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Re: CMS 4192 – Proposed Rule: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

INTRODUCTION

The Special Needs Plan (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 25 health plans offering over 550 plan benefit packages (PBPs) and 175 contracts through special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs). These plans have over 3 million beneficiaries enrolled in 47 states and the District of Columbia—totaling more than 60% of the national SNP and MMP enrollment. Our primary goals are to improve the quality of service and care outcomes for complex populations and to advance integration for those dually eligible for Medicare and Medicaid. The SNP Alliance is pleased to offer comments to this significant proposed rule.

The mission of the SNP Alliance is to improve the lives of adults with complex needs, including those with multiple chronic conditions, behavioral and functional support needs, and those facing social risk factors. Our members serve large proportions of the highest risk beneficiaries. SNP enrollees have significantly higher HCC risk scores and struggle with greater disparities and inequities than the average enrollee in Medicare Advantage (MA). We applaud the focus CMS has made towards addressing Health Equity and Inclusion. SNP Alliance members are recognized by CMS and others as leaders in addressing health inequities and disparities through a variety of innovative and person-centered approaches. Our comments within this letter will further expand on these principles and offer recommendations to improve both data capture and quality measurement.

We have long supported the advancement of dual integration and appreciate the directional intent of CMS in these proposals. We also identify a number of areas where we caution CMS regarding unintended

consequences whereby specific areas of rulemaking may create barriers for the plans and the beneficiaries seeking integrated solutions. We have attempted to highlight those specific areas to offer constructive suggestions and recommendations, and also to identify those proposals that, we believe, will indeed continue the work to advance integration for those dually eligible for Medicare and Medicaid. We look forward to continued collaboration with CMS as rule provisions are implemented and as we continue our mutual efforts to improve services for the complex and diverse populations we serve.

SNP ALLIANCE SUMMARY of KEY COMMENTS

Section II. A. 3-13. Medicare Medicaid Integration Provisions for People with Dual Eligibility

The SNP Alliance commends CMS for proposing changes that will take significant steps towards clarification of integration policies, definitions, coverage and carve out parameters, enrollment alignment and cross walk opportunities for FIDE and HIDE SNPs and for providing pathways for application of key MMP features to D-SNPs. We also appreciate CMS endorsement of mechanisms that allow partially dual members to continue to have access to D-SNP enrollment and care coordination.

While many of these proposals involve welcome short term technical changes, CMS also seeks comment on conceptual changes that signal a long-range direction and pathway for D-SNPs to become the primary platform for Medicare and Medicaid integration for people with dual eligibility, a goal the SNP Alliance has long worked for and that was envisioned by the original SNP legislation as well as the 2018 BBA changes. As CMS points out, focus on the D-SNP platform for furthering integration makes sense given the widespread adoption, availability and popularity of D-SNPs as evidenced by growing enrollment, and significant ongoing investments by plan and states in D-SNP infrastructures. Further, we view these rule proposals as a logical alternative to other more radical integration proposals being considered, some of which would eliminate D-SNPs and call into question the continuation of these significant investments.

We note that many of these proposals will take substantial work for plans, and some may be somewhat painful, and to that end we have provided a number of constructive suggestions for consideration. In addition, in order to be successful, these steps towards integration will continue to require extensive state collaboration over time that will necessitate renewed focus on education and technical assistance to states.

We are pleased to support the CMS proposal for establishing advisory committees and suggest that members have access to participate through telecommunication when needed and to allow them to be compensated for their expertise and participation.

We recommend that CMS establish a technical expert panel to work out details of more standardized and comprehensive enrollment data exchanges and to include HCBS waiver status in that process. We also recommend that CMS look at how to better align MLR cost reporting definitions and requirements between Medicare and Medicaid prior to utilization of any integrated MLR. CMS should also be mindful of the lack of transparency and standardization of actuarial soundness across states as it considers creative means of coordinating supplemental benefits to reduce confusion about coverage, as well as to find savings for states. We support extending exclusively aligned enrollment to HIDE SNPs along with access to the frailty adjustment. We also suggest CMS might want to establish a technical expert panel of states and plans to identify and promote best practices for handling capitation of cost sharing in various case scenarios and to further explore barriers and solutions to capitation beyond FIDE SNPs.

We also strongly recommend that CMS further evaluate its current authorities and/or seek additional authorities where needed to make additional changes such as expansion of passive enrollment to align

with Medicaid passive enrollment policies and to address MA operational details that continue to impede integration. While this rule presents a refreshed opportunity to focus investments on D-SNPs and incorporate learning from the FAI demonstration, many other technical and operational modifications remain necessary to further tweak the D-SNP platform to fully meet the diverse needs of stakeholders for a seamless enrollee experience. We also support changes discussed at MACPAC for states to submit a plan addressing key elements for achieving further integration and to provide states with the necessary resources and expertise for implementing such plans and recommend that CMS work to develop and implement such an approach. In addition, we support new or clarified language to enhance CMS and MMCO authority to continue to facilitate more efficient operational integration in these programs.

Overall, we congratulate CMS for taking these next steps toward strengthening integrated programs for people with dual eligibility and are eagerly looking forward to continued collaboration with CMS for successful implementation as the rule is finalized.

Section II. A. 4. Standardizing SDOH Questions on HRAs.

The SNP Alliance has long called for recognition of social determinant of health characteristics which predominate in special needs populations and impact health outcomes. We support this proposal with modifications. We offer several recommendations to improve utility and advance the stated goals. First, we believe SDOH risk screening should be extended for dually-eligible beneficiaries enrolled in any type of MA plan. Second, we recommend CMS give attention to the top risk factors experienced by dually-eligible individuals (social isolation, food insecurity, housing instability). Third, we ask the Agency to consider how to recognize social risk information already collected from other individuals working with the beneficiary (multiple screeners, settings, and tools are already used). Fourth, we recommend that CMS consider the utility of using these other sources of SR information to populate the beneficiary's HRA when the information came directly from the beneficiary within a given timeframe (rather than asking the person to repeat the information or answer alternative questions on social risk again). Fifth, we recommend that CMS work with experts to harmonize data across screens and scoring algorithms, to create a cross-walk with guidance on how to standardize scoring. Finally, while we support CMS looking at whether the AHC assessment tool items are adequate, we pose a number of practical questions that need to be addressed. We strongly suggest considering utility and feasibility, supporting best practices, and avoiding unnecessary burden. We applaud CMS' commitment to working toward having standardized data around SDOH risk factors. We stand ready to assist in any way we can.

Section II. A. 6. a. D-SNP Contracting Changes

The SNP Alliance supports the opportunity to allow states to request that D-SNP contracts for exclusively aligned D-SNPs be combined under one plan contract number in a state, in particular where the plan and the state are in agreement on requesting this change, in order to assure that reported data reflects the D-SNP populations served under that contract. A single "clean" contract number for D-SNPs in each state is an important and game changing requirement for integration which has long been proposed and supported by the SNP Alliance because it can align performance evaluation and data collection and enable clearer understanding of DNP population outcomes and needs state by state. It also facilitates continuation of best practices from MMPs and other demonstrations as they transition from demonstration status. We appreciate that CMS paved the way for this change in its earlier NOIA guidance for 2023. We also appreciate the additional cross walk exception process and the outline of detailed steps which would be followed to achieve this change.

However, many of our members, particularly those with multi-state contracts, have serious concerns about this change, because this change will impact Star ratings, measurement and data collection, Models of Care, supplemental benefits and IT systems. They are also concerned that requiring new contracts (and potentially new product names) may be confusing to existing enrollees subject to transition cross walks and thus result in unintended negative consequences for beneficiaries. CMS also needs to consider impacts on IT costs for plans, impacts on the frailty adjustment and impacts on Star measures, cut points and survey response rate changes and what additional work for D-SNPs and CMS and states will be necessary for implementing this proposal successfully. Some are suggesting there are other pathways to finding longer-term solutions that would be less disruptive and CMS should seriously consider such alternative suggestions. As the California MMPs transition to D-SNPs there may be opportunities for monitoring or testing new ways of implementing PBP level reporting which could also be instructive to this process.

The SNP Alliance provides a number of recommendations and suggestions for parameters and guard rails that should be in place to make this proposal more workable.

In moving forward, beneficiaries should not have to navigate hurdles and disruptions across two programs that arise from federal and state rule conflicts or duplications. Alignment around quality measures, models of care, and performance evaluation as well as rewards is very important. Additional guidance and capacity building will be needed by most States to make this fully operational and there are potential problems for health plans that operate across state lines, for example around a Model of Care. Characteristics of beneficiaries require providers and plans to navigate their care coordination across settings, disciplines and services and between the two programs. Complexity in chronic and medical condition management, behavioral health needs, social determinant of health needs, and long-term services and supports arise. In addition, the alignment of quality measurement can be another integrating mechanism or lack of alignment can present an unfortunate barrier. We request CMS identify a national core set of measures specific to dually- eligible special needs populations and request that states use these measures to evaluate integrated programs. We hope that this single D-SNP contract opportunity helps realize the goal of better alignment in programs, care management, provider service, and quality monitoring. We stand ready to assist CMS and states in this effort in any way we can.

See also Related comments in II A 13 around Model of Care Coordination.

Section II. A. 14. Converting MMPs to D-SNPs

The SNP Alliance supports the approach CMS proposes in this section with a caveat that there may be need for additional accommodations for some states and MMPs that have large investments in the FAI model. The SNP Alliance commends CMS for strongly signaling a direction for the future after the end of the FAI demonstrations, something our members, both D-SNP and MMPs, have requested for a number of years. We also commend CMS for working to incorporate key learning from the FAI by modifying key elements allowed to MMPs in order to adapt them for D-SNPs.

However, we also recognize that MMP members and some states and stakeholder groups have invested heavily in the FAI model. For example the OneCare program for people under age 65 in Massachusetts has been strongly supported by the state, plans and stakeholders. While we agree with not starting up any additional FAI demonstration states and continuing the planned phase outs, it may be beneficial to allow some high performing MMPs to remain in place permanently or stay in the FAI longer while transition processes are worked out, particularly where state authorities must be sought to include behavioral health or other services that had previously been carved out. CMS should consult stakeholder groups that may be

heavily invested in their MMP models and consider the impact of features that may be lost such as passive enrollment and shared savings prior to final decisions in each state.

CMS should clarify as soon as possible whether CMMI authority can be extended or at what point it is no longer available, what authorities would be necessary for continuing high performing programs, or to what extent this is still an open question. In particular, CMS should address whether it will be possible for any of the current FAI states to remain in an FAI or whether all must be transitioned at once, or one by one, and announce transition dates for each. If additional time is needed to minimize disruption in a particular state it will be important to note these instances as soon as possible so everyone has a clear understanding of their path forward.

CMS outlines a number of policy and operational issues that must be addressed to make this transition work. We agree with these and suggest that CMS could help to avoid 50 different state approaches, by developing and offering several templates to states for starting points reflecting different stages that include minimum standards for key elements with some customization opportunities along with best practices needed to provide flexibility.

Section II A. 12. Maximum Out of Pocket (MOOP) Limits

The SNP Alliance understands the importance to states of the changes to the calculation of the MOOP value, however we caution CMS to be conscious of unintended consequences. Since these changes will most certainly impact those plans serving the greatest number of dually eligible individuals, and will directly impact rebate dollars, the impact will be most significantly felt by those smaller D-SNP plans and will be translated into reduced supplemental benefits by the very members who need them most. Many D-SNPs already must use part of their rebates to buy down Part D premiums for their enrollees to assure they don't have premiums, putting them at a competitive disadvantage with other MA plans.

Secondly, this may drive greater numbers of dually eligible members AWAY from integrated D-SNP plans into general MA, thus further creating another barrier to address the goal of CMS and of the SNP Alliance to advance dual integration.

II. C. Amending MA Network Adequacy Rules to Facilitate I-SNPs

We are concerned that the changes in contracting deadlines for the MA network adequacy proposal will make it even harder for small D-SNPs already facing challenges in obtaining providers to serve high-cost complex populations with serious SDOH barriers, even harder, driving up costs and stimulating provider resistance.

