a corresponding action item in the ICP for every problem raised in the HRA. Furthermore, it is unlikely that every nurse, physician, counselor, home care worker, etc., will be part of a virtual IDT. Needs and providers change reflecting changes in health status. A comprehensive IDT with multiple clinicians and service providers rarely can occur at the same time. This is neither practical nor possible in our current health and social services delivery system. Even prior to COVID-19 this ideal is still just a vision. It would require an integrated health delivery system with free and rapid exchange of information and robust communication between practitioners and settings that does not currently exist.

Recommendation:	The SNP Alliance recommends CMS **NOT** apply the new Model of Care requirements developed for C-SNPs to D-SNPs or I-SNPs. The extension is **NOT** required by statute and many of the stated requirements are already well-addressed in the NCQA MOC scoring guidelines.

Recommendation:	The SNP Alliance recommends CMS and HHS consider using their authority as outlined by the national emergency declaration to temporarily suspend the requirement of C-SNPs for annual MOC submission and to delay application of the new requirements until 2022.
Recommendation:	The SNP Alliance recommends CMS delay implementation of the new C-SNP requirements regarding enhanced care management within their Model of Care until 2022.
Recommendation:	The SNP Alliance recommends CMS clarify how the new care management requirements differ from existing MOC guidelines and requirements for C-SNPs.
Recommendation:	The SNP Alliance recommends CMS auditors receive the same training around Model of Care, HRA, IDT, and ICP as NCQA reviewers, so that the CMS audit and NCQA review criteria for meeting requirements are consistent and so that different standards are not applied.

E. Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§422.514) (page 9018)

Summary of Changes:

- *CMS proposes to not enter into or renew a contract for a D-SNP look-alike for plan year 2022 in any state where there is a D-SNP or any other plan authorized by CMS to exclusively enroll duals when:*
    - *Plan projects in its bid that 80 percent or more of the plan's total enrollment qualify for Medicaid.*
    - *Plan has actual enrollment, as determined by CMS using the January enrollment of the current year, consisting of 80 percent or more of enrollees who qualify for Medicaid, unless:*
- *CMS proposes to limit the prohibition to MA plans that have been active for one or more years and with enrollment equal to or greater than 200 individuals at time of determination.*
- *Proposed requirements only apply to non-SNP plans to allow for the predominant dually eligible enrollment that characterizes D-SNPs, I-SNPs, and come C-SNPs.*
- *CMS allows a transition of individuals from the D-SNP look-alike that is not being renewed into one or more MA plans (including a D-SNP) if individuals are eligible to enroll in the receiving plans. CMS would also allow, but not require, the MAO to transition duals from a D-SNP look-alike into one or more D-SNPs offered under the MAO, or another MAO that shares the same parent org as the MAO if the resulting total enrollment in each of the MA plans receiving enrollment consists of less than 80 percent duals.*

SNP Alliance Comments:

Background

The SNP Alliance supports and appreciates CMS efforts to advance integration of Medicare and Medicaid services for individuals dually eligible for such services. It is widely understood by MedPAC, states, consumer organizations, researchers and others that the growth of look-alike plans is a hindrance to integration efforts and can be highly confusing to enrollees. While look-alikes may offer supplemental benefits that are attractive to dually eligible beneficiaries, unlike D-SNPs, they are not required to work with states to integrate or coordinate Medicaid services, have specific MOCs or additional SNP quality measures designed for complex needs populations. We understand how some market pressures and state MLTSS approaches have further pushed the creation of look-alikes, including state procurement policies that do not allow D-SNPs to operate unless they are also chosen to offer a companion Medicaid plan. We also recognize that there may be a limited role for look-alike plans in certain cases depending on markets and state policy, presuming they are steps towards dual integration and do not directly compete with integrated options. However, where there are active alternatives and efforts to develop integrated Medicare and Medicaid programs through MMPs or D-SNPs, competition from look-alike plans can be detrimental to beneficiaries who would benefit more from integrated services.

This CMS proposal appears to be a reasonable and incremental approach to limit the growth and availability of look-alike plans that aligns with the SNP Alliance mission of integrating services for individuals dually eligible for Medicare and Medicaid.

Unfortunately, the current COVID-19 pandemic is likely to disrupt safe transitions and implementation plans for this policy. While we do not want to lose the opportunity to implement this proposal, we do understand that some states and plans may not be equipped to respond to these changes or that disruptions in care during this pandemic could be harmful to enrollees. We address this further below under considerations for the transitions policy.

The SNP Alliance supports the 80 percent threshold proposed by CMS.

The SNP Alliance understands the market forces driving the creation of and enrollment in look-alike plans, and the procurement challenges for plans in some states. We support the 80 percent threshold as a first and incremental step towards addressing the issue of look-alike plans and their impact on integration efforts. MedPAC's analysis of enrollment data from CMS and Medicare Advantage landscape files demonstrates a cluster of non-SNP plans with a share of plan enrollees who are dually eligible above the 80 percent threshold. We agree with CMS that

non-SNP plans with 80 percent or greater dual eligible enrollment "far exceeds the share of dually eligible individuals in any given market and, therefore, would not be the result for any plan that had not intended to achieve high dually eligible enrollment."

We appreciate CMS' incremental approach and the choice of the 80 percent threshold in that it addresses the most obvious targeting of dually eligible individuals by non-SNP plans, in addition to providing time to observe how plans respond, and allows some non-SNP plans with enrollment of dual eligible individuals above 50 percent to continue to operate in markets where D-SNPs are not offered.

Clarity on Contract Level vs PBP Application

The SNP Alliance recommends that CMS correct an apparent drafting error in the text of the proposed regulation. The proposed text at §422.514(d) identifies the action to be taken if the 80 percent threshold is projected to be met or actually is met as "CMS does not enter into or renew a contract under this subpart . . . for an MA plan . . ." In most cases, the action would be the non-renewal or non-approval of a new MA plan, not the denial or non-renewal of the contract itself. This issue has engendered confusion among our membership. CMS should ensure that the language is clear that the action CMS undertakes if the threshold is triggered is applied at the plan level, not the contract level.

