SNP Alliance

The National Voice for Special Needs and Medicare-Medicaid Plans

May 21, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1744-IFC P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency – *Interim Final Rule with Comment*

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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 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.

The SNP Alliance recognizes and appreciates the enormous work done by CMS in response to the COVID-19 pandemic and the President's declaration of a national emergency. Thank you for that work. We welcome the opportunity to respond to the Interim Final Rule with Comment (IFC), outlining revisions to the Medicaid and Medicare programs in response to the COVID-19 public health emergency (PHE). We support most of changes in the rule and focus our comments on the proposed Star Rating and quality measurement changes.

SNP and MMP enrolled populations are comprised entirely of individuals most at-risk of COVID-19 serious infections and its most severe complications. Most beneficiaries are dually-eligible for Medicare and Medicaid, with multiple underlying chronic and disabling conditions and high social determinant of health (SDOH) risk factors. The impact of the changes in communities, health care and the threat of the virus fall disproportionately on these people and on these types of health plans.

Across the United States, access to medical, behavioral health, long-term services and supports and other key chronic care management services and to community resources varies significantly from region to region. There is wide variability in how states are responding to

the public health emergency (including timing of reopening state economies, availability of public transportation, food supplies, and other community resources)—all of this has the most negative impact on vulnerable populations. These external changes also substantially impact performance on healthcare quality measurement.

We engaged with our plan members through in-depth discussions to better understand the impact of the PHE on beneficiaries, providers, and plans and to analyze the potential impact of the IFC. We observe a potential outsize impact on SNPs, particularly smaller special needs health plans serving the most vulnerable beneficiaries. We are concerned about unintended consequence of IFC changes to MA quality measurement rules. One concern is that some plans may have to curtail supplemental benefits due to loss of quality bonus payments. These supplemental benefits have been shown to be important to beneficiaries. They are key to providing enhanced care management approaches within their Models of Care. In a worst-case scenario, these plans may no longer be financially viable.

We recognize these are extraordinary times. Everyone is stretched to respond to needs and resource constraints. We have taken into consideration the important goals of reducing burden on providers and on CMS, while also trying to maintain balance/fairness, equity, accuracy, and utility goals for quality measurement under the Medicare and Medicaid programs.

In this spirit, we provide comments on the Star Rating proposed IFC changes (FR pages 19269 – 19275) and offer five recommendations:

1) **Provide a way to recognize evidence of plan performance improvements achieved since last year's 2020 Star Ratings (by accepting MY 2019 service data).**

2) **Maintain the 2020 Star cut point thresh holds for HEDIS and CAHPS measures for the 2021 Star Ratings.**

3) Hold harmless plans serving the most vulnerable, from unintended consequences of the IFC changes made mid-course, and recognize unique measurement issues of SNPs.

4) **Use the Health Outcomes Survey (HOS) for information and analysis. Move measures generated from HOS to the Display Page.**

5) **Suspend changes to HEDIS and CAHPS Star measure weight changes—maintaining weights that were applied in 2020 Star Ratings, and suspend progression for new or returning measures, delaying progression for two years.**

We provide additional detail on each recommendation:

1.) Provide a way to recognize performance improvement made since 2020 Star Ratings.

The IFC proposed modifying the calculation of the 2021 Part C and D Star Ratings by replacing the measures calculated from HEDIS and CAHPS with last year's values from the 2020 Star Ratings. The reasons given were to avoid collecting information from providers during this time and to reduce burden on the Agency. The IFC states that "measure scores and Stars do not fluctuate significantly year to year." This statement is not consistent with information we are receiving from our SNP and MMP member health plans.

Several plans report having spent significant effort on improvement around HEDIS and CAHPS measures in 2019 and early 2020 toward receiving a higher Star rating in 2021. These efforts had been producing better results, based on complete or nearly complete data collection and measure calculation prior to the IFC issued on April 6, 2020. They base this on the assumption that 2020 cut points would be carried forward for these measures and on additional modeling of predicted results.

Plans followed previous CMS quality measurement rules (underway up to April 6, 2020) in good faith. They ask for a way to provide these data to CMS and have this information reflected in performance reporting. They note that NCQA, the measure steward for HEDIS measures and many States have adopted the "better of the two" policy for Medicaid and commercial plans on HEDIS measures for quality measurement and reporting programs. NCQA guidance reads: *For commercial and Medicaid plans reporting to NCQA, for measures reported using the hybrid methodology only, we will allow plans to report their audited HEDIS 2019 hybrid rate if it is better than their HEDIS 2020 hybrid rate as a result of low chart retrieval.* This demonstrates the workability of this approach.