We also have recommendations on how network adequacy standards should recognize unique issues for I-SNPs. CMS' network adequacy requirements are intended to assure that members of MA plans have reasonable access to Medicare covered services. However, these requirements do not recognize the unique provider access and needs of individuals enrolled in an I-SNP. The SNP Alliance has had discussions with CMS around these issues and remains disappointed that CMS has not recognized the serious nature of these problems. Failure to recognize how providers and services are provided often results in an inability for I- SNPs to start up or to expand their service area because CMS does not consider access to provider types who travel to the facility to furnish services but whose offices are not located within CMS' time and distance standards and does not consider changes to network requirements for providers that I-SNP members seldom need. In addition CMS has not recognized the fundamental challenge arising from the increased concentration of market power by health care systems in their

catchment areas which has resulted in a growing number of markets health care systems unilaterally refusing to negotiate with I-SNPs regardless of the terms in circumstances where the health care system may currently contract with MAOs.

To address these problems, the SNP Alliance recommends a plan by which CMS could address these issues allowing I-SNPs the option of being approved either to offer both an I-SNP plan and other MA plans or to offer only an I-SNP plan. For I-SNPs that elect the latter option, the network adequacy requirements would be tailored to meet the access needs of Medicare beneficiaries residing in a nursing facility.

Section II. D. Part C and D Quality Rating System

The SNP Alliance is concerned that the use of the HOS instrument and methods to calculate these measures is ill-advised, particularly during the measurement years of 2020, 2021 and 2022 as the impact of the pandemic continues. The virus and mutations remain present in communities and the impact on healthcare, social service, mental health and other providers in the measurement year has been profoundly negative. This has impacted ability of providers to conduct screening, communicate directly with their patients, and has impacted beneficiaries' experience of care. Such external environmental factors impact the self-report of the beneficiary on these HOS-derived measures. Special needs populations are particularly impacted, their enrolled members have complex conditions and high vulnerability to COVID-19. We are therefore concerned that data collected from the self-report HOS during these years to generate measures may indicate changes in provider practice or beneficiary behavior (reluctance to go into an office and inability to access telehealth given lack of technology) rather than health plan actions. In addition, survey response rates have been low and may not be representative of the enrolled membership in the plan. For these reasons, we cannot support this provision to include these three HOS measures and remove the 60 percent rule.

II. SNP ALLIANCE COMMENTS ON PROVISIONS OF THE PROPOSED RULE

A. Improving Experiences For Dually Eligible Individuals

3. Enrollee Participation in Plan Governance (§ 422.107)

c. Proposal for D-SNP Enrollee Advisory Committee

CMS proposes to require MA organizations offering D-SNPs in a state to establish at least one enrollee advisory committee in each State to solicit direct input on enrollee experiences, including a reasonably representative sample of individuals enrolled in the D–SNP(s), to solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations. Medicaid already requires an advisory committee for plans offering MLTSS programs and CMS states these committees could be combined. CMS asks for comment on whether more prescriptive requirements are needed and whether a merged committee could negatively impact an MLTSS committee.

SNP Alliance Comments: The SNP Alliance is pleased to support the requirement that MA organizations sponsoring D-SNPs establish an advisory committee including enrollees, family members and other care givers for direct input on enrollee experiences and other important topics. We agree it is essential to include the perspective of these stakeholders in plan operations and that their input and

feedback will strengthen the value of D-SNPs to members as it has in MMPs, and other programs cited by CMS.

In general we support allowing a combined advisory committee that includes both LTSS and non-LTSS members. Many SMAC contracts include both eligibility groups and it would be burdensome on states and plans and also on consumers to be required to establish and track feedback from two separate committees where significant issues would undoubtedly overlap unless the members, states and the plans agree there are important reasons to maintain separate committees and are willing to make the additional effort for two committees. However, we also understand that it would be best if the committee membership included members with the same managed care benefit structures and coverages. This could be resolved by allowing sub-committees of larger committees or other arrangements best worked out between states, stakeholders, and plans.

CMS should also clarify whether committees are to be organized at the contract level or the PBP level and should consider how the final rules related to the D-SNP contracting sections relate to the committee structures. For example, even if contracts are still allowed to be multi-state, it will not work for advisory committees to span states, given the need to coordinate with state Medicaid committees.

We agree with CMS that additional proscriptive requirements are not necessary at this time. Flexibility should be maintained to accommodate differences in populations served, service areas (rural versus urban for example), models of care and services provided, as well as to build on past experience of committees that are already in place and recognition that others would be just starting. Additional requirements at this point may be premature, as they could conflict with combining the two committees and/or with current or proposed committee parameters in states where such committees are already established and operating.

Once more of these committees are fully operational and as CMS monitors and evaluates committee experience as proposed through CMS audit protocols, CMS could consider added requirements in the future if necessary. CMS might also want to consider the option of implementing the committees in the FIDE and HIDE SNPs first, giving less integrated plans (coordination only D-SNPs without provision of Medicaid services or D-SNPs serving only partial-duals) a little more time to build their committees prior to starting audits.

Finally, we ask that CMS provide technical assistance and guidance documents and/or training to plans, states, and consumer advocates on effective and standardized practices for these committees. CMS should also clarify expectations around the meaning of "at least a reasonably representative sample of the population enrolled" requirement. In addition, CMS should make provisions for removing any barriers to enrollee participation by ensuring that appropriate transportation or other means of access to meetings is covered, allowing teleconferencing options, and allowing participants to receive some remuneration for their expertise, time and efforts, such as lunches or gift cards.

4. Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments (§ 422.101)

CMS proposes to amend § 422.101(f)(1)(i) to require that all SNPs (chronic condition special needs plans, D-SNPs, and institutional special needs plans) include one or more standardized questions on the topics of housing stability, food security, and access to transportation as part of their HRAs.

SNP Alliance Comments: ***We support with modifications.***

The SNP Alliance has long called for recognition of social determinant of health characteristics which predominate in special needs populations. We support this with modifications. We offer several recommendations and considerations that we hope will improve utility and advance the stated goals.

Consistent Screening for All Beneficiaries, Particularly Dually-Eligible Individuals - There is an extremely robust body of evidence indicating that social risk factors impact health and health outcomes across all population groups, and that people who are dually-eligible are especially at risk. We believe it is crucial that social risk screening be done for all beneficiaries, particularly dually-eligible individuals, at least once a year, whether they were enrolled in a general Medicare Advantage plan, SNP, or in Traditional Medicare. This foundational for understanding individuals and for building better systems of care and support—all beneficiaries in these programs may have hidden risk factors that we hope they will share with providers in the course of their health and social support care-seeking. We'd recommend that CMS work to incorporate social risk factor (SRF) screening consistently across the Medicare and Medicaid programs.

Additional Risk Factors Are Very Important – In this and other rules, CMS is proposing enhanced social risk factor screening, on housing instability, food insecurity and transportation barriers. Based on working with special needs populations we recommend additional risk factors be included in this effort. Additional assessment around factors such as functional status, frailty, spoken language, and health literacy as these characteristics strongly impact both beneficiary behavior and care/treatment approaches. Moreover, the

Need to Utilize Data from Many Sources - We recommend that CMS work with stakeholders to harmonize and standardize SRF data obtained from many sources--so that where-ever and when-ever the individual beneficiary chooses to answer SDOH/social risk factor questions, there will be a standard way to score/interpret the information and capture/transfer this to an electronic record. Again, understanding a person's social risk factors helps understand some of the barriers to health for that person. Such barriers are also likely some of the impediments to achieving health equity at a population level.

Requiring a Standard Tool or Standardizing Information? - Over the last decade there have been efforts to develop, test, and use SDOH screening and assessment tools in all settings (including the AHC tool referenced). These efforts and the SDOH information generated have been welcomed by SNPs and MMPs. Many good tools, processes, and scoring algorithms have been developed. We have seen their use in clinics, FQHCs, social service agencies, care management programs, counties, government agencies, and other settings including by health plans—by physicians/primary care providers, care coordinators, county case workers, community health workers, and other disciplines. This work needs to continue and should be supported.

CMS issued the 2023 Advance Notice where it indicates NCQA is also developing a SRF measure for these areas. While we support standardization of SRF data, we believe requiring the use of one tool and focusing only on the HRA as the instrument and only on health plan as the screener will miss many opportunities to understand the beneficiary's risk issues and therefore will have limited impact. Utilizing multiple sources and creating a crosswalk from various data sources to a common standardized scale might be preferred if the goal is to have a timely and accurate picture of social risk factor vulnerabilities.

The SNP Alliance supports standardizing the scoring/scaling for key social risk areas and this direction by CMS. We do not know if the AHC screening items on housing, food, and transportation are widely used by providers or plans. We do know that providers and plans, as well as others, such as nonprofit advocacy or community organizations, counties, Medicaid agency case managers, are also conducting social risk screening.

CMS is encouraged to work with stakeholders to harmonize and standardize data obtained. This may be on top of a standardized HRA that plans administer once a year.

We have several recommendations along this line to improve the utility, feasibility, and accuracy of this effort:

1) Recognize the top risk factors experienced by dually-eligible individuals. Based on those enrolled in special needs plans, these top risk factors are: (*1) social isolation, (2) food insecurity*, and (*3) housing instability* (transportation is not ranked by SNPs we've surveyed as in the top three)

2) *Support the work already being done*—screenings, assessments, scoring, processes—are often already being done to obtain SDOH risk factor information directly from the beneficiary. We recommend using what is already collected and captured in a data set in a standardized way, and that providers, state or county agencies or others who work with the beneficiary must provide these data to the health plan (under Medicare and Medicaid, particularly for dually-eligible beneficiaries).

3) Recognize multiple sources of SDOH information, not only that which is collected from an HRA once a year; *allow these sources to populate that portion of the HRA* when the information is still timely/relevant/recent.

4) Develop a *sound methodology for cross-walking and harmonizing SDOH risk factor information* for each target item (e.g., housing instability, food insecurity, social isolation, etc.) across the frequently used validated instruments to allow for a consistent risk factor score/scale

5) Consider when/if there need to be *exclusions or adjustments*, such as if a person permanently resides in a nursing facility—the risk factors of housing and food insecurity may not be applicable.

Each one of these points is discussed in more detail to provide CMS with additional information and analysis from special needs health plans. We've worked to organize our comments to offer important and practical considerations to increase the utility and value around stated goals.

Top SDOH risk factors in the SNP and MMP populations –We've surveyed SNP and MMP members for five+ years on the many sources for SDOH information that they use to better understand these risk factors facing each member. These plans already use multiple sources, starting with the member (usually in conversation with their care manager, community health worker, primary care provider, or other regular social services provider). NOTE: *The HRA is not the primary source of SDOH information, nor should it be.*

As observed and reported by the care manager and clinical services teams as well as outreach specialists, the SDOH ranked priorities (in addition to addressing poverty) are: (1) social isolation, (2) food insecurity, and (3) housing instability. Transportation has not been as high on the list of observed needs/risk areas--perhaps because many SNPs provide transportation as a supplemental benefit, knowing that their members need access to transportation for medical appointments, and key daily living needs, such as getting food.

Allow Multiple Sources - We recommend that health plans be able to receive SDOH information from multiple sources and then crosswalk this to the standardized items preferred by CMS and use this

information to populate the HRA. We do not believe requiring the use of one instrument at one time of administration by a health plan designee will recognize all of the important work and current sources, people, and timing for when SDOH items are queried.

SNPs already mine the following data sources for SDOH information:

- Care management interactions, care management records
- ICD-10 z codes
- Member surveys
- Member services contacts (phone and other communication)
- Provider records/EMR or EHRs
- Enrollment forms
- HRA
- Claims data
- Encounter data
- MLTSS or State Medicaid data - For fully integrated plans where the state provides that information

This information comes from a variety of individuals who work with the member, and in the form of electronic data, manual records, and also may be generated from A.I. algorithms that are based on patterns of access, use, and other behavior by the member. The beneficiary is the primary source of data on SDOH. These other sources listed can provide "early warning signals" for the provider or plan to act earlier than might occur if waiting for an annual HRA to be completed. These multiple data sources are used for outreach, member support, care management, interdisciplinary teams, individualized care planning, service provision, treatment, and other purposes.