Recommendation: The SNP Alliance recommends CMS clarify that enforcement for this provision occurs at the PBP level to provide more transparency and avoid misunderstandings.

Clarity on Partial Duals and 80 Percent Threshold

Additionally, **the SNP Alliance seeks clarification on what members CMS is counting towards the 80 percent threshold**, and has the following two questions:

1. Do partial benefit dual eligible beneficiaries count as part of the 80 percent threshold for enrollment, **OR**
2. Does the 80 percent threshold apply only to full benefit dual eligible (FBDE) beneficiaries?

The SNP Alliance supports advancing integration of benefits and services for individuals dually eligible for Medicare and Medicaid, whether the individual is a FBDE or a partial benefit dual eligible. We continue to believe that the MOC and other specialized D-SNP features are valuable to both FBDE and partial-duals and have long argued that D-SNPs should continue to be allowed to serve those partially dual eligible.. If it is CMS' intention to consider both full and partial

benefit dual eligible beneficiaries as counting toward the 80 percent threshold, we support that method.

It is our understanding that during the comment period, CMS may be asked to remove partial duals from the calculation of the threshold, recognizing that partial duals do not receive Medicaid benefits, may not be as reliant on MOC features, and may experience disruptions in care if high quality look-alike plans are no longer available in their market. The point of the 80 percent threshold is to reduce the expansion and prevalence of look-alike plans. We are concerned that if CMS counts only FBDE beneficiaries toward the 80 percent threshold without changing the threshold accordingly, eliminating partial duals from the equation would reduce the number of plans subject to the threshold quite drastically, leaving a substantial number of FBDE beneficiaries in look-alike plans and potentially rendering the entire proposal meaningless.

Recommendation:	The SNP Alliance seeks clarification on and recommends CMS clarify what members—partial and dual—CMS is counting towards the 80 percent threshold.
Recommendation:	The SNP Alliance supports the inclusion of full benefit and partial duals in the calculation of the 80 percent threshold, however, if CMS decides to remove partial duals from the equation for reaching the 80 percent threshold, the SNP Alliance recommends evaluating the number of plans impacted and lowering the threshold to a corresponding number below 80 percent to achieve the same approximate result as originally proposed.

Clarify Transitions Policy

The SNP Alliance appreciates CMS efforts to provide a transition to other products, including non-SNP products offered by the plan sponsor for affected dually eligible members. However, we have several concerns about the transitions policy:

- The transition period appears be very short and under the best of circumstances may not be adequate for the preparation or rearrangement of products to ensure an orderly and safe transition of enrollees. But, particularly now, with the COVID-19 pandemic hitting states and plans, procurement, contracting and implementation timelines are being disrupted. In addition, the SNP Alliance is aware that several states are not able to finalize current contracting, let alone deal with additional D-SNP requests. We do not want to lose this valuable opportunity to address the issues around look alike plans, but we are concerned that now would not be the time to disrupt any enrollment for highly vulnerable dual eligible populations.
- We are also concerned that without additional incentives designed to transition individuals to D-SNPs, the new threshold also could result in transitioning those dually

eligible to non-SNP plans to keep enrollment of dual eligible beneficiaries to just below 80 percent.

We think efforts should be made to create flexibility and incentives that encourage plans to transition dual eligible beneficiaries from a look-alike to a D-SNP when a MA organization offers both products. CMS could accomplish this by prioritizing transition of FBDE individuals to D-SNP products including integrated plans. For example, CMS could actively facilitate service area expansion or allow other changes in timelines such as off-cycle D-SNP applications to work with states to increase the likelihood that dual eligible beneficiaries are enrolled in D-SNPs that promote integration of benefits and services according to goals set by Congress, CMS and states.

Recommendation:	The SNP Alliance recommends and thinks it essential that CMS finalize this regulation before bids are due.
Recommendation:	The SNP Alliance recommends a careful review of impacts and timelines for the look-alike transitions and consideration of timeline extensions or state requests for temporary waivers in specific circumstances to accommodate problems arising from the current COVID-19 pandemic process in order to ensure that disruptions to dually eligible members are minimized and that plans have adequate time to develop additional products and/or respond to state changes in procurement policy related to this proposal.
Recommendation:	The SNP Alliance recommends CMS provide additional flexibilities such as facilitating service area expansions or extending application time frames as incentives for plans to facilitate transition of dually eligible enrollees from look-alike plans to D-SNPs wherever possible.

V. Enhancements to the Part C and D Programs (page 9039)

B. Out-of-Network Telehealth at Plan Option (page 9041)

Summary of Changes:

CMS is considering whether to permit Additional Telehealth Benefits (ATBs to be provided by non-contracted providers in cases where the non-contracted providers satisfy ATB requirements and solicits comment on whether revisions should be made to allow all MA plan types, including PPOs, to offer ATBs through non-contracted providers and treat them as basic benefits under MA.

SNP Alliance Comments:
The SNP Alliance supports CMS' proposal to allow these telehealth services to be covered as a basic benefit. Many out-of-network providers can meet these regulatory requirements. Utilization of additional telehealth providers will increase access for beneficiaries and will be especially important for rural areas and during emergency situations such as the current COVD-19 crisis. We also recommend that CMS clarify that MAOs may impose reasonable standards on the use of out-of-network providers, such as requiring them to accept the Medicare allowable as payment in full and not to bill MA plan enrollees more than their applicable cost sharing.

Recommendation: The SNP Alliance recommends CMS clarify that MAOs may impose reasonable standards on the use of out-of-network providers, such as requiring them to accept the Medicare allowable as payment in full and not to bill MA plan enrollees more than their applicable cost sharing.

E. Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System (§§ 422.162, 422.164, 422.166, 422.252, 423.182, 423.184, and 423.186) (page 9043)

***Summary of Changes*:**
CMS proposes new measures for Stars, removes some measures and proposes to make other changes such as to the cut point methodology and risk adjustment methods to HOS measures and increase some measure weights.