In our discussions, plans pointed out that not all HEDIS Star measure calculations require collection from medical charts. The four HEDIS administrative measures can be completed with claims and supplemental data that is collected year-round. Further, some plans explained they did not have trouble accessing medical records electronically and performing chart extraction to complete their HEDIS medical record review, as these 2019 data were nearly all transmitted before the IFC announcement. They report that since providers postponed elective procedures and non-urgent visits, clinics were updating records and continued to provide transmittals to the health plan. Plans request that CMS receive and recognize these 2019 service year HEDIS data and would like to have this information reflected in performance reporting.

We also are aware that providing an avenue for consideration of actual 2019 performance will help decrease the number of requests for reconsideration submitted to CMS by health plans following Star rating calculation and reporting. This post-Star measurement CMS review and appeal process places a high burden on the Agency—so we are trying to offer options to help diminish the number of plans that might request this process.

Recognizing these considerations, two alternative approaches are offered. We believe option A would be the preferred approach.

OPTION A: Consistent with NCQA's guidance to Medicaid and commercial health plans, ***allow Medicare Advantage plans to submit the better of the two years' data*** for HEDIS measures. This should at least be considered for the four administrative HEDIS measures where calculations do not require medial record review (Breast Cancer Screening, Osteoporosis Management in Women who had a Fracture, Rheumatoid Arthritis Management, Statin Therapy for Patients with Cardiovascular Disease).

These measures are also used in the Improvement Measure calculation and in the CAI adjustment, so if we can use actual 2019 service year data without burden on providers, the results will more accurately reflect actual performance and guide these adjustments. This would also avoid extra burden on SNPs where they need to report HEDIS measure results to the State and to CMS. Having to calculate HEDIS measures using two different service year data sets could be burdensome for plans with a high proportion of dually-eligible members. This provides some consistency across approaches between Medicare and Medicaid—better alignment of quality measurement for dually eligible beneficiaries remains an important goal. CMS has already reviewed last years' data for plans that will use their measurement results from 2020 Star ratings and would not need to do so again. Since only a portion of health plans would submit service year 2019 data for review, hopefully the burden on the Agency would be lessened.

CMS could ensure that plans that stopped collecting data after CMS' April 6th announcement are not disadvantaged, by providing a hold harmless provision to these organizations. We have offered a hold harmless provision specific to SNPs and MMPs in the next recommendation, but an additional provision could be applied for all MAOs.

OR

OPTION B: If plans could not submit 2019 HEDIS data, then provide ***an additional one-time "demonstrated performance adjustment factor"*** (add-on coefficient) to be applied after CMS' calculation of each plan's overall Star level rating. This would allow plans that can demonstrate improvement using 2019 service year data as compared to 2020 Star Ratings (using 2018 service year data), to present these data to CMS for consideration for

a one-time adjustment to be applied. Plans would apply and present evidence that 2019 service data and measurement results would have demonstrated improvement in their 2021 Star ratings, had existing rules and guidance been followed. We recognize that CMS could use its "good cause" exception authority to establish a process for this one-time adjustment as given to them and HHS under the PHE—as they have used to issue the IFC on April 6. These extreme and uncontrollable circumstances which are affecting the entire country provide justification.

2) **Maintain the 2020 Star cut point thresh holds for HEDIS and CAHPS measures for the 2021 Star Ratings.**

With so many unknowns, it is important to build some stability into the 2021 Star measure ratings. We recommend that ***CMS maintain the 2020 Star cut point thresh holds*** for the HEDIS and CAHPS measures—and consider also maintaining the 2020 cut points for the other remaining measures. HEDIS and CAHPS measures make up a substantial portion of the total Star measures, therefore burden on CMS and on the plans would be reduced. Under these extraordinary times, we believe that new cut point thresh holds would not have to be calculated by CMS. Health plans will know now what the benchmarks are and can turn their attention and resources to current service, measurement, and data issues arising in 2020 given the PHE.

3) Hold harmless plans serving the most vulnerable from unintended consequences of the IFC changes made mid-course and recognize unique measurement issues of SNPs.