For example, if a dually-eligible person is receiving SNAP benefits to address food insecurity and is nearing the date when that person needs to re-apply, the care manager working with the individual may receive an alert one month early to ensure that the application is completed and submitted in time. This helps avoid a gap of weeks or months where the individual no longer has food assistance. In this example, the care management system is the SDOH risk factor data source—and the plan can use the information already collected to address this risk area. With all of the work put in place already by systems, providers, advocates, government agencies, and others, we assume CMS does not want to dismantle or supersede these efforts.

Support SDOH Pathways and Validated Screening/Assessments Already in Place and Recognize the Beneficiary Preferred Contact –

Consider the Beneficiary –The beneficiary may be willing to report on their SDOH risk factors to a trusted provider, case worker, or other person who is involved in their care and have this information be included /considered in the Interdisciplinary Care Team communication, and incorporated into care planning, care management, and service provision. This would not rely on a once-a-year HRA process to obtain this SDOH information for health plans to be compliant. If the information from the member to a trusted provider would be acceptable to be transmitted to the health plan, then the health plan would be able to use this in HRA, ICP, ICT and other care coordination and outreach efforts.

An important consideration is that of burden and burnout on individuals who may be asked these SDOH questions multiple times. These types of questions are often seen as private/intimate questions, and the person who has the greatest trust of the person is often the best person to ask the questions. Timing is important as well. The HRA is conducted one time a year and many people choose not to participate or are hard to reach—this is not the primary source of SDOH information used by health plans anyway. We

would recommend that CMS recognize and support ways to populate standard SDOH items that would be incorporated into the HRA and other key elements of care, but not require one tool at one time.

Data Standardization - One consistently identified challenge reported by SNPs and MMPs is that there is no standardization in SDOH data definitions or harmonizing in scaling/scoring between instruments. To address this one can either require a specific instrument across all settings and providers as well as health plans (e.g. AHC) or allow for multiple instruments where items and scoring are cross-walked to create a universal scale. This is an important decision to be made around HOW to standardize data elements and items/scales to arrive at a comparable scoring method.

Standardizing after data collection using multiple sources would recognize and support the use of SDOH risk information already collected and will further the stated CMS objective: "*having a more complete picture of the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence, "and* also to*: "facilitate better data exchange . . .as well as facilitate the care management requirements."*

Cross-walk Methodology and Harmonize SDOH Sources for Equivalency - We recommend that CMS work with experts to conduct a cross-walk of the chosen SDOH risk factor items from validated instruments and then create an acceptable equivalence to harmonize, calibrate and connect the items, scaling, scores, and findings from the various instruments to one standardized universal scale for each SDOH risk item. This can be done. The process would require experts in survey design, quality measurement, SDOH risk areas, health I.T., and providers, plans, government agencies and consumer stakeholders. This effort is fundamental. Many have called for this work to happen; the time is right.

HHS/CMS would serve in a leadership role to ensure the crosswalk meets acceptable scientific standards has the appropriate testing among various population groups and can produce results that are usable. In this way multiple instruments would be the source of information that populates the SDOH items in a profile of the member (which could be then included in the HRA). It would be used to populate part of the HRA as long as the information was collected according to some parameters (e.g., directly from the member within the last year or specified time period) as an alternative to asking the individual directly again. In other words, if they've answered these SDOH items, that information would populate these items on the HRA.

With more data sources and disciplines involved—the individual beneficiary's response and information collected has exponentially greater utility. With this information harmonized using the universal scale, it can be used by the provider, plan, social service and support agencies—those who have a relationship with the individual in care planning, treatment, service provision, and coordination. Important information already being collected would not be lost or discounted, and this would reduce beneficiary refusal and burden.

AHC Screening Tool - If CMS choses to go ahead with the AHC assessment tool and the requirement to focus on the three risk factors and use the items as they are now in the AHC tool, we have the following questions:

1. Will all MA plans (not only SNPs) be required to perform annual screening through an HRA?

2. Would the standardized questions be required at the initial, reassessment, and transition HRAs?

3. Would responses by the individual where a need is found then trigger specific action within a specific time period by a specific entity (such as referral to a county case worker to respond and

assist with rental assistance)? Who will decide what action is necessary? Who/when is action/follow-up documented?

4. Have the AHC questions and scoring been tested with diverse population groups to ensure there is adequate understanding such as with persons having significant cognitive limitations or linguistically/ethnically diverse communities? Can this information be shared?

5. Are there considerations around accommodation, translation, or method/format changes needed to reach diverse individuals and gather the information in an appropriate manner? We are thinking of the diverse populations—ethnically, racially, linguistically, culturally—served by SNPs and would appreciate insights on how these groups have responded to the AHC screening questions and follow-up.

6. If an individual refuses to complete the HRA, but this information is gathered in other ways, can the health plan continue to utilize these other sources to comply with the spirit of the intent? How can this be demonstrated?

7. Will CMS be developing a standardized set of items for all HRA questions, not just the social risk factor questions? (currently there is not a standardized set of items or scale)

8. Are there exclusions (for example, Nursing Home Residents) - We appreciate the importance of focusing on specific social risk areas and support this work. However, the housing, food, and transportation needs of people permanently residing in nursing facilities are already addressed. Would these questions be relevant for these individuals? There may be other important characteristics to consider as the measure is developed—such as contraindications, attention to beneficiary refusal and beneficiary rights/consent, and exclusions.

The improvement in consistent SRF screening, use of SRF data already collected, engagement of the person being screened, and aggregation of information to guide measurement are all steps that will be needed and capacity that must be built. We strongly support this work. These are building blocks for addressing health disparities and improving health equity.
Therefore, we encourage the efforts around SRF screening and Health Equity improvement and evaluation to be synchronized and aligned. Social risk screening, stakeholder outreach and engagement, measure development, and performance evaluation should be seen as components of a system to support health and health equity improvement.

In closing, we understand that CMS will be exploring with stakeholders the utility and feasibility of social risk screening. We hope that there is interest in the harmonization and universal scale for the chosen SDOH risk areas. We hope the agency will be open to the use of multiple instruments and reporters and recognize existing work that has been done to incorporate SDOH attention into care planning documents, EHRs, outreach and service records, and other databases. We applaud CMS' commitment to working toward having standardized data around SDOH risk factors. We stand ready to assist in any way we can.

5. Refining Definitions for Fully Integrated and Highly Integrated D-SNPs (§§ 422.2 and 422.107.

***a. Exclusively Aligned Enrollment for FIDE SNPs (*§ 422.2)**

CMS proposes that all FIDE SNPs must have exclusively aligned enrollment. CMS indicates that with this change, twelve plans would lose FIDE status but could continue as HIDE SNPs. Six would no longer get the frailty adjuster but could move to HIDE SNP status and CMS would allow a cross- walk and a separate PBP if plans can't meet this requirement in order to maintain access to the frailty adjuster. CMS also proposes that FIDE SNPs could no longer enroll partial dually eligible members, but CMS will allow separate PBPs for partially duals only.

SNP Alliance Comments: The SNP Alliance is pleased to support this provision. There are longstanding assumptions among many researchers and policy makers that FIDE SNPs already have exclusively aligned enrollment, and that such alignment is a basic element of integrated care delivery under a D-SNP model. The original demonstration plans that resulted in the first FIDE SNPs all had exclusively aligned enrollment as do the MMPs. However, more recently it has become obvious that current interpretations of technical regulatory provisions did not require that FIDE SNPs fully align their enrollment so that enrollees are provided both Medicare and Medicaid by the same plan or parent company, weakening the original intent for meaningful seamless coverage of services under one entity and causing confusion as to the purpose and definition of the FIDE SNP category.

We agree with CMS that the FIDE SNP should represent the highest level of integration and that this change will help clarify the currently confusing levels of integration among D-SNP categories while also assuring access to integrated grievance and appeals which are required for exclusively aligned plans and thus, we welcome this change. While this change will require some adjustment, where six plans may need to move to HIDE SNP status where they would currently lose access to the frailty adjustment, we appreciate that CMS provides a mechanism for affected plans to maintain access to the frailty adjustment through a separate PBP and by providing a cross walk exception to facilitate these enrollment changes.

We also recommend that CMS consider making exclusively aligned enrollment a requirement for HIDE SNPs and as part of that change, we recommend that CMS allow HIDE SNPs providing MLTSS services to access the frailty adjustment. With these new changes, there will be no significant differences between the Medicare populations served under HIDE status versus FIDE status, so there should be consistent payment rules between the two categories as well.

The SNP Alliance strongly supports pathways for continued enrollment of people with partial dual eligibility into D-SNPs. As more is known about the partial dual population it is clear that the characteristics of this group are more similar to fully dually eligible groups and can benefit from access to stronger care coordination models not generally available in non-SNP MAOs. While we understand that FIDE SNPs thus far have not included partial duals in their enrollments, we appreciate CMS clarifying their intentions on this issue by providing a pathway for continued enrollment of people with partial dual status into non-FIDE D-SNPs through establishment of separate or additional PBPs for each group. This provision will help avoid the complications arising from the differences in access to Medicaid benefits between the two Medicaid eligibility groups by allowing necessary distinctions in communications and member materials.

This PBP mechanism also allows for differences in supplemental benefits designs between full benefit dually eligible and partially dual eligible groups. Targeting some supplemental benefits to

members with partial dual eligibility who do not qualify for full Medicaid could increase access to services for that group and be useful to states, perhaps leading to some financial incentives for states to support D-SNP enrollment and possible shared savings opportunities.

While we recognize that these changes also place an additional burden on some plans, we believe these measures are much preferable to disallowing enrollment of those with partial dual status in D-SNPs as some policy makers have advocated and are far less radical than some other integration legislative proposals that have been promoted.

We are concerned that states will need extensive education and assistance to plan for these changes so we strongly request that CMS work closely with states to explain how they may need to plan ahead to change contracts and procurement accordingly as well as to encourage the use of the cross walks into D-SNP options for partially dual eligible members. Such options could include enrollment into HIDE SNPs. CMS should also work to inform states about how differences between aligned and non-aligned plans impact unified grievance and appeals and marketing materials and clarify that such unified features do not work well for non-aligned enrollees. We also recommend that CMS provide further clarification on the cross walk for transitioning unaligned enrollees from FIDE SNPs, including allowing plans to initiate such movement towards exclusive alignment.

Finally, SNP Alliance members point out that alignment should also include matching Medicare and Medicaid effective dates for enrollment and disenrollment into FIDE and HIDE SNPs. Without alignment of effective dates, there are significant gaps in coverage (often one to two months) where beneficiaries may still remain in non-aligned plans or FFS for either program causing disruption and confusion for members and providers as to what plan, program or system is responsible for providing benefits. We recommend that CMS look at states where effective dates have been aligned and facilitate CMS mechanisms that promote such alignment, including encouraging states to tweak their processes where needed and providing them technical assistance in how that can be done.

b. Capitation for Medicare Cost-Sharing for FIDE SNPs and Solicitation of Comments for Applying to Other D-SNPs

CMS proposes that FIDE SNPs would be required to capitate cost sharing including for QMB and non QMB FBDEs. All FIDE SNPs currently are capitated for cost sharing, CMS wants feedback on applying this requirement to all D-SNPs despite their observation that there are problems involved in that expansion.

CMS also solicits feedback on the pros and cons of requiring State Medicaid data exchanges to provide real-time Medicaid FFS program and Medicaid managed care plan enrollment data with D-SNPs, and the impact on States, Medicaid managed care plans, D-SNPs, providers, and beneficiaries.

SNP Alliance Comments: The SNP Alliance supports the application of this proposal to existing and new FIDE SNPS. The ability to use one transaction for provider billing reduces burden on providers while facilitating more efficient integrated claim determinations and also reduces barriers to access to providers where some are electing not to serve dually eligible beneficiaries because of cost sharing issues. The fact that all FIDE SNPs are currently meeting this requirement

indicates that it makes sense to build on this current experience to work toward application to all D-SNPs.