SNP Alliance Comments:
Before we comment on the proposed changes and additions, we feel compelled to present our analysis on the anticipated impact of COVID-19 on quality measurement for MA plans under Stars, as this substantially affects what Star measures (current or proposed) can be pursued in 2020 for 2021 Star ratings, and has clear implications for 2022 Star ratings.

We predict the impact on SNPs will be much larger than on general MA plans, as all of SNP and MMP enrollment is potentially affected by COVID-19. Their populations are comprised entirely of people with underlying conditions and other risk factors. The negative effects associated with delays in chronic condition management, screening, follow-up, and other normal practice patterns due to restricted access/visit availability by providers and reduced capacity within medical, behavioral health, home care, and other providers will be much higher on these individuals. As there is predictably a much higher negative impact on these SNP enrollees, there will also be a higher impact on the plans and on SNP performance under the Star quality measures.

We have reviewed all the Medicare Advantage Star measures proposed for 2020 and

conducted initial analysis around some of the current challenges or barriers that are being experienced, which are restricting ability of providers and plans to pursue actions that are normally recommended. For 2020, we determined at least 29 measures are likely to be impacted by COVID-19. Those measures consist of HOS, CAHPS, HRA, HEDIS, and Part D measures. Negative impact stems from suspended preventative visits, clinic closures, facility capacity, restrictions on screenings, cancelling of non-urgent procedures, prohibitions by facilities disallowing in-person care management visits, inability to provide certain member incentives, restrictions on accessing wellness or supplemental benefits (including fitness, transportation, dental, vision), mail order underutilization, inability to access/receive data given reduction in provider documentation, chart reviews on hold, key staff being re-assigned to focus on other efforts such as telephone outreach, member call center support, and limitations on face to face visits and other restrictions related to care coordination, assessment, screening, and follow-up.

Potentially Impacted Star Measures

As SNP populations have a much higher proportion of their enrollment with the chronic conditions enumerated in Star measures, the negative impact on their performance measurement from these measures is anticipated to be much greater than in general MA plans. The following list of 29 measures are those we have initially determined are most likely to be impacted in 2020—some of these will carry over into 2021 and subsequent years given the methodology and measure specifications:

Star Measure	Issue given current health system and societal disruption arising from COVID-19
Measure: C17 - Reducing the Risk of Falling (HOS)	These measures require members to speak with their providers. All preventative visits have been suspended until further notice and member incentives for these measures are on hold. While we hope that the new telehealth flexibility addresses some of these limitations, the capacity of providers is still stretched, and prevention/screening activities are not priority for providers.
Measure: C18 - Improving Bladder Control (HOS)	
Measure: C06 - Monitoring Physical Activity (HOS)	
Measure: C04 - Improving or Maintaining Physical Health (HOS)	These measures are self-report. Individuals state if their physical and mental health is better than in the previous year. Given the scarcity of preventive, wellness, screening, follow-up and supportive medical, behavioral health, and social services currently available in the system, it is very likely
Measure: C05 - Improving or Maintaining Mental Health (HOS)	

	that the answer will be "No." These answers cannot be attributed to health plan action. The most vulnerable SNP populations will likely be disproportionately impacted, unfortunately.
Measure: C22 - Getting Needed Care (CAHPS)	These questions ask how easy and quickly it is to get the needed care. All preventative care is currently suspended. Access is driven by provider capacity and state, federal, and regional priorities and directives as well as delivery organizations. Again, we hope that the telehealth access will help beneficiaries access the care they need.
Measure: C23 - Getting Appointments and Care Quickly Title	
Measure: C24 - Customer Service	Plans' customer service areas are being overwhelmed with calls in some regions. Dropped calls due to all staff working from home are more frequent. SNPs with a higher proportion of people at risk anticipate an exponential rise in the call volume, at the very time when staff capacity is being affected.
Measure: C25 - Rating of Health Care Quality	If members are not able to see their doctors or gain access to facilities and services (even when care is needed for chronic care issues that are worsening), member rating of health care quality is likely to be very low. The SNP population is most likely to be negatively impacted, as their needs for ongoing support from multiple settings and services is much higher and the risks associated with delay are also more severe. SNPs are redeploying staff where possible to conduct telephone outreach and provide guidance on how to access provider services. The response to this depends on local provider capacity. We hope telehealth services will assist.
Measures related to Health Risk Assessment, Screening, Care Planning and Follow-up	
Measure: C01 - Breast Cancer Screening	Providers have cancelled all preventive, screening and related follow-up visits, including vision and dental care and those for chronic conditions that do not require immediate or short-term attention. In some areas, nurse calls and virtual visits for ongoing condition management are limited due to
Measure: C02 - Colorectal Cancer Screening	
Measure C07: Adult BMI Assessment	