Hold SNPs Harmless - We are concerned that health plans with the most compromised and vulnerable populations may be disproportionately affected. Given the potential for plans with the highest proportion of vulnerable populations to be more profoundly impacted, we recommend that CMS ***hold harmless*** plans serving the most vulnerable, by ensuring that these plans' ***overall Star rating will not fall below their 2020 rating***. This would provide some reassurance for them during this difficult time.

We recognize the impact can be very severe on smaller plans serving the most vulnerable beneficiaries. If these plans lose their quality bonus payment and rebate dollars next year arising from IFC changes in Star measurement methods and the external factors from the PHE, it will impact what they can offer to these vulnerable populations in supplemental benefits and enhanced care. These SNPs are already performing substantial adjustments in operations, such as weekly check-in calls with their members, providing meals or essential groceries via home delivery, enhancing members' access to telephone technology, redeploying staff to increase remote support access, and making personal protective

equipment available. We do not want to see these plans be forced to make decisions to restrict or curtail supplemental benefits during these PHE times. Furthermore, the impact seems likely to extend into next year. As plans consider their 2021 bids and take into account the financial implications of COVID-19—on costs of care, plan operations, and potential loss of quality bonus payments—they may need to curtail what they can offer beneficiaries. In the worst-case scenario some plans might be forced to cease operations. Many of these smaller plans have focused for decades on the elderly, disabled, and low-income populations and have developed models of care that work to connect medical, behavioral health, and long-term services and supports. We need this work and these plans to continue.

SNP-Specific Care Management Measure - There are also SNP-specific measurement issues pertaining to data being collected this year. For example, the SNP Care Management measure which is defined as *the percentage of SNP members who had a health risk assessment (HRA) during the year*. The inability to conduct face to face visits and challenges with reaching vulnerable members is impacting the ability of plans to complete HRAs within the 365-day window. Plans are encountering the following issues: lack of phone lines/phone access, prohibition of entering nursing homes to conduct face to face visits, and beneficiary limitations around technology (e.g. smart phone, iPad) and sensory function (e.g., hearing impairment) which restricts ability to conduct the HRA remotely. Plans are re-working their HRA processes, but this takes time. They request and we support CMS implementing an ***additional grace period of 90 days for HRA completion*** during the time of this pandemic—to reach beneficiaries and request participation in the assessment. Until the threat of contagion is removed and access to technology is more abundant to allow for alternative ways to conduct the HRA, this seems a reasonable request.

4) **Use the HOS for information and analysis only. Move measures generated from HOS to the Display Page for Star Ratings 2022, 2023 and 2024.**

The Health Outcomes Survey (HOS) measures are problematic, particularly during this public health emergency period. We recommend CMS ***move the HOS-generated Star measures to the Display Page.***

Particularly the HOS longitudinal measures, such as "Maintaining or Improving Physical Health" (PCS) and "Maintaining or Improving Mental Health" (MCS,) are likely to be severely compromised by the impact of COVID-19. These self-report measures ask the beneficiary if he/she has maintained or improved his/her physical or mental health. The responses are compared to what that person reported two years ago. The methodology of HOS in surveying and sampling among beneficiaries involves a two-year look-back time-period. *COVID-19 would make conclusions invalid or highly suspect for data* collected in 2020 when compared to 2018, and likewise call into question data collected in 2021 that

would be compared to 2019—to the extent the impact on communities and providers of the PHE continues. Likewise, since HOS survey data collected this year would be compared to 2022 responses by beneficiaries, the implications continue into subsequent measurement years, as the table below shows.

Health Outcome Survey Cohort Survey Timeframe & Measurement Reporting			
Cohort	**Baseline Collection (Year)**	**Follow Up Collection (Year)**	**Performance Measurement Data Available (Year)**
23	2020	2022	2023*
22	2019	2021	2022*
21	2018	2020	2021*
20	2017	2019	2020*
19	2016	2018	2019*

Postponement of HOS until later this summer of 2020 will not address the issue.

The longitudinal measure results from the baseline or the follow-up year where CMS' methodology would compare beneficiary response during PHE-impacted year(s) to non-COVID years introduces enormous bias. We have seen that the impact of the PHE is highly variable from one geographic region to another, and bias is also introduced when comparing the population most vulnerable to COVID-19 with a healthier population. These environmental and contextual issues cannot be ignored.

Other measures that draw from the HOS survey (e.g. the "Effectiveness of Care" measures such as Improving Bladder Control, Monitoring Physical Activity, Reducing the Risk of Falling), will also be affected by the pandemic. We recommend that CMS move these HOS/HEDIS measures to the Display Page as well for Star Ratings 2022 and 2023.