Capitation of Cost Sharing Beyond FIDE SNPs.
However, as CMS notes, applying this to all D-SNPs may pose additional challenges which, we want to clearly point out, can only be resolved by cooperation and agreement from states. While we agree with CMS goals to move in this direction, we are concerned that some states may be invested in their current cross over claims processes for cost sharing which may be organized based on historical Fee for Service (FFS) structures, separate from plan capitations. There is concern over the potential that some states might reject or reduce D-SNP contracting if it is too difficult for them to adapt their operations to accommodate this new feature. If CMS were to implement this for all D-SNPs, we also strongly recommend that CMS ensure there are mechanisms in place to avoid jeopardizing a D-SNP's overall SMAC agreement with the state over lack of agreement on this issue.

As CMS noted, it may be less complicated for states where there is no Medicaid managed care perhaps resulting in fewer barriers to making this change, however, it may still take some investment in actuarial and systems modifications for states to do so. CMS notes further complications arising when enrollment is not aligned between D-SNPs and Medicaid managed care organizations.
Therefore, we further recommend that CMS provide further clarification of how this proposal would work in non-FIDE D-SNPs where the state does not adopt capitated arrangements to pay the D-SNP for cost sharing or how this provision would work when enrollment is not aligned. Whether or not CMS expands this provision beyond FIDE SNPS, we recommend that CMS develop additional technical assistance and guidance documents for states to assist them with implementation of this provision. It could also be helpful if CMS could clarify whether additional FFP is available to state Medicaid agencies such as whether any needed IT changes for addressing this issue would qualify for the enhanced 90% Medicaid FFP and convey this to states. We also wonder whether there are any financial benefits for states in applying a capitation provision to both categories of Full Benefit Dual Eligibles (FBDEs), i.e. QMBs and Non-QMBs, and whether this could act as a small incentive for states to make such a change. If so, CMS should also point this out to states.

We suggest that CMS might find it helpful to establish a technical expert panel of states and plans to identify and promote best practices for handling capitation of cost sharing across various case scenarios and to consider some of the responses CMS may receive from proposals and requests for comment on capitating cost sharing beyond FIDE-SNPs.

Ultimately, we request that CMS explore its authority to make this a requirement for the state, instead of a requirement directly on the D-SNP, since states have control over this feature and D-SNPs do not.

Enrollment Data Exchange
CMS also requests comments on pros and cons of requiring State Medicaid data exchanges to provide real-time Medicaid FFS program and Medicaid managed care plan enrollment data with D-SNPs, and the impact of such a requirement on States, Medicaid managed care plans, D-SNPs, providers, and beneficiaries. The SNP Alliance has supported recent changes requiring daily submission of Medicaid dual status and eligibility data by states through the MMA files and we would support efforts to improve and increase exchange of useful data such as Medicaid

enrollment between states and D-SNPs, particularly those where enrollment is not aligned. We are not sure whether "real time" data exchanges are realistic for states or what the advantages over daily submission of Medicaid and Medicare enrollment in the MMA or other files would be, however we support data exchange that would provide access to comprehensive information on which plans are responsible for which benefits and we think such a data base would benefit states, plans and ultimately beneficiaries by facilitating communications and care coordination between the payers.

The SNP Alliance has long pointed out that the current MMA data exchange includes a serious gap, in that there appears to be no consistent or required process for states to provide D-SNPs (especially those serving members with unaligned enrollment) with information on the Medicaid plans in which those enrollees may be enrolled as well as HCBS waiver status and contact names and numbers for Community Based Organizations responsible for providing those HCBS services. As we have stated before, obtaining this information directly from enrollees is often unreliable because of the complexity of Medicare, Medicaid and provider care system products and product names as well as language and cognitive barriers. Knowing where Medicaid enrollees are enrolled as well as their waiver status is necessary for D-SNPs in order to fulfill their integration requirements for coordination with Medicaid benefits. Current data sharing mechanisms for care coordination as required under the 2018 BBA requirements may cover only a subset of members. Since CMS already uses the MMA file to provide Medicare enrollment data to states, we have suggested it could include this Medicaid enrollment and waiver status data which states or CMS could then share with D-SNPs responsible for coordinating with Medicaid.

If it is not realistic to include this information in MMA files and share it back with D-SNPs, we continue to request CMS to determine other consistent and reliable methods of exchange which should be included in any proposed data exchange improvements. Some states have provider and plan portals that can be accessed to determine enrollment status, and some include clearly marked integrated products and waiver status in these portals. This might be another option, though it would still require daily maintenance and updating and would lack the utility of shared files that can manage a more comprehensive data exchange.

We strongly recommend that CMS establish a technical expert panel of states, plans, CMS and IT experts to work out details of this exchange. CMS should also assure states that related IT costs would be covered for at least 90% FMAP for any necessary system changes on their part. We continue to be interested in working with CMS to find solutions that provide efficient and timely tools to states and plans for sharing of this essential information and would look forward to participating in this effort.

c. Scope of Services Covered by FIDE SNPs

(1) Need for Clarification of Medicaid Services Covered by FIDE SNPs

CMS says the way they have interpreted current provisions which allows carve out of all BH and other services "consistent with state policy" is not in keeping with full integration. FIDE SNPs should represent the highest level of integration. However they would revise carve out policies and allow some according to section A. 1 e. below.

SNP Alliance Comments: The SNP Alliance appreciates CMS' acknowledgement that previous carve out provisions were not consistent with the original intent of integration goals and that the FIDE SNP definition needs clarification. We welcome and support this

change along with the continued flexibility to allow some limited carve outs. (See further discussion of carve out language below under Section e. Medicaid Carve-outs and FIDE SNP and HIDE SNP Status.)

(2) Requiring FIDE SNPs to Cover All Medicaid Primary and Acute Care Benefits

CMS would require FIDE SNPs to cover all primary and acute care benefits covered by Medicaid including cost sharing, CMS asks for comment on examples for items that should be exempted. CMS would not consider NEMT to be primary or acute.

SNP Alliance Comments: The SNP Alliance supports this requirement. This provision provides further clarity and standardization to the FIDE SNP definition and also begins to address our previously requests for further consistency and transparency in the contract review process. However, additional clarification on how states will conform to this requirement and what happens if a state refuses to clarify their contracts is still needed. We agree with CMS that NEMT, while an important services, should not be considered a primary or acute care services for purposes of this definition.

We do have a question as to how dental benefits will be considered under this proposal. Some states cover dental benefits under Medicaid, though coverage is often limited, and some may not. Some states have contracts with larger dental management companies to provide such benefits making it harder to include these benefits in D-SNP capitations. Many MA plans including some D-SNPs provide additional dental services through supplemental benefits. CMS should clarify whether and how dental benefits are considered as part of the scope of benefits and carve out policies.

(3) Requiring FIDE SNPs to Cover Medicaid Home Health and Durable Medical Equipment

CMS proposes that this provision would be effective 2025 and is not expected to impact any current FIDE SNPs.

SNP Alliance Comments: The SNP Alliance supports this proposal. Again, this provision appears consistent with the original intent of the FIDE SNP category of integration and other changes being made. We appreciate the delayed implementation in 2025 in case there are unforeseen issues and request that CMS clarify what happens if states do not conform to this requirement.

(4) Requiring FIDE SNPs to Cover Medicaid Behavioral Health Services

CMS has allowed FIDE SNPs to have full carve out of behavioral health (BH) services, but CMS points out conflicts between their 2019 final rule which added BH to FIDE SNP requirements and their "consistent with state policy" language. Therefore CMS proposes to replace the earlier language with "requires coverage of the following benefits to the extent Medicaid coverage is available to individuals eligible to enroll in a FIDE except as approved by CMS" in A. 5 e. below.

SNP Alliance Comments: The SNP Alliance welcomes CMS' clarifications which would correct previous inconsistences, help reduce confusion as to the different D-SNP integration categories and strengthen the FIDE SNP as the most integrated D-SNP model.

We also appreciate the delayed effective date of 2025 which we hope provides enough time for states and plans to make any necessary network changes.

While we appreciate the analysis that CMS has provided on impacts on current FIDE SNPs, given that there is great variety among states on how behavioral health programs are designed, funded and delivered, CMS should provide further clarification on how the remaining seven FIDE SNPs will be able to comply with this requirement, as well as provide technical assistance to both D-SNPs and the states involved to find pathways for them to comply. CMS could also consider a longer timeframe for compliance or additional temporary carve outs to allow for transitions. CMS should also clarify what happens if states do not want to conform to this requirement.

d. Clarification of Coverage of Certain Medicaid Services by HIDE SNPs (422.2)

CMS updates the HIDE SNP definition with similar language to that for FIDE SNPs though it requires at minimum that MLTSS OR BH be included. CMS also clarifies that LTSS includes "community based LTSS and some days of nursing facility coverage services during the plan year" or behavioral health to the extent Medicaid coverage of such services is available to individuals eligible to enroll in a HIDE SNP in the state.

SNP Alliance Comments: The SNP Alliance supports this proposal. This provision also parallels the FIDE SNP provisions, and further clarifies the differences between D-SNP levels of integration, reducing current confusion and providing more transparency of the SMAC review process that determines these categories of integration while continuing to allow some carve outs and retaining the initial flexibility for HIDE SNPs to provide either LTSS or behavioral health services. However, we request clarification on whether these or other CMS provisions in this rule limit HIDE SNP enrollments to exclusively aligned enrollment or otherwise limit unaligned HIDE SNP plans. While we fully support enrollment alignment, we also recognize that states may be on different pathways towards that goal and may need some flexibility to design programs and benefit offerings to meet their needs as they move along. For example, we can envision such flexibility might also be needed temporarily to reduce beneficiary disruptions while states seek legislative, procurements or other permissions to make these changes. We request that CMS provide additional clarification on defining these options for states.

e. Medicaid Carve-outs and FIDE SNP and HIDE SNP Status.

CMS proposes to codify current CMS policy allowing limited carve-outs from the scope of Medicaid LTSS and Medicaid behavioral health services that must be covered by FIDE SNPs and HIDE SNPs. A *D-SNP may meet the FIDE SNP or HIDE SNP definition at § 422.2 even if the contract between the State and the plan carves out some Medicaid LTSS, as long as the carve-out, as approved by CMS, applies primarily to a minority of beneficiaries eligible to enroll in the D-SNP who use long-term services and supports (*and or *behavioral health) or constitutes a small part of the total scope of Medicaid LTSS (or behavioral health) provided to the majority of beneficiaries eligible to enroll in the D-SNP. CMS seeks comment on whether they have struck the right balance in permitting such carve-outs, including comments on several examples cited.*

SNP Alliance Comments: The SNP Alliance supports this proposal since it codifies current policy and CMS has already acknowledged that there have been inconsistencies in past interpretations. However, without eliminating the necessary CMS flexibility for conducting

reviews and making these decisions, the SNP Alliance requests more clarification on what is meant by "a minority of beneficiaries eligible to enroll" and "small part of the total scope of services." CMS should provide additional examples or further description of the review process they will utilize to make these determinations. In addition, please see comments on dental benefits mentioned earlier. CMS should also clarify what happens in certain states that impose caps on MLTSS eligibility resulting in enrollment limits and how this carve out provision would be applied or affected in those cases.

In addition, CMS should take into consideration when determining criteria for carve outs in applicable integrated plans (AIPs with exclusively aligned enrollment) that even minor Medicaid carve outs can greatly complicate the unified G&A process to which they are subject, causing more confusion for beneficiaries and providers as well. CMS should educate states about these impacts as part of the process.

f. Service Area Overlap between FIDE SNPs and HIDE SNPs and Companion Medicaid Plans

Currently, D-SNPs can meet the requirements to be designated as a FIDE SNP and HIDE SNP even if the service area within a particular State does not fully align with the service area of the companion Medicaid plan (or plans) affiliated with their organization, CMS says this is an unintended loophole and that some plans have been approved with little overlapping service areas (as pointed out by MedPAC and MACPAC). CMS proposes to require that the FIDE or HIDE SNP capitated contract must include the entire D-SNP service area starting in plan year 2025. CMS will not limit the Medicaid service areas. CMS wants comments on alternatives such as a minimum percentage or to codify how current requirements could allow this and whether this would accomplish integration goals in this rule.