<table>
<tr><td>Measure: C08 – Special Needs Plan (SNP) Care Management</td><td rowspan="9">nursing and provider capacity being re-directed to COVID-19 related response. Screening and annual assessments are not a priority right now.
Plans report not being able to conduct HRAs or reminders due to:
Face to face visits not allowed, and limited access to smart devices with cameras within the population; attempts are being made for phone check-in but a complete HRA or assessment can be taxing on the individual.
HRA incentive mailers on hold by vendor,
Care managers re-directed to providing telephonic or virtual visits for more critical chronic care issues vs. screenings or risk assessments that are not urgent.
Charting for these activities is also on hold in some areas.
As SNP populations have a much higher proportion of their enrollment with these chronic conditions, the impact on their performance measurement and results from these Star measures is anticipated to be much lower.</td></tr>
<tr><td>Measure: C09 - Care for Older Adults – Medication Review</td></tr>
<tr><td>Measure C10: Care for Older Adults – Functional Status Assessment</td></tr>
<tr><td>Measure: C11 - Care for Older Adults – Pain Assessment</td></tr>
<tr><td>Measure: C12 - Osteoporosis Management in Women who had a Fracture</td></tr>
<tr><td>Measure: C13 - Diabetes Care – Eye Exam</td></tr>
<tr><td>Measure: C14 - Diabetes Care – Kidney Disease Monitoring</td></tr>
<tr><td>Measure: C15 - Diabetes Care – Blood Sugar Controlled</td></tr>
<tr><td>Measure: C19 - Medication Reconciliation Post-Discharge</td></tr>
<tr><td>Measure C-27 -Care Coordination</td><td></td></tr>
<tr><td colspan="2">Measures around Medication Adherence for Chronic Condition Management</td></tr>
<tr><td>Measure: C21 - Statin Therapy for Patients with Cardiovascular Disease</td><td rowspan="5">We are hearing reports of plans having issues with getting diagnosis verifications from providers due to COVID-19. Without this, prescriptions cannot be filled. We hope that more recent CMS guidance is addressing this issue. Plans are reporting that there is a substantial subset of their members who do not use mail order services. Given that individuals are advised to stay home and with fear of COVID-19 among patients with underlying conditions, plans see a decrease in prescription pick up. Members may choose to cut their dose in half may be skipping doses. This is, obviously, inadvisable, but is common behavior during times of scarcity.</td></tr>
<tr><td>Measure: C16 - Rheumatoid Arthritis Management</td></tr>
<tr><td>Measure: D08 - Getting Needed Prescription Drugs</td></tr>
<tr><td>Measure: D10 - Medication Adherence for Diabetes Medications</td></tr>
<tr><td>Measure: D11 - Medication Adherence for Hypertension (RAS antagonists)</td></tr>
</table>

Measure: D12 - Medication Adherence for Cholesterol (Statins) Measure: D14 - Statin Use in Persons with Diabetes (SUPD)	Coupled with the lack of capacity for follow-up visits, plans are concerned that condition management, particularly where medication regimens with 30-day supplies are involved—will decline. As SNP populations have a much higher proportion of their enrollment with these chronic conditions, the impact on their performance measurement and results from these Star measures is anticipated to be much lower.
Additional HEDIS Measure for SNP and MMP PBP Reporting in 2020 *Transitions of Care* *Follow up after Emergency Department visit for People with Multiple High-Risk Chronic Conditions*	This measure requires substantial action by providers for data transmittal in very short time windows and for follow-up by other providers in a short time window. Moreover, the measure often requires chart review and is a substantial burden on providers/plans. The measure is expected to apply to many SNP and MMP beneficiaries given the chronic care and complexity nature of these populations.

While we appreciate CMS' actions in the recently issued Rule that modified the calculation of the 2021 and 2022 Part C and D Star Ratings to address disruption to data collection and measure scores, we are concerned that this does not fully account for the impact of the COVID-19 public health emergency on Star Ratings.

Plans are already reporting that generating Star measures will be challenging for the foreseeable future. Difficulties with data collection will impact some plans more than others. In some areas there are already widespread issues with data availability. Understandably, providers' documentation, capture of all relevant diagnostic codes, and transmittal timeframes for claims and other data to health plans is slowed. Providers in some states have even been informed that they are not to be concerned about documentation during the COVID-19 crisis. We all can see that the most severely impacted regions will have the least capacity to collect and transmit data. For many measures the health plans are the recipients of provider data, not the entities that generate these data.

As SNPs and MMPs have populations with substantially more conditions to manage, their beneficiaries and these data issues are more pervasive for these types of plans. We anticipate greater difficulty among SNPs and MMPs to capture/obtain the data needed to generate Star measures for 2021 where measures continue to be requested by CMS. For 2022, and even

2023 and 2024 for some measures, this will persist.

Therefore, while the recent CMS guidance around Stars and quality measurement is much appreciated, questions remain and additional guidance is requested. We've outlined several specific issues brought to our attention:

- Some plans have devoted substantial resources toward improvement in 2019 and early 2020, and had evidence of improvement already accomplished in their CAHPS measures. However, if previous CAHPS survey data is used, those improvements will not be taken into account. Essentially, all past activity is now presumed to reflect the present. Plans have requested some kind of remedy, such as: (1) ability to at least report improvement and have some set-aside to adjust the quality bonus payment system, (2) consideration of averaging of two years of data if past patterns are considered relevant for today—given that last year's measure results may have been an anomaly, or other option that recognizes improvements made.

- Provide for some recognition that SNPs and MMPs have a preponderance of the most affected beneficiaries related to COVID-19 vulnerable populations at the highest risk levels—and the effects of the changes in healthcare access, delivery, and capacity are most likely to impact these individuals and therefore the plans with a high proportion of them in their enrollments. This might include some kind of additional adjustment in Star ratings, quality bonus payment, risk adjustment, or other method to hold harmless plans with the highest risk populations. This would extend into 2021 and 2022 data collection. This is consistent with recommendations that Congress, CMS, ASPE, NQF, and other agencies have been making to better account for social risk and care complexity issues for several years now.

Looking Ahead: Given that Congress recognized the unique nature and characteristics of SNPs and permanently established them in 2018, it is time to set up a tailored quality measurement system or take steps that at least acknowledges the unique characteristics and issues of these most vulnerable populations in our measurement system.

Recommendation: We ask that CMS consider how to *hold harmless* plans that have a high proportion of the most vulnerable populations in their enrollment given the impact of the virus and this national emergency, or *apply an additional adjustment t*o 2021, 2022 Star ratings and consider these remedies going forward for subsequent measurement years.

Recommendation: We recommend measurement results be grouped into two pools—general MA and SNPs/MMPs or those with high DE/LIS/Disabled proportion of total enrollment, so that we can discern and more accurately reflect distributions in performance that may be correlated with characteristics of the populations enrolled. If we can examine results from plans with similar populations and understand other regional or community-level variations, we have better information to understand the results. This may be particularly important to do to analyze impact of the COVID-19 pandemic.