We do recognize, however, that HOS survey data are used for other purposes (in addition to serving as the source data for several measures in the MA Star measure set)—such as to calculate risk levels for the frailty adjustment factor for FIDE-SNPs when comparing to the risk levels of PACE populations.

Therefore, we recommend that the ***HOS survey be conducted for these other purposes in 2020, 2021 and 2022, and that CMS use these data to conduct expanded analysis.*** If the HOS samples are representative, survey data could be used as one source to inform CMS, plans, beneficiaries, policymakers, and other stakeholders about the impact of COVID-19. Expanded analysis by special population subgroup could be conducted to help reveal where

the negative effects of the PHE were/are especially pronounced. These HOS data, collected during these aberrant years, will help reveal the impact by beneficiary subpopulation. We have already seen in other public health data the outsized impact of the corona-19 virus on African American, Latino, and low-income populations. We might reasonably predict that some of these disparity results will also be revealed in HOS survey results. Such variables and environmental factors must be taken into account in any use of the data.

We believe analyses will reveal that HOS results from data collected in 2020, 2021 and 2022 will not be consistent with past years. We predict there will be variability by region or by population with more negative results among subpopulations with high social risk, disability, low-income, or dual eligible status. We point to the need for this kind of more granular analysis to interpret survey results.

For these reasons we recommend that ***HOS data not be used in the MA Medicare Stars ratings for 2022, 2023, and 2024. The measures could be calculated, but for analysis and information only.*** The information would be provided to each plan and CMS would provide both overall plan distribution as well as enhanced analysis around subgroups of diverse, low-income, disabled and dually eligible populations. We recognize such work will require time to properly conduct the analysis and present findings for stakeholder input.

The HOS measures would therefore be ***moved to the Display page for 2022, 2023, and 2024*** Star ratings. We recommend that they not be included in the overall Star measure results for these three years. Especially during this time and given the measurement specifications and methodology, it is crucial that these changes be made—the external PHE factors and population disparities must be taken into account or the entire validity of the measurement system is called into question.

We have previously provided extensive analysis around the limitations of the HOS survey and methods as applied to the most vulnerable populations. When the impact of the PHE has subsided and is better known, and when there is capacity in the Agency and within stakeholder groups, we recommend a different instrument and methods be used in the MA Medicare Stars program where the health plan actions can be strongly correlated to the self-report outcomes. See: SNP Alliance Health Outcomes Survey White Paper.

5) **Suspend changes to HEDIS and CAHPS Star measure weight changes—maintaining weights that were applied in 2020 Star Ratings, and suspend progression for new or returning measures, delaying the progression for two more years.**

It is not prudent to use old service year data and prior Star measure results and then go ahead

and apply new measurement weights. ***All measurement weight changes should be suspended for 2021 Star ratings.*** Thus, for example, CAHPS patient experience measure weight should not be raised from 1.5 to 2 for 2021 Star ratings.

In addition, new measures or returning measures should be held from progressing to Stars. This is needed to take into account the public health emergency impact and recognize that data collection cannot be adequately performed to prepare for the application of new or returning measures. We recommend that CMS ***postpone implementation of any new Star measures in for 2021 and 2022 Ratings and extend, for two years, the time period for Display measures.*** Neither plans nor providers have the bandwidth to begin collecting or transmitting additional data for new measures. Several of the new measures coming online, such as the *Transitions of Care* measure, require substantial data capture, transmission, notification, and follow-up by providers.

Finally, we recommend that CMS adjust their policy to extend relief under an enhanced definition of "Extreme and Uncontrollable Circumstances," to ensure fairness across the country. It is widely predicted that the 2020 and 2021 service years will be anomalous. Data collected from those service years will have wide variability due to factors outside of plan control. It is difficult to control for all the external variables that might negatively affect 2021 and 2022 measurement and Star ratings. If CMS needs additional information to allow for enhanced application of the provision, health plans could follow a process set forth by CMS to make their case for eligibility by providing information about the impact on beneficiaries, providers, and plan operations during the PHE.

Once again, we appreciate the incredible work already accomplished by your Agency to address this public health emergency. We know that the burden is great on everyone. We thank you, in advance, for considering the most vulnerable groups in our society and the special needs health plans serving these groups. We welcome the opportunity for follow-up discussion related to these recommendations.

Respectfully,

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