SNP Alliance Comments: The SNP Alliance supports applying this proposal to FIDE SNPs since all of them currently already comply with this requirement. The SNP Alliance has long held the position that dually eligible members should be enrolled under one parent company for both Medicare and Medicaid as are most FIDE SNP enrollees. But for actual enrollment alignment to take place and for any efficiencies or simplifications and effective care coordination to be gained for both plan sponsors and members there also needs to be significant overlap of service areas. We have often asked for more detail on how CMS conducts SMAC reviews and how decisions on HIDE status are being made and we continue to wonder what has led to decisions that result in little alignment, so we appreciate CMS' willingness to review these policies and propose this more aligned approach. We believe that this change is better than the status quo and will create improvements addressing overall policy goals for enhancing integration.

We also appreciate CMS providing options for HIDE SNPs to achieve additional enrollment alignment or to utilize cross walks exceptions to serve members in non-HIDE coordinated D-SNPs. We are hopeful that as states become aware of the need to address this issue in their contracting that they will make the necessary changes. However CMS must aggressively educate states about how this issue impacts access to integrated options for people with dual eligibility and we urge CMS to provide states strong guidance and technical assistance on the need to address this issue in their procurement practices.

We also note that coming into compliance may take longer than the proposed 2025 effective date. Therefore, we support temporary extension of the current policy which permits D-SNPs to be designated HIDE SNPs even if their service area within a particular State does not fully align

with the service area of the companion Medicaid plan (or plans). This should be carefully crafted to be invoked only on a limited and temporary basis for the purpose of reaching a goal of full compliance for HIDE SNPs in cooperation with a state. Such a policy would provide CMS and plans some flexibility as HIDE SNPs and states work to phase in more aligned arrangements over time. At this point we would not support a specific minimum percentage of a service area because a useful percentage would be hard to determine. Would it be based on geography, population density or access to medical services, characteristics of enrollment or some other metric? Since service areas can be assessed in a variety of ways, we would support an attestation for this provision. If CMS sees problems with the attestation process, they could address this in a later proposed rule.

We see no need to include FIDE SNPs in such an amendment and would oppose their inclusion since it would erode some of the alignment currently expected as part of fully integrated plans, and also could interfere with data collection changes designed to capture outcomes for integrated programs as proposed elsewhere in this rule.

6. Additional Opportunities for Integration through State Medicaid Agency Contracts (§ 422.107)(e)

a. Limiting Certain MA Contracts to D-SNPs

As indicated in the November NOIA guidance, CMS proposes to codify a pathway for States with parameters for how CMS will work with the State when the State wishes to require D-SNPs with exclusively aligned enrollment in that State to operate under D-SNP-only MA contracts and use specific integrated enrollee materials using the existing MA application process. CMS says this will promote quality ratings reflecting dual populations outcomes and experiences specific to the state, greater transparency on financial experience, and allow state specific MOCs as well as provider networks specific to D-SNPs. CMS says most D-SNPs are in contracts that also include other types of plans, but this will only affect those D-SNPs with exclusively aligned enrollment and there are not that many states requiring exclusively aligned enrollment at this point. They propose a list of follow up steps including cross walks for handling this process.

SNP Alliance Comments: The SNP Alliance supports this opportunity, in particular where the plan and the state are in agreement on requesting this change. A single "clean" contract number for D-SNPs in each state is an important and game changing requirement for integration which has long been proposed and supported by the SNP Alliance because it can align performance evaluation and data collection and enable clearer understanding of DNP population outcomes and needs state by state. It also facilitates continuation of best practices from MMPs and other demonstrations as they transition from demonstration status. We appreciate that CMS paved the way for this change in its earlier NOIA guidance for 2023. We also appreciate the additional cross walk exception process and the outline of detailed steps which would be followed to achieve this change.

However, many of our members, particularly those with multi-state contracts, have serious concerns about this change, because this change will impact Star ratings, measurement and data collection, models of care, supplemental benefits and IT systems. They are also concerned that requiring new contracts (and potentially new product names) may be confusing to existing enrollees subject to transition cross walks and thus result in unintended negative consequences for

beneficiaries. CMS also needs to consider impacts on IT costs, potential costs for creating or changing legal entities, impacts on the frailty adjustment and impacts on Star measures, cut points and survey response rate changes and what additional work for D-SNPs and CMS and states will be necessary for implementing this proposal successfully. Some are suggesting there are other pathways to finding longer-term solutions that would be less disruptive and CMS should seriously consider such alternative suggestions. As the CA MMPs transition to D-SNPs there may be opportunities for monitoring or testing new ways of implementing PBP level reporting which could be instructive to this process. In addition CMS could consider the MN FIDE SNP experience with a unified CAHPs survey which eliminates duplicative CAHPs surveys and should increase their return rate.

At the same time, many members of the SNP Alliance, including a number of FIDE SNPs and MMPs, have had long experience with contract level measurement and data collection provisions which reflect their aligned membership resulting in data and tailored MOCs for more useful for CMS, states, D-SNPs and beneficiaries. The SNP Alliance acknowledges all of these concerns and makes the following suggestions for what will be required to make such a proposal work.

The SNP Alliance supports aligned enrollment so that the dually-eligible individual can be enrolled in one health plan for both sets of benefits and so that the federal and state processes, measures, and review are integrated as much as possible. The person should not have to navigate hurdles and disruptions across two programs that arise from federal and state rule conflicts or duplications. This is so important for people who have benefits from both Medicare and Medicaid—they deserve an integrated approach. We also agree that alignment around quality measures, models of care, and performance evaluation as well as rewards is very important.

However, additional guidance and capacity building will be needed by most States to make this fully operational and there are potential problems for health plans that operate across state lines, for example around a Model of Care. The Model of Care offers an example of operational considerations needed to have states integrate with federal requirements. Characteristics of beneficiaries require providers and plans to navigate their care coordination across settings, disciplines and services and between the two programs. Complexity in chronic and medical condition management, behavioral health needs, social determinant of health needs, and long-term services and supports arise. There should be one model of care approach that is clear.

In addition, the alignment of quality measurement can be another integrating mechanism or lack of alignment an unfortunate barrier. We request CMS identify a national core set of measures specific to dually- eligible special needs populations and request that states use these measures to evaluate integrated programs.

In the interim while this is being developed, we encourage there be separate cut points (benchmarks) for D-SNPs. Plans with similar enrollment profiles (SDOH, complexity, and other characteristics) should be compared to each other rather than to general MA plans. Work by researchers has demonstrated that SNP populations are different than general MA plans (Medicare Advantage vs. Traditional Medicare Beneficiaries Differ | Commonwealth Fund). This could improve the accuracy and utility of performance results and reporting and guide quality improvement. It would provide more accurate benchmarks for dually-eligible individuals.

States are interested in this information as well. We hope that this single D-SNP contract opportunity helps realize the goal for better alignment in programs, care management, provider service, and quality monitoring. We stand ready to assist CMS and states in this effort in any way we can.

See also Related comments in II A 13 a.

b. Integrated Member Materials

CMS intends to facilitate a State's election to have D-SNPs with exclusively aligned enrollment use certain communications materials that integrate content about Medicare and Medicaid. Under this proposal, the applicable Medicaid managed care and MA requirements and standards would continue to apply to the integrated materials. CMS would codify a pathway by which CMS would coordinate with a State that submits a letter of intent indicating that they choose to require, through its State Medicaid agency contract, that certain D-SNPs use an integrated SB, Formulary, and combined Provider and Pharmacy Directory according to operational and administrative process they would establish. CMS also considered including the EOC and the ANOC in the scope of this process and ask for comment on whether that would suit state needs better, but also mention due to the PRA process it might be better to reassess that at a later date.

SNP Alliance Comments: The SNP Alliance supports this provision, noting that the need for integrated member materials it is a long-standing SNP Alliance position. However, since CMS cannot change timelines for preparation of materials, we agree CMS should start with the initial documents SBs, Formulary and Directories and reassess integration of EOCs and ANOCs once those documents are in place except in cases where collaboration on those additional documents already exists.

In addition, CMS should require states, in their letter of intent, to indicate support from D-SNP partners for proceeding with this approach and CMS should assure requirement of involvement and cooperation with participating D-SNPs in this process. For example, CMS could provide additional guidance and technical assistance to states by outlining and requiring a standardized coordinated process across states for including or consulting with all plans in a given state with the goal of reaching consensus/agreement with all participating plans on basic models and changes. This process should include agreement by the state to abide by necessary CMS review process timelines and should specify which materials are included. Such a process has already been in use in some D-SNP and MMP states. CMS should consider establishing a workgroup including states, plans and consumer advocates to develop this process.

In addition, many D-SNPs and MMPs note how the current MMP handbook is more useful to members than the current form of the EOC. As part of the reassessment of the ANOC and EOC documents in the PRA process, the SNP Alliance continues to request CMS to facilitate allowing D-SNPs to use the member handbook format and approach upon request and agreement with the state. If this is not possible, CMS should clarify what additional authorities are needed in order to do so.

Finally, please see again comments in 5.a. regarding alignment of enrollment dates. Unaligned enrollment dates also complicate efficient and timely distribution of integrated member materials.

CMS should work with states to implement necessary state and federal changes that will support alignment of enrollment dates.

c. Joint State/CMS Oversight (§ 422.107) (e)

(1) State Access to the Health Plan Management System

CMS proposes allowing access by States to the CMS Health Plan Management System (HPMS) (or a successor system) to better coordinate State and CMS monitoring and oversight of D-SNPs that operate under the conditions described at proposed paragraph (e)(1). (These are the MA organizations offering D-SNPs with exclusively aligned enrollment that maintain one or more contracts that only include one or more D-SNPs with a service area limited to that state.)

State access would be limited to approved users and subject to compliance with HHS and CMS policies and standards and with applicable laws in the use of HPMS data and the system's functionality. Based on the current architecture of HPMS, approved State officials would only have access specific to information related to those MA contract(s).

SNP Alliance Comments: The SNP Alliance supports this provision, contingent on CMS and state assurance that appropriate safeguards will be in place for state employees accessing HPMS to assure protection of proprietary information.

(2) State-CMS Coordination on Program Audits

CMS proposes to coordinate with State Medicaid officials on program audits for exclusively aligned D-SNPs under a contract number limited to certain D-SNPs in that state. This coordination would include sharing major audit findings for State awareness related to D-SNPs subject to proposed paragraph (e)(1).

SNP Alliance Comments:

While the SNP Alliance recommends support of this provision in general, this provision needs additional parameters. We applaud the goal of reducing the number of program audits and reducing duplication for single contract D-SNPs. There should be alignment and reduction in administrative burden for all parties involved. With regard to care coordination specifically – tied to the Model of Care—the federal and state efforts need to be aligned, particularly documentation and timeframes, whenever possible. Therefore, we recommend that CMS provide guidance to states on the current federal care coordination program audits (e.g., content, process, data submission requirements on sample of records of members to audit care coordination practices consistent with the plan's Model of Care, timing, review process, etc.). We recommend capacity-building, technical support, and assistance to the states and additional training for CMS auditors and the states. Currently all plans have their MOC reviewed and scored (conducted by NCQA) and CMS may audit the plan within the approval period (conducted by CMS auditors based on the MOC submitted to NCQA)—states should be encouraged to consider what is already done and then determine if there is anything over and above needed, and then coordinate on that content, process, and timing with CMS. Wherever possible, these should be linked. That D-SNPs that have a clean audit are deemed in compliance with state standards, wherever possible.

Enhanced training for State and CMS auditors would be needed to increase awareness of state specific additions and of federal requirements for special needs plans. Again, where possible it would be preferrable for one audit to be deemed as meeting the requirements of both sets of requirements so that the plan is in compliance with both set of requirements if the results are reviewed and approved by the other government agency. If that is not possible, at a minimum CMS and the states should work together to develop a cross-walk reference for auditors and for plans to ensure that the expectations and parameters (e.g., data elements, records required, timeframe period, sample, timing, etc.) are clear and not in conflict with one another. Plans should be provided with a process for appeal at both the state and federal levels.