Star Measures and Methods in the Proposed Rule

Cut Point Methodology *(p. 9043)*
The Medicare Stars cut point methodology currently treats all MA plans as being the same; measure results are pooled nationally. We have asked in previous years for CMS to separate out plans with a high proportion of dually-eligible, disabled and low-income individuals—e.g., 80 percent or above of total enrollment—before determining cut points or analyzing results. This would improve the accuracy and utility of findings. This would support comparison of plans with greater similarity of population characteristics. These characteristics impact what, how, and when care can be delivered and what outcomes can be achieved. The highest risk groups and the highest risk plans should not be grouped with all other general MA plans—particularly in this time period. This national emergency shines a floodlight on this issue.

As stated, SNP populations have a much higher proportion of their members with underlying chronic conditions and vulnerabilities. These population characteristics impact performance measurement results. Current risk adjustment models have not been set up to take into account the severe and predictable impact of COVID-19. SNPs will be disproportionately impacted.

CMS states: “The primary goal of any cut point methodology is to disaggregate the distribution of scores into discrete categories or groups such that each grouping accurately reflects true performance.” To the extent that the Star measure results are under the control or can be influenced by health plan action, AND to the extent that underlying characteristics of the population are not disproportionately influencing some plans more than others, we agree. However, it is arguable that neither of these conditions are met during this national emergency.

Before changes are made to the cut point methodology as proposed, **we request and recommend that CMS re-test their models and present analysis that identifies if the proposed changes to the cut point methodology will have an outsized impact on SNPs serving the most vulnerable.**

Lacking this information, the SNP Alliance cannot provide comment on whether this will help address some of the issues and challenges observed. We cannot discern the impact on special needs health plans of removing the outliers.

In general, our member plans continue to state that **setting a specific target for each measure for each Star level in advance of the measurement year would be the most straightforward approach.**

Looking Ahead: The SNP Alliance would appreciate CMS modeling a different approach for distributing score results and setting cut points—such as by first grouping measure results, prior to adjustment, based on populations served by the plan. This grouping would help demonstrate the impact of fundamental differences by population (e.g., proportion dually eligible/disabled/low-income). Three groups could be set as: (1) general MA plans where DE/D/LI proportion of enrollment is low, (2) SNPs and MA plans where DE/D/LI proportion is high, and (3) plans that are in the middle (between high and low proportion based on corridors set by CMS). Such modeling would provide insight as to how strongly population characteristics are correlated with performance and could be used to test whether current case mix adjustment is adequately taking into account these population differences. If there are still gaps, CMS could commit to revising the cut point methods or establishing a different set of cut points for the highest risk populations/plans based on this group as a separate cohort. It is likely that the patterns of care and care management is much more complex in these populations and plans. By pooling all results into one group, it is very difficult to discern differences arising from or associated with enrollment characteristics.

Recommendation:	The SNP Alliance recommends CMS re-test their models and present analysis that identifies if the proposed changes to the cut point methodology will have an outsized impact on special needs plans serving the most vulnerable.
Recommendation:	The SNP Alliance recommends setting a specific target for each measure for each Star level in advance of the measurement year, which would be the most straightforward approach.

New Measures

The SNP Alliance **recommends that CMS postpone implementation of any new Star measures and extend for two years the time period for Display measures.**

In addition, **we recommend that CMS and measure developers re-consider measures that require substantial data exchange between providers, particularly in short timeframes.** This capacity and operational sophistication even in the best of times is extremely varied. We all agree and want to improve the speed and quality of health information transfer between and among providers for better care management and targeted quality improvement. Unfortunately, providers are unlikely to have bandwidth in the next year to invest resources or time in working toward more robust health information exchange or new technologies.

Looking ahead, the field may need time to recover from this current crisis at least into 2021. **We recommend revisiting the capacity and capability expectations to be definedin specific measures, such as the Transition of Care, ED Follow-up, and other measures, and meeting with provider and plan stakeholders when the crisis has abated.** Measure developers are advised to take their counsel and re-tool measures so that scarce resources are devoted to building the capacity and functionality of the health and social services delivery system rather than measuring something that cannot yet be done in most places due to lack of infrastructure or capacity.

Recommendation:	The SNP Alliance recommends CMS postpone implementation of any new Star measures and extend for two years the time period for Display measures.
Recommendation:	The SNP Alliance recommends CMS and measure developers re-consider measures that require substantial data exchange between providers, particularly in short timeframes.
Recommendation:	The SNP Alliance recommends CMS revisiting the capacity and capability expectations baked into specific measures such as the Transition of Care, ED Follow-up, and other measures—meeting with provider and plan stakeholders when the crisis has abated.

Proposed Measure Updates

Health Outcome Survey (HOS) – The SNP Alliance appreciates the proposed changes around the HOS, where additional variables will be included in the case mix adjustment for the PCS and MCS measures. This is a welcome change. We also agree and support the proposed change to increase the minimum required denominator from 30 to 100 for these two measures.

However, our concerns remain around HOS methods and these two measures—maintaining or improving physical health and maintaining or improving mental health. These are self-report of health status without the necessary context to understand the person's response and no ability to trace the results back to actions by the health plan. The time lag between information gathering and producing the measure is about four years—with the chronically ill and complex populations as served by SNPs, the time horizon substantially impacts utility. Even with these welcome changes, our concerns remain.

With the effects of COVID-19 just beginning to be felt—we can clearly see that it will not be prudent to use any data gathered from HOS in 2020—the people most at risk of the virus are the very individuals enrolled in SNPs and every aspect of their lives as well as ability to pursue chronic care management and wellness/preventive practices as recommended is upended. The measure results, if they could even be gathered from these individuals, are likely to be bleak. The results cannot be attributed to health plan actions. This is an illustration of how the measure does not work as it is being applied in Stars.

We recommend that CMS suspend use of the Health Outcomes Survey in 2020 and 2021. Particularly for SNPs, the results such as for PCS and MCS measures are likely to be bleak. Given the methodology of HOS and two-year look-back, the impact will continue to be felt. COVID-19 would make conclusions invalid for data collected in 2020 and results should not be compared to two years prior. This likewise invalidates data collected in 2022 that would be compared to 2020—this affects Star ratings in CY2024. To address the need to continue to provide frailty adjustment to FIDE-SNPs, **we recommend that these adjustments be continued into 2021 based on the last complete HOS or HOS-M survey data.**

Rheumatoid Arthritis – SNP Alliance supports removing this measure.

Transitions of Care—Transitions of care is a very important focus. This is particularly important for people with multiple complex care needs. We appreciate NCQA's desire to create a measure of effective transitions of care and work done to date. However, this composite measure still focuses on documentation of events rather than the substance of the transition experience. Our concerns remain that this is primarily a measure of data interoperability and exchange capabilities between providers and is not under the control of the plan. The measure timeframes will not be met by many providers—particularly in the current environment. The measure requires labor-intensive chart review—as most providers are not part of an integrated health information delivery system and very few include a health plan in their integrated information system technology. Furthermore, we hear reports that providers do not even have time to enter

data into charts/medical records. Thus, even if timely documentation and notification occurs, it will not be in the chart. Another concern is that this is a 4-part composite measure. Composite measures, by definition, pool several data points together—which does not allow for understanding on the individual components. NCQA's own analysis shows low performance in several components of this measure, including: 16% for Notification of Inpatient Admission, and 10.8% for Receipt of Discharge Information. **We recommend that this measure be postponed for another two years and that further work be done to focus on other elements of transitions of care while the provider community and delivery systems ramp up their information systems for better exchange.**

Emergency Department (ED) Follow-up for People with Multiple Chronic Conditions – We encourage CMS to delay the inclusion of the *Follow-up after ED Visits for People with Multiple Chronic Conditions* measure for an additional two years in order to improve the measure accuracy regarding the transition to home, particularly given the challenges related to the increase in ED visits and challenges with provider capacity for follow-up given the effects of COVID-19 and this national public health emergency.

Patient Experience/Complaints and Access Measure Weights – While the SNP Alliance supports and promotes consumer engagement, feedback, and feedback, **we recommend that CMS not proceed with increasing the measure weights around these CAHPS measures at this time.** The impact of COVID-19 is just starting to be felt, but there is widespread restriction to access among providers because of concern about capacity and public safety. Providers, states, and others have issued directives to eliminate all prevention, screening, wellness, non-urgent, and elective visits. Even with flexibility around telehealth, access and follow-up is substantially affected. Health care access will be severely restricted for several months, if not longer. This will disproportionately impact SNP populations, as these individuals have multiple chronic and other conditions requiring more frequent visits and follow-up. We must consider that the system will not return to normal for some time.

We recommend that CMS return to a weight of 1.5 since they will be using old CAHPS survey data for the 2021 and 2022 Star Ratings, and then conduct a critical evaluation of survey and response issues to ensure validity and appropriateness and accuracy of results where the underlying chronic conditions, complexity, and social risk characteristics are fully addressed—this is relevant for CAHPS and HOS.

Recommendation:	The SNP Alliance recommends CMS not proceed with changes in the cut point methodology until the impact on SNPs is determined.

Recommendation: The SNP Alliance recommends CMS consider plan stratification based on proportion DE/LI/Disabled prior to setting cut points.

Recommendation: The SNP Alliance recommends CMS issue additional guidance around measurement for 2021 and 2022 Star ratings to take into account and implement remedies arising from the differences among plans' enrollment in order to recognize plans with the highest proportion of vulnerable populations and adjust measurement ratings and quality bonus payments.

Recommendation: The SNP Alliance recommends CMS suspend use of the Health Outcomes Survey in 2020 and 2021.

Recommendation: The SNP Alliance recommends CMS maintain the FIDE-SNP frailty adjuster as determined from 2019 data –so that the current adjustment extends from 2020 and 2021 to hold harmless FIDE-SNPs.

Recommendation: The SNP Alliance recommends CMS postpone implementation of new Star measures and delay movement of measures from the Display page.

Recommendation: The SNP Alliance recommends CMS re-tool the Transition of Care and Follow-up to ED measures reflecting provider and plan input on what aspects of transitions of care and ED visit follow-up for people with chronic conditions can be assessed and taking into account the reality of information exchange and recognizing provider reporting burden.

Recommendation: The SNP Alliance recommends CMS do not proceed with increase in measure weights for patient experience and access measures, and return to a weight of 1.5 for 2021 and 2022 in these years when old data is being used to calculate Star measure results.

Recommendation: The SNP Alliance recommends that CMS conduct a critical re-evaluation of CAHPS and HOS survey instruments, methods, and results to determine what additional adjustments should be made to take into account population differences.

I. Medical Loss Ratio (MLR) (§§ 422.2420, 422.2440, and 423.2440) (page 9065)

***Summary of Change*s:**

CMS proposes to change the definition of incurred claims in MLR calculations to allow for more accurate accounting of supplemental benefits including SSBCI benefits such as expenses from

non-providers.

SNP Alliance Comments:
The SNP Alliance supports this change and commends CMS for recognizing the role played by organizations and providers who fall outside of the current definition of providers for MLR purposes in implementing the new expanded benefit flexibility. We have long supported additional benefit flexibility to address SDOH, health maintenance and homebased services as now allowed under the increased benefit flexibility.

We also join with others in recommending that CMS make the same accommodation for expenses necessary to providing care and services during this COVID-19 crisis. SNPs serving complex and vulnerable populations will need to employ a range of community resources to prevent the spread of this virus to their enrollees and to combat it most effectively, including the flexibility to creatively address SDOH prevalent among their members.

Recommendation: The SNP Alliance recommends CMS expand the MLR provision to specifically accommodate necessary COVID-19 expenses provided through non-provider partners.

VI. Codifying Existing Part C and D Program Policy (page 9072)

E. Medicare Advantage (MA) and Cost Plan Network Adequacy (§§ 417.416 and 422.116) (page 9092)

Summary of Changes:
CMS proposes to codify its general rules that an MA plan must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility specialty type, with each contract provider type within maximum time and distance of at least one beneficiary in order to count toward the minimum number. CMS proposes additional changes to the time and distance methodology to apply a standard that 85% of beneficiaries have access to at least one provider of each specialty type versus the current 90% for beneficiaries in Micro, Rural and CEAC counties. They also propose a 10% credit towards the percentage of beneficiaries required for to dermatology, psychiatry, neurology, otolaryngology, and cardiology when the MA plan includes one or more contracted telehealth providers and another 10% credit toward the beneficiary percentage for affected providers and facility types in states with CON laws or other state impose anti-competitive restrictions.