(3) State Input on Provider Network Exceptions

CMS proposes to use existing authority and flexibility for the review of medical provider networks network exceptions, to solicit and receive input from State Medicaid agencies. CMS intends to reach out to States when a MA organization with a D-SNP contract described in § 422.107(e)(1) ((exclusively aligned enrollment etc.) submits an exception request that does not meet the requirements at § 422.116(f)(1). In those instances, CMS may collaborate with the respective State to identify if there are other factors, as described at § 422.112(a)(10), that may be relevant before making a determination on the exception request.

SNP Alliance Comments: The SNP Alliance supports this provision. It reflects a long-standing SNP Alliance position and previous SNP Alliance proposal stemming from our 2017 network adequacy work group discussions with CMS. The Minnesota demonstration experience indicated that states can be helpful in providing additional information that can prevent unnecessary network disapprovals. However, we also strongly recommend that CMS add a provision that would require notification and consultation with the affected plan when this process is invoked so that they are fully informed of any additional factors that are being considered.

d. Comment Solicitation on Financing Issues

Based on experience in the FAI, CMS is assessing whether there are ways to take two elements of MMP financial methodology and apply them to D-SNPs: (1) integrated MLRs; and (2) consideration of the expected impact of benefits provided by MA organizations on Medicaid cost and utilization in the evaluation of Medicaid managed care capitation rates for actuarial soundness.

SNP Alliance Comments: The SNP Alliance appreciates CMS' efforts to evaluate FAI mechanisms for how they could apply to D-SNPs, something we have long advocated. In general we support CMS' creative exploration of these possibilities and encourage additional analysis, modeling and thought to develop them further. The directions these proposals signal would be preferable to major changes included in more radical proposals that would eliminate D-SNPs or require D-SNPs to adopt MMP payment methodologies. These proposals provide windows into how MMP experience could be applied to D-SNPs to work toward improving state incentives for integration through allowing access to some savings or perceived value, without major disruption to current D-SNP financing and infrastructure. We also appreciate CMS' May 27, 2021 guidance providing more information on how to coordinate supplemental benefits with Medicaid.

SNP Alliance members do have concerns about how useful and accurate an integrated D-SNP MLR would be, given the differences between Medicare and Medicaid MLR requirements, how impacts of supplemental benefit data overlapping Medicaid services would be distinguished and evaluated, and how variations in supplemental benefits due to bid and benchmark changes from year to year would be factored in. In particular we recommend CMS look for ways in which definitions and cost reporting between the two requirements could be more aligned or standardized. We encourage CMS to consult plans and states as they move forward with these concepts and to provide additional modeling and detail on how these can work under the D-SNP platform. The SNP Alliance would appreciate being involved in this ongoing effort.

However, we also want to raise the prospect that focusing on advocating for integrated programs largely on the basis of cost savings to states may be a shortsighted approach. We note that overall, MMPs have not achieved significant savings for most states, and that other D-SNP models have been effective at managing hospitalizations and providing access to primary care and MLTSS services without promises of shared savings, indicating value to beneficiaries and reasons for promotion of integrated care beyond financial impacts.

Furthermore, as is well known, ongoing savings in managed care programs for highly complex populations is also more elusive due to unmet needs (including SDOH needs that are unrecognized by risk adjustment systems). While some savings may occur after initial implementation due to closer management of obvious issues, costs often rise later as unmet needs are addressed. In addition large segments of dual populations served under SNPs (those with severe disabilities, chronic or terminal illnesses or facing end of life care) are not likely to improve over time. As the FAI phase out, there is less reason to carry over the CMMI criteria that there must be program savings to indicate the success of integrated programs. MAOs are not held to those current CMMI standards, and Medicaid capitations for integrated D-SNPs are set by states according to their own needs and separate standards of Medicaid actuarial soundness. (Initial CMMI criteria discussed for the FAI would have allowed budget neutrality with improvements in quality.)

There may be enough good reason to pursue integration based on the widespread agreement that it makes more sense than the current fragmented and inefficient system, that primary and acute care should of course be coordinated with behavioral health and long-term services and supports, and that a more unified system would be simpler for beneficiaries, along with evidence of beneficiary satisfaction. It is possible that with advocacy and encouragement, other incentives such as access to implementation resources and ongoing increased FFP for administrative and IT changes, improved coordination, quality, access and simplification for beneficiaries may prove to be as or more important to states than savings promises.

7. Definition of Applicable Integrated Plan Subject to Unified Appeals and Grievances Procedures (§ 422.561)

CMS proposes to expand the universe of D-SNPs that are required to have unified grievance and appeals processes by reorganizing the definition of applicable integrated plan and after January 1, 2023 to include certain combinations of Medicaid managed care plans and D-SNPs that are not FIDE SNPs or HIDE SNPs but meet three other alignment conditions where enrollees receive all of their Medicare and Medicaid benefits that are available through managed care in the State through a D-SNP and affiliated Medicaid managed care plan and provide at least one of the following Medicaid services: home health,

DME or nursing facility services. This provision also extends the requirement for continuation of benefits during appeal to these D-SNPs.

SNP Alliance Comments: The SNP Alliance supports this recommendation since it continues to move towards more consistent policy for dually eligible consumers by increasing integration and pathways to integration for additional plans. CMS should provide further clarification that this would not apply to non-exclusively aligned plans. CMS also should clarify what happens when states are not willing to engage in the additional administrative effort it will take to modify their current grievance and appeals processes to adopt the uniform process.

8. Permitting MA Organizations with Section 1876 Cost Contract Plans to offer Dual Eligible Special Needs Plans (D-SNPs) in the Same Service Area (§ 422.503(b)(5))

This provision allows entities in Minnesota that currently offer both D-SNPs (subject to the Administrative Alignment demonstration waiver) and cost contract plans in the same market to continue enrollment in both plans after the end of the demonstration, thus avoiding potentially significant disruption to enrollees. More broadly, the exception removes a regulatory barrier that, in Minnesota and several other states, can impede D-SNPs from entering a market where cost contract plans operate. CMS tracked it and found no problems and is now extending it beyond the demonstration.

SNP Alliance Comments: The SNP Alliance commends CMS for proposing this long hoped for change which is highly technical and therefore not easily understood. It will provide relief to several SNP Alliance members in MN as their administrative alignment demonstration phases out, and who have been relying on a CMMI waiver granting an exception to the current policy through the demonstration and so would not have been able to continue to operate under the current rule.

9. Requirements to Unify Appeals and Grievances for Applicable Integrated Plans (§§ 422.629, 422.631, 422.633, and 422.634)

Based on initial implementation experience and feedback from stakeholders, CMS is proposing several adjustments, clarifications, and corrections. They do not intend for these proposals to substantially change current policy.

SNP Alliance Comments: The SNP Alliance supports these changes, which are largely technical but and helpful clarifications for applicable integrated plans. The SNP Alliance particularly appreciates the accommodation of state Medicaid representatives which will ultimately simplify beneficiary representation when both Medicare and Medicaid benefits or overlapping benefits are involved. CMS should also clarify that providers appealing on behalf of beneficiaries cannot do so for reimbursement purposes.

10. Technical Update to State Medicaid Agency Contract Requirements (§ 422.107)

CMS strikes the State Medicaid Contract requirement for documentation of how D-SNPs verify Medicare eligibility.

SNP Alliance Comments: In general the SNP Alliance supports simplifications such as this proposal. While this provision applies to contract requirements for D-SNPs to document Medicare verification, (which they already do through other means upon enrollment) some plans note that it is important for states to track Medicare eligibility as well and referencing it in the contract enables states to provide them with information that distinguishes between types of dual eligibility such as MSP, FBDEs and partially

dual members. CMS should evaluate this provision further to determine how such data is being used by plans and states before striking the requirement.

11. Compliance with Notification Requirements for D-SNPs that Exclusively Serve Partial Benefit Dually Eligible Beneficiaries (§ 422.107(d))

This provision would exempt partial dual only D-SNPs from data exchange requirements where the MAO also offers a full benefit only D-SNP with enrollment limited to FBDEs and meets integration criteria and is in the same state and service areas and the same parent company. Currently there are nine such partial dual only PBPs and they would be able to continue.

SNP Alliance Comments: The SNP Alliance supports this provision and thanks to CMS for allowing this alternative that supports continued enrollment of partial duals in D-SNPs where they have access to additional care coordination.

12. Attainment of the Maximum Out-of-Pocket (MOOP) Limit (§§ 422.100 and 422.101)

CMS proposes to specify that the MOOP limit in an MA plan (after which the plan pays 100 percent of MA costs for Part A and Part B services) is calculated based on the accrual of all cost-sharing in the plan benefit, regardless of whether that cost sharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid because of State limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing.

SNP Alliance Comments: This proposal appears to provide some savings for states and more complete Medicare cost sharing for providers. However, MA plans will incur higher costs in bids, and many are concerned about the impact on smaller integrated D-SNPs because this will significantly reduce rebates and thus decrease available supplemental benefits, and/or in lower benchmark areas, result in premiums that dually eligible members can't pay.

The SNP Alliance understands the importance to states of the changes to the calculation of the MOOP value, however we caution CMS to be conscious of unintended consequences. Since these changes will most certainly impact those plans serving the greatest number of dually eligible individuals, and will directly impact rebate dollars, the impact will be most significantly felt by those smaller D-SNP plans and will be translated into reduced supplemental benefits by the very members who need them most. CMS should consider that many D-SNPs must first buy down the Medicare Part D premium to ensure that dual beneficiaries are not subject to Part D premiums before any rebates can be employed for other types of supplemental benefits including those that help them compete with larger MAOs. Secondly, this may drive greater numbers of dually eligible members AWAY from integrated D-SNP plans into general MA, thus further creating another barrier to address the goal of CMS and of the SNP Alliance to advance dual integration.

13. Comment Solicitation on Coordination of Medicaid and MA Supplemental Benefits

CMS seeks comments on examples of potential coordination of Medicaid and MA supplemental benefits and on other potential ways that D-SNPs and States can work together to coordinate Medicare and Medicaid benefits in order to improve D-SNP enrollee experiences and outcomes.

(a) Using the D-SNP Model of Care (MOC) to Coordinate Medicaid Services

CMS points out that the D-SNP MOC also provides a vehicle for State Medicaid agencies to work with D-SNPs to meet State goals to improve quality of care and address SDOH.

The SNP Alliance supports integrated care delivery and understands that coordination of MOCs with Medicaid requirements is important. However, while we support flexibility for States, this section describes various options and alternatives for States to apply to D-SNPs MOCs (presumably not on I-SNPs or C-SNPs) which, without appropriate parameters, could make it hard for special needs plans to operate their care coordination and management approaches effectively. This could be overly intrusive—such as requiring the plan to use specific staff from the community rather than hire their own staff to perform certain functions. As written, this is unclear where the limits on State action would be set and by whom. Having the state dictate hiring and staffing and setting payments seems over-reaching. We need more information on how this would be operationalized.

There are special needs health plans that have developed highly effective care models with more than three decades of experience with these special populations. We would not want to see this dismantled inadvertently by well-meaning state action that supersedes the best practices developed by these plans. CMS contracted with RAND to explore best practices in top quality rated health plans for addressing social determinants of health among dually-eligible beneficiaries – the case studies featured were all special needs plans and all members of the SNP Alliance (see: RAND-CMS 2018).

SNPs create a model of care document by describing the structures and processes for member outreach, assessment, care planning, interdisciplinary team communication, service coordination, specialty provider networks and provider training, and other functions that comprise their care coordination and care management approach. They also identify key quality improvement targets around their special population subgroups. SNPs use one set of national standards to develop their Model of Care for review by a national organization (NCQA) and for approval by CMS.

If there are multiple State-issued additional requirements that do not sync with the federal requirements, then health plans may be caught in the middle. We offer our recommendations to CMS here to increase the feasibility and utility of this opportunity. We number our recommendations as "Additions."

Addition #1 – Incorporate Language that State requirements must take into account CMS requirements-

For example, around Model of Care, we request that CMS require that states begin with existing federal MOC guidelines (NCQA/CMS-issued Model of Care Guidelines updated annually) and add in state-specific coordination and related requirements only where those items are not already covered in the federal MOC requirements.

The federal MOC is based on statutory requirements so every SNP must comply. States may not alter the federal guidelines or issue requirements that force plans to go against the federal mandates, but they can add requirements pertaining to unique aspects of their*r state Medicaid services or processes around care management and related activities (such as in the FAI or other

demonstrations). We'd look to CMS to educate, provide resources, and assist states to start with the MOC federal guidelines and produce a redline "add-only" version that highlights additions to the MOC and submit these to CMS for approval.

Addition #2 – Educating/Assisting NCQA - We further recommend that CMS then submit these state-specific MOC documents to NCQA for their training of NCQA reviewers—not for scoring plans MOC differently, but to be aware of what the state is also asking plans to do. In other words, reviewers should not penalize SNPs for following state requirements, and this may occur if the NCQA reviewers are not aware of additional state-specific expectations. CMS would need to be clear that NCQA scoring of MOC submissions should be based ONLY on the federal guidelines, not state additions to allow for national standards to be applied consistently across health plans.

Addition #3 – National Repository of State-specific Requirements – It would be very important as this D-SNP single contract was expanded to be available at a national level to have an accessible, searchable repository of all of the MOC Federal-State versions that health plans would need to comply with—to maintain fidelity to contract requirements. As the number of versions for Model of Care or other state-specific care coordination requirements grows, this could potentially expand to 50 state versions. Currently the NCQA reviews and scores all MOCs on behalf of CMS. Therefore, we'd ask CMS to contract with NCQA or other agency to create and maintain a national MOC federal-state repository updated annually that would identify the State-specific additional requirements over and above the national/federal MOC guidelines.

This would need to be searchable and organized by element and factor and domain as set forth in the MOC national guideline template. A searchable database platform would allow states and plans (particularly those that serve beneficiaries in multiple states) to more easily track state-specific MOC additions and stay in compliance. It would also help safeguard from states applying requirements that run counter to national requirements. The plans that serve people in more than one state would need such information in a timely and accessible format.

Addition #4 – Alignment on review of MOC or other requirements - Currently NCQA scores all MOCs and provides a 1-, 2-, or 3-year approval cycle based on score received. Those NCQA staff or consultants who are charged with reviewing the MOCs would need to have additional training on state-specific requirements that have also been applied on plans in that state (or in multiple states if their members cross state lines in one D-SNP single contract). This is necessary to align the MOC review process and reduce confusion by plans, NCQA reviewers, and state or CMS auditors. All need to be aligned and informed in order to assist in making this single D-SNP contract opportunity work.

Alignment and coordination of requirements, training for states on federal standards and Medicare requirements, and roles and actions of NCQA, and CMS (e.g., MOC, program audits) are necessary to ensure an efficient and effective Medicare and Medicaid coordination process. This is also important around quality measurement for dually-eligible individuals. The alignment of quality measurement can be another integrating mechanism or lack of alignment an unfortunate barrier. We request CMS identify a national core set of measures specific to dually-eligible special needs populations and request that states use these measures to evaluate integrated

programs. Plans with similar enrollment profiles (SDOH, complexity, and other characteristics) should be compared to each other rather than to general MA plans. Work by researchers has demonstrated that SNP populations are different than general MA plans (Medicare Advantage vs. Traditional Medicare Beneficiaries Differ | Commonwealth Fund).
This could improve the accuracy and utility of performance evaluation guide quality improvement. We all know the high cost of duplication, conflicting regulatory requirements, and high burden on providers, plans, or members. We support taking the time to review and align federal and state requirements. Toward that end we recommend creating a national repository of state to federal requirements including MOC and quality measures/methods, with expected timeframes that is searchable will be an important resource—for clarity, transparency, training, efficiency, and quality improvement toward the goal of making this more viable as it is scaled nationally.

(b) Coordinating Coverage of Medicare Cost-Sharing

D-SNPs in States with capitations can combine Medicaid capitated payments and Medicare rebate dollars to more fully cover MA cost sharing provided that the State Medicaid capitation payment and MA bid do not both pay for the same costs. The amount paid using MA rebates must be based on the actuarial value of the reduction in Medicare cost-sharing that is part of the MA plan benefit design, and the State Medicaid capitation payment must be based on the actuarial value of Medicare cost-sharing paid for Medicare Parts A and B services under the "lesser-of" payment method. The overall reduction in Medicare cost-sharing must be actuarially equivalent to the Medicare cost-sharing paid for by the Medicaid capitated payment plus the Medicare rebate dollars allocated to additional reductions in Medicare cost-sharing compared to the actuarial value of Medicare cost-sharing in the original Medicare FFS program.

SNP Alliance Comments: The SNP Alliance appreciates the additional discussion of coordination of supplemental benefits provided in the preamble in addition to the previous guidance on coordination of supplemental benefits issued on May 27, 2021. We support an amendment to 422.100(d)(2) as CMS proposes, to clarify that supplemental benefits for dually eligible enrollees would meet Medicare uniformity requirements when some enrollees receive a benefit from Medicaid while others (on waiting lists or not currently eligible under Medicaid criteria) receive that benefit through a D-SNP supplemental benefit.

We request more information on how other MLR supplemental benefit reporting changes in Section G. would figure into methodologies for determining and or tracking overlapping benefits to prevent double payments and as mentioned earlier we recommend that CMS consider some standardization or alignment of cost definitions and reporting between Medicare and Medicaid MLR requirements. We also request that CMS to encourage states to use capitation and more transparent actuarial soundness methodologies which would simplify these determinations and tracking mechanisms. We caution CMS that Medicaid actuarial soundness methodologies can vary considerably from state to state and there is a general perception that these processes lack transparency (as discussed in the March 3, 2022 MACPAC meeting) leading to concern that there may be pressure to lower Medicaid rates in response to misunderstanding about the scope of some of the more targeted supplemental benefits.

In addition, CMS should provide additional training and technical assistance to plans and states for better understanding of these arrangements and opportunities and to encourage establishing ongoing of methods

of exchanging information on supplemental and Medicaid benefits to reduce confusion. While we appreciate the earlier guidance provided, we suggest that CMS take that to the next step by providing states and plans with more detailed templates or suggested methods for determining where a supplemental benefit begins and ends and how that relates to any overlapping or similar Medicaid services.

In relation to use of plan rebates for "buying down" cost sharing, in some cases we believe some plan contracts are already picking up cost sharing for dually eligible members, but that this may not be clearly understood by all parties. For example, as mentioned earlier, many D-SNPs are already applying significant rebates to Part D premiums to assure that dually eligible enrollees do not have to pay them, but many states are not even aware of this. Therefore, we would support requiring states to more clearly delineate how cost sharing is handled in its contracts with D-SNPs. D-SNPs should also be able to negotiate how supplemental benefits including cost sharing are recognized or included in these contracts.

Further, while we agree with the general logic of the preamble discussion with regard to cost sharing and rebates, as noted earlier we have some concerns about expectations around this benefit. D-SNPs cannot control states decisions about whether and how to capitate cost sharing or how they apply their actuarial soundness methodologies. While we agree capitation is the best way to handle cost sharing, some states have not adopted this approach (see earlier discussion of capitation of cost sharing in Section 5.b.) When cost sharing is not capitated, it will reduce the ability of plans to offer creative approaches such as those outlined in the CMS preamble discussion.

In addition, as these policies are further developed, we hope that CMS is mindful and can also remind states that there is already great competitive pressure on D-SNPs around demand for supplemental benefits. First D-SNPs, especially those that are very integrated, have tended to be smaller entities, and have to use considerable rebates just to keep up with general MAO supplemental offerings to attract members (including buying down the Part D premium as mentioned). Second, by design they are going to be serving larger proportions of members with complex care and SDOH needs, and risk adjustment systems are often not sensitive enough to pick up all of those nuances. Third, many of the supplemental services states may want to see covered can be expensive (such as CMS examples of home and community-based services) and of longer duration than may be possible under benefits that may change from bid year to bid year. While the new opportunities to offer these benefits should be of great value to states and to dually eligible beneficiaries, care must be given to ensure that state expectations are realistic and sustainable and CMS messages to states should include some of these cautions.

14. Converting MMPs to Integrated D-SNPs

CMS points out substantial changes in the integrated care landscape since the FAI was created that offer the opportunity to implement integrated care at a much broader scale than existed when MMPs were first created. As a result, should CMS finalize the proposals in this rule that facilitate or require greater integration, CMS would work with the states participating in the capitated financial alignment model during CY 2022 to develop a plan for converting MMPs to integrated D-SNPs

The process for converting MMPs to integrated D-SNPs would depend in part on each State's circumstances. States may choose to use the opportunities under proposed § 422.107(e) to structure the integrated D-SNP products to replicate key features of MMPs or submit letters of intent to MMCO. CMS seeks comment on this contemplated approach to working with States to convert MMPs to integrated D-SNPs.

Preliminary SNP Alliance Comments: The SNP Alliance supports the approach laid out by CMS with a caveat that there may be need for additional accommodations for some states and MMPs that have large investments in the FAI model. The SNP Alliance commends CMS for strongly signaling a direction for the future after the end of the FAI demonstrations, something our members, both D-SNP and MMPs, have requested for a number of years. We also commend CMS for working to incorporate key learning from the FAI by modifying key elements allowed to MMPs in order to adapt them for D-SNPs.

We especially appreciate that CMS is providing D-SNP pathways for transition of FAI demonstrations that are ending and is working closely with states and plans in these situations, including facilitating the continuation of some MMP features in their D-SNP successors under the same parent companies. We agree that the broad availability of D-SNPs in nearly all states, the evidence of considerable investment in this model, and the permanence of the D-SNP platform provide the best foundation for focus on future integration efforts. Therefore we view this rule and these statements from CMS as a large step forward consistent with SNP Alliance previous requests and positions.

However, we also recognize that MMP members and some states and stakeholder groups have invested heavily in the FAI model. For example, we understand advocates involved in OneCare in MA, which is specifically designed for and by people with disabilities under age 65 may object to the termination of their FAI demonstration. MMPs may have actuarial concerns about changing the financing model, how to compete with larger MAOs with high levels of supplemental benefits and impacts on cost sharing arrangements. In addition, there are key elements of the MMP demonstrations that may be lost since they have still not been fully addressed in this rule, including passive enrollment, and incorporation of MLTSS measures, along with fully integrated financing that allows states to share in savings. We appreciate that CMS is trying to find creative ways to address what may be otherwise lost but it may take some time, and additional CMS authority to fully fill those gaps. As soon as possible CMS should further consult stakeholders in those states where the FAI is scheduled to end.

Therefore, while we agree with not starting up any additional FAI demonstration states and continuing the planned phase outs, it may be beneficial to allow some high performing MMPs to stay while transition processes are worked out particularly where authorities must be sought to include behavioral health or other services that had previously been carved out. In a few cases, such as the OneCare demonstration where states and consumers strongly support continuation of the MMP model and it has been seen as successful, CMS should consider allowing some demonstration plans permanent authorization. CMS should clarify as soon as possible whether CMMI authority can be extended or at what point it is no longer available or requires additional authorities and to what extent this is still an open question and announce this information clearly.

Based on that information, CMS should address whether it will be possible for any of the current FAI states to remain in an FAI or whether all must be transitioned at once, or one by one, and transition dates for each. If additional time is needed to minimize disruption in a particular state it will be important to note these instances as soon as possible so everyone has a clear understanding of their path forward and to avoid politicization of decision making.

CMS outlines a number of policy and operational issues that must be addressed to make this transition work. We agree with these and suggest that CMS could develop and offer several templates to states for starting points reflecting different stages that include minimum standards with some customization opportunities along with best practices needed. If we are to move in this direction, it is going to be

important to provide states with some flexibility while also some nationwide standardization to avoid ending up with 50 different versions of D-SNP integration.