SNP Alliance Comments:
The SNP Alliance supports these changes to the time and distance standards. We are encouraged by the telehealth expansions provided here and in the recent COVID-19 guidance. In addition,

we suggest that CMS carefully but rapidly evaluate the temporary COVID pandemic flexibilities to see which provisions might be appropriate for more permanent inclusion in these standards. We also recommend that CMS include diagnoses from telehealth encounters in risk adjustment. This will be critically important as SNPs experience spikes in illness rates where telehealth will be an even more important tool in serving vulnerable enrollees. Where appropriate technology is available, **we also suggest adding "Ophthalmology" and "Allergy and Immunology" to the list of provider specialty types covered under the proposed 10% credit.** CMS should also consider providing an additional credit where plans establishes telehealth services at a remote clinic that reduces the travel burden for enrollees.

We ask that CMS carefully review the data sources utilized in determining provider availability. In the past these data have not always been current and in some cases it has impeded network adequacy compliance by counting providers in a neighboring state as accessible even though it would require hours of driving around a lake or traveling by boat to reach them. CMS should assure that the data incorporates recognition of such ongoing geographical obstacles and provide permanent exceptions where it does not. As it is codified, the exceptions process should remain flexible enough to accommodate these situations, as well as situations where it is documented that providers are using anticompetitive means to leverage fiscal arrangements and impeding a plans ability to achieve network adequacy. CMS should allow applicants to assert anti-competitive efforts by a provider even if that provider is currently contracting with more than one existing MAO.

The SNP Alliance also believes that the proposed rule fails to apply network adequacy standards that are appropriate to I-SNPs. As noted in the beginning discussion of network adequacy in the preamble, the MA plan must maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served.

Thus, the statutory obligation that CMS needs to implement is to focus on the needs of the **population served**. The population served are the residents of the long-term care facility where the I-SNP members reside. In this context, CMS has the responsibility to interpret the "prevailing community pattern of health care" to the patterns of care for services received by these residents. The SNP Alliance asserts that using CMS' existing review methodology, which focuses on community patterns of care of beneficiaries residing throughout the counties of the service area is inappropriate for I-SNPs and inconsistent with CMS' statutory obligation of focusing on the needs of the population served. To address this issue, the SNP Alliance recommends that CMS revise proposed §422.116 as follows:

- Allow for the removal of a specialty or facility type from the network adequacy evaluation for facility-based I-SNPs by modifying proposed §422.116(b)(3), which, as

proposed, would give CMS the discretion to remove the entire specialty or facility type. Our proposed modification would give CMS the added discretion to remove designated specialty or facility types only for I-SNPs.

- In evaluating network adequacy, allow I-SNPs to meet the standard for specialty types where the specialists furnish their services in the facility itself. This suggestion could be implemented by allowing an I-SNP to request an exception for any specialty type that does not meet the time and distance standards and that the I-SNP can demonstrate that it has arrangements for that specialty type to provide services to its enrollees on a regular basis. To effectuate this suggestion, we recommend that CMS revise the proposed exceptions language in §422.116(f) to expressly provide for this exception.
- Allow for an exception by an I-SNP that does not meet CMS' time and distance standards by either allowing the I-SNP to limit its time and distance evaluation to the location of its facility(ies) or by demonstrating that the I-SNP is providing access to the provider type in the same manner as Medicare fee-for-service residents of the facilities have access. To effectuate this recommendation, we recommend that CMS revise its proposed exceptions paragraph, §422.116(f), to expressly incorporate this flexibility.

Underlying the last two recommendations is the SNP Alliance's disagreement with CMS regarding CMS' flexibility to limit its network adequacy review only to an I-SNP when the sponsor does not offer a general MA plan. CMS has taken the position that, when a contract is approved by CMS, it approves the applicant to offer a general MA plan. Therefore, the services need to be accessible and available throughout the services area. The question is whether CMS is obligated to maintain this policy if a sponsor wants to offer an I-SNP and not a general MA plan. The SNP Alliance believes that CMS is not legally required to apply this policy if an applicant only intends to offer an I-SNP. We also believe applying this practice blindly is poor public policy. The SNP Alliance asserts that CMS ought to be promoting I-SNPs – a model designed to serve the most vulnerable of Medicare beneficiaries. Adoption of this recommendation is needed to further promote the development of I-SNPs and to serve the best interests of this important and vulnerable population.

Recommendation:	The SNP Alliance recommends CMS evaluate and permanently incorporate additional telehealth flexibilities based on COVID guidance and experience.
Recommendation:	The SNP Alliance recommends CMS incorporate diagnoses from telehealth encounters into risk adjustment as soon as possible in order to capture the true impacts from the COVID pandemic.
Recommendation:	The SNP Alliance recommends CMS add specialty types Ophthalmology and Allergy and Immunology to the list of specialty types covered under the 10% credit and consider providing additional

credit for telehealth at remote clinics that reduce travel burdens for enrollees.

Recommendation: The SNP Alliance recommends CMS review data sources for network adequacy expectations and provide assurance that it accurately reflects availability of providers where there may be repeated exception requests based on geographical barriers. CMS should grant permanent exceptions for such circumstances.

Recommendation: The SNP Alliance recommends CMS consider exceptions based on documented provider activities that have resulted in anticompetitive practices impeding efforts to meet network adequacy standards.

Recommendation: The SNP Alliance recommends CMS adopt the I-SNP specific recommendations noted above.

I. Past Performance (§§ 422.502 and 423.503) (page 9111)

Summary of Changes:
CMS is updating its past performance methodology. In doing so CMS notes that the agency intends to exclude intermediate sanctions imposed on D-SNPs (2021 through 2025) as a basis for denying a MA or Part D application.