CMS should also pay particular attention to current features being discussed at MACPAC where states contracting with D-SNPs would submit a plan to CMS that addresses key elements as specified by CMS for pursuing integration. We assume such a process could identify areas where there will be clear parameters for various operational and policy features as well as where customization is allowed. However, the biggest barriers to further integration will likely be tackling operational alignment between CMS and state Medicaid processes and timelines for enrollment and procurement. We recommend that CMS look at how longstanding successful D-SNP models are resolving these issues and advocate for further application to additional D-SNPs. If CMS does not have current authority to address the kind of day-to-day operational alignment that will be needed to afford a more simplified and seamless beneficiary experience similar to what has been provided under the MMPs or the D-SNP Administrative Alignment demonstration, CMS should make that clear and work with Congress and stakeholders to seek that authority.

C. Amend MA Network Adequacy Rules by Requiring a Compliant Network at Application (§ 422.116)

CMS proposes to amend § 422.116 to require MA applicants to demonstrate that they meet the network adequacy standards for the pending service area as part of the MA application process for new and expanding service areas and to adopt a time-limited 10-percentage point credit toward meeting the applicable network adequacy standards for the application evaluation.

SNP Alliance Comments:

The SNP Alliance recommends that CMS consider the impact of this proposal on obtaining network participation by providers, in general but also particularly for smaller SNPs. SNPs already face challenges in obtaining network agreements with providers because SNPs enroll only those beneficiaries with higher complexity needs compared to other MAOs. This proposal could give providers greater leverage to negotiate higher rates. Many providers do not want to sign contracts in a timely manner under the current timelines for network requirements and SNPs expect this earlier deadline will lead to even more push back from providers (especially those with large market shares) impeding negotiations, creating uneven playing fields and driving up payment rates. If it is more important to move up the timelines, CMS could allow utilization of letters of intent instead.

In addition, the SNP Alliance would like to take this opportunity to re-introduce key public policy issues and concerns about flaws in current network adequacy requirements with respect to their appropriateness for I-SNPs. We raised these issues with CMS in our network adequacy workgroup discussions a few years ago but did not receive a response as to why our input was not addressed. We request that CMS re-evaluate these issues and for that purpose we provide the following rationale and recommendations.

- I-SNPs offer Medicare beneficiaries a program that has been documented to improve the quality of care and to promote cost effective health care services furnished to nursing facility residents. Further, I-SNP enrollees are predominately beneficiaries who have dual eligible and/or Part D LIS status. This is the population that traditionally has suffered from health disparities. Thus, supporting the growth of I-SNPs would align with an important public policy objective of the Biden Administration.

- CMS' network adequacy requirements are intended to assure that members of MA plans have reasonable access to Medicare covered services. However, these requirements do not recognize the unique provider access and needs of individuals enrolled in an I-SNP. Failure to recognize how providers and services are provided often results in an inability for I SNPs to start up or to expand their service area due to:

    - CMS refusal to consider access to provider types who travel to the facility to furnish services but whose offices are not located within CMS' time and distance standards;

    - CMS' failure to adjust their network access requirements for provider types for which nursing facility residents rarely need; and

    - CMS' failure to recognize and address a fundamental challenge arising from the increased concentration of market power by health care systems in their catchment areas. This power has resulted in a growing number of markets health care systems unilaterally refusing to negotiate with I-SNPs regardless of the terms in circumstances where the health care system may currently contract with two MAOs.

SNP Alliance Recommendations:
To address these issues and concerns the SNP Alliance has the following recommendations.

1. First, the SNP Alliance recommends that CMS allow I-SNPs the option of being approved either to offer both an I-SNP plan and other MA plans or to offer only an I-SNP plan. For I-SNPs that elect the latter option, the network adequacy requirements would be tailored to meet the access needs of Medicare beneficiaries residing in a nursing facility. The SNP Alliance believes that CMS is not precluded from adopting this approach through its regulations. This approach would facilitate the offering of I-SNPs to residents of nursing facilities who live in areas where it is impossible for the sponsor to meet the general network adequacy requirements for the reasons discussed here.

2. CMS would then have the option of adopting the following recommendations either through the establishment of I-SNP-specific access standards or through inclusion in the exceptions portion of CMS' Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance:

    a. If the applicant wanted to be approved to offer only an I-SNP, the review of the I-SNP's network access requirements would be measured from the location of the contracted nursing facilities.

    b. For purposes of meeting access requirements, CMS would accept documentation that would demonstrate certain practitioners visit the nursing facility a minimum number of days a month to see patients. A practitioner would no longer be excluded from the network adequacy review if the practitioner's address for Medicare enrollment purpose was beyond CMS' time and distance standards, because the practitioner is furnishing service where the member lives.

    c. Modify access standards for practitioner types, such as chiropractors. I-SNP members very rarely access chiropractic care. The access standards should reflect these patterns of care.

d. If the I-SNP is unable to meet the network adequacy standards through network contracts, allow for the I-SNP to meet ___ % of the standards by allowing their enrollees to obtain services from non-network providers at in-network cost sharing and the I-SNP would guarantee to hold the member harmless from any liability for services received from non-network providers. There is precedent for this approach in the following two instances:

   i. CMS allows this for sponsors to meet network adequacy requirements for employer group waiver plans as long as at least 50% of the services are furnished through in-network providers and

   ii. CMS allows a comparable approach for MA private fee-for-service plans, which has structure allowing for deemed providers.

e. Allow for a good-cause exception that would permit an I-SNP to obtain an exception from the network access standards for good cause at the administrative discretion of CMS. This recommendation would allow for exceptions in instances not intended by the specific recommended provisions.

D. Part C and Part D Quality Rating System

CMS is proposing a specific provision for 2023 Star Ratings for measures derived from the HOS data collection administered in 2020. CMS proposes to amend § 422.166(i) to specifically address the 2023 Star Ratings, for measures derived from the 2021 HOS survey only, by adding § 422.166(i)(12) to remove the 60 percent rule for affected contracts.

SNPA is concerned that the use of the HOS instrument and methods to calculate these measures is ill-advised, particularly during the measurement years of 2020, 2021 and 2022 as the impact of the pandemic continues.

The virus and mutations remain present in communities and the impact on healthcare, social service, mental health and other providers in the measurement year has been profoundly negative. This has impacted ability of providers to conduct screening, communicate directly with their patients, and has impacted beneficiaries' experience of care. Such external environmental factors impact the self-report of the beneficiary on these HOS-derived measures. In some areas within the measurement year, providers were closed, then there were extended wait times for screening appointments; clinic and diagnostic visits were extremely limited.

Special needs populations are particularly impacted. Individuals, particularly those with complex conditions and high vulnerability to the COVID-19 virus continue to experience difficulties in reaching their providers other than for specific acute symptoms or treatment related to their diseases. Providers have not been able to fully address or coach patients on prevention activities.

We are therefore concerned that data collected from the self-report HOS during these years to generate measures may indicate changes in provider practice or beneficiary behavior (reluctance to go into an office and inability to access telehealth given lack of technology) rather than health plan actions. In addition, survey response rates have been low and may not be representative of the enrolled membership

in the plan. For these reasons, we cannot support this provision to include these three HOS measures and remove the 60 percent rule.

Instead, we encourage CMS to remove any HOS-generated measure *temporarily* from Stars for the 2023 Star Ratings calculations and instead include these measures as Display only. In this way the information can be compared to previous years to determine if the patterns are anomalous, indicating underlying changes in the environment or significant shifts. These can then be explored further. This would include three measures:

- Monitoring Physical Activity
- Reducing the Risk of Falling
- Improving Bladder Control

Additional Comments

The SNP Alliance also strongly recommends additional CMS action around quality measure adjustment for Stars 2023. Timing is imperative.

We have been searching for options that offer relief. We believe this is a time to separate out the plans with the highest proportion of individuals who have been most severely affected by COVID-19, pandemic disruption in care, and community impact and make a temporary adjustment. In our proposed option, we have worked to balance the need for some kind of adjustment with the need for administrative consistency, and therefore offer this one strategy with five steps. No new data collection would be needed. CMS already also uses the methods for taking the measure result distribution and calculating five Star-levels. We do not propose any change. We are requesting only that the highest impact plans be separated out for 2023 and that these plans receive a separate set of cut point thresh holds with the option to be scored with peers.

We believe this would offer some relief to the hardest hit plans. Our assumption would need to be verified by CMS, though, so it is theoretical at this point. CMS could use data from last year's measure results to model this approach. It does not seem like a substantial lift, but we do not know the details and what data or methodology issues would arise.
We these caveats, we offer a recommendation which recognizes "High Impact Plans." The five steps for CMS are outlined as follows:

1. First, temporarily return the measure weights to pre-pandemic levels for all measures and for all health plans, since the pandemic continued its impact on communities in 2021 and is still doing so in 2022. This helps even out some substantial measure weight changes that were made before the pandemic had occurred and before such dramatic impact had occurred in so many communities.
2. Second, separate out the measure results from all high-dual and high-disabled plans –those at Levels 8, 9, and 10--using the deciles and quartile levels already developed by CMS—to create a second cohort of plans.
3. Third, calculate a second set of cut point thresholds for measure results for this cohort of plans. Inform these plans of the resulting cut point thresholds for each measure.
4. Fourth, apply the cut points and calculate Star ratings and provide opportunity for plan review as usual. Allow the high impact plans to be held harmless—that is, if they would have achieved a higher Star rating through the general MA cohort, they could remain in this general cohort.
5. Fifth note the "High Impact Plans" with a new icon on the Medicare Plan Finder indicating the characteristics of the enrolled population served within these plans and note where these plans

achieved higher than average Star ratings (more than 3.0), despite the impact of the pandemic and the challenges faced by individuals within these plans.

E. Past Performance (§§ 422.502, 422.504, 423.503, and 423.505)

CMS is seeking to include, in §§ 422.502(b)(1)(i)(D) and 423.503(b)(1)(i)(D), a recent history of low Star Ratings as a reason for application denial. We are proposing that CMS would deny an application for a new contract or a service area expansion from any organization that received 2.5 or fewer Stars.

The SNP Alliance supports safeguarding beneficiaries around poorly performing health plans, but we need clarification on what is being proposed.

We agree with the goal of limiting or removing organizations with indicators of poor performance, inadequate service, or lack of financial viability from expanding contracts or entering into new contracts. We ask for clarification around this provision – is CMS referring to the overall MA Star rating of 2.5, or is the Agency requiring a 3.0 or above on Part C, Part D, and the overall Star rating? If the reference is to the overall rating, we support this provision. If the plan must achieve 2.5 on every part, we are concerned that this will be overly punitive and suggest at least two years' review, versus a single year performance rating as a reason for application denial.

F. Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§§ 422.2260 and 423.2260, 422.2267, and 423.2267)

CMS proposes to require a standardized multi-language insert in all materials required under §422.2267 (e).

SNP Alliance Comments: The SNP Alliance supports CMS' proposal for distributing standardized multi-language inserts, which will be particularly important for D-SNPs whose members include large proportions of non-English speaking and diverse communities. These inserts are essential for enabling members to call for assistance in translation so they can understand what the document they are receiving is about. However, CMS should allow D-SNPs with Medicaid contracts where states and plans are working to integrate member materials to utilize a joint form. CMS should assure that similar overlapping Medicaid requirements can be integrated with this Medicare requirement to avoid duplicative documents and conflicting or inefficient approaches for access to translation resources and provide guidance to D-SNPs and states on how best to integrate these language inserts.

III. REQUESTS FOR INFORMATION

C. Request for Comment on Data Notification Requirements for Coordination-Only D-SNPs (§ 422.107(d)

While integration related data notification requirements have only been in effect for a few months, CMS points out that this coincided with the COVID–19 public health emergency. Through this proposed rule CMS invites MA organizations, States, and other stakeholders to submit comments on their experience implementing the data notification requirements thus far and any suggested improvements for CMS consideration in future rulemaking.

SNP Alliance Comments:

The SNP Alliance appreciates CMS asking for this input. Feedback from our members indicates wide variety in these data sharing