SNP Alliance Comments:
The SNP Alliance appreciates CMS acknowledgement that given the new requirements of the BBA of 2018, some D-SNPs may be subject to intermediate sanctions under that authority and are not tied to overall contract performance.

We do not recommend that CMS use only one year of low Star performance as a criterion for judging applications. This is not adequate time for understanding trends, and given the challenges with some of the Star measures, the rating may not reflect true performance for high-risk, complex beneficiaries. Furthermore, external events, such as are occurring now in 2020, may greatly impact Star ratings independent of health plan action.

Recommendation: The SNP Alliance recommends CMS stay with a 3-year look-back on Star measures and considering other evidence of poor performance if additional criteria are needed.

M. Special Election Periods (SEPs) for Exceptional Conditions (§§ 422.62 and 423.38) (page 9116)

Summary of Changes

CMS is proposing to codify Part A and B (C) SEPs that CMS adopted and implemented through sub-regulatory guidance as exceptional circumstances. Except where noted in the proposed rule, the intent of CMS is to codify the current policy, as reflected in section 30.4.4 of Chapter 2 of the Medicare Managed Care Manual. CMS also seeks specific comment on whether CMS has overlooked any feature of the current policy that should be codified and if there are other exceptional circumstances CMS has not identified for which establishing a SEP should be considered. Part D SEPs: Also based on the Secretary's authority to create Part D SEPs for individuals who meet exceptional conditions, CMS proposes to codify SEPs currently outlined in sub-regulatory guidance that coordinate with Part D election periods.

SNP Alliance Comments:

In general, the SNP Alliance supports this CMS proposal, including the proposal to codify a SEP for individuals affected by a FEMA-declared weather-related emergency or major disaster. The SNP Alliance also commends CMS' decision to retain existing §422.62(b)(4) as §422.62(b)(26) in order to give CMS the administrative discretion in the future to identify additional exceptional circumstances through policy issuances. We have two suggestions in response to CMS' invitation to suggest other exceptional circumstances.

Given the current COVID-10 pandemic, **we strongly encourage CMS to clarify SEPs for enrollees impacted by public health emergencies like the COVID-19 pandemic and to align such SEPs with the extreme and uncontrollable circumstances Star Ratings policies.** Enrollees may not be able to make informed decisions or may need to make decisions outside of normal timeframes during these extreme circumstances. In addition, as more states change their policies while implementing new integration standards to facilitate further alignment with Medicaid, **we recommend a SEP to account for varying state Medicaid enrollment timeframes for FIDE and HIDE SNPs.**

Finally, we **recommend that CMS consider returning to a continuous open enrollment SEP for dually eligible individuals wishing to enroll in a FIDE or HIDE SNP.** We are aware that states within the FAI demonstration all accepted an option to waive the move to quarterly SEPs instituted in 2019 so MMPs are operating with a continuous SEP for dually eligible members. However, D-SNPs, including fully integrated plans such as FIDE SNPs, are restricted to a quarterly SEP. We understand that the move to quarterly SEP was to address issues of enrollment churn in some states, often related to supplemental benefits. However, we are not aware of any evidence that churn has been a serious problem among FIDE SNPs.

Longstanding FIDE SNPs indicate this this change has placed undue burden and unnecessarily introduced administrative complexity for stakeholders, including: enrollees and caregivers who help make health insurance decisions; county staffs who administer eligibility for Medicaid programs for aged, blind and disabled populations; providers who serve these enrollees and must track enrollment/eligibility; Medicaid agencies that work closely with contracted integrated D-SNPs and counties to achieve an aligned, seamless, enrollee-friendly, integrated enrollment process for these enrollees; and finally, health plans offering FIDE and HIDE SNPs. Adding this limitation on plan change has increased the complexity aged and disabled FBDE enrollees already face related to health care eligibility and enrollment (e.g., this limitation adds a another, unnecessary layer to the existing complexity of maintaining Medicaid eligibility).

Recommendation:	The SNP Alliance recommends CMS expand the SEP for individuals affected by a FEMA-declared weather-related emergency or major disaster to include public health emergencies such as the COVID-10 pandemic.
Recommendation:	The SNP Alliance recommends CMS establish a SEP to be used to ameliorate problems with varying state Medicaid enrollment timeframes for FIDE and HIDE SNPs.
Recommendation:	The SNP Alliance recommends CMS provide a continuous SEP for dually eligible individuals wishing to enroll in a FIDE or HIDE SNP.
Recommendation:	The SNP Alliance notes that CMS, through proposed §422.62(b)(26), has the administrative discretion to expand the terms of one of the SEPs that CMS is proposing to be added to the regulations.

H. Requirements for Medicare Communications and Marketing (§§ 422.2260–422.2274; 423.2260–423.2274) (page 9108)

Summary of Changes

CMS is proposing to codify existing policy with regard to tis Medicare Communications and Marketing provisions

SNP Alliance Comments:

In the proposed rules, CMS omits the provisions in the Communications and Marketing Chapter that apply to practices occurring in long-term care facilities. It is unclear why CMS decided to omit these provisions from the regulations. CMS is proposing to retain these provisions in the Manual chapter, as noted in the August 6, 2019, CMS guidance. As proposed, it may be confusing to have most of the provisions related to activities in a healthcare setting to be included in §422.2266 while retaining the long-term care facility provisions in the Manual. The long-term care facility provisions in Section 60.4.1 of the Chapter are important provisions to I-

SNPs and the SNP Alliance supports retention of those provisions.

Recommendation: The SNP Alliance recommends CMS, in order to avoid confusion, either add the long-term care facility provisions that are in the Manual to §422.2266 or, in the alternative, to include a statement in the preamble to the final rule that these provisions have been retained and are included in Section 60.4.1 of the Manual.

PART 4. CONCLUSION

The SNP Alliance is committed to the quality and excellence in service delivery to the individuals enrolled in our member plans. We appreciate this opportunity to provide comment and seek to work together to enhance the lives and well-being of all Americans, including those with complex needs. We are happy to answer any follow-up questions or provide additional information, should that be helpful.

Respectfully,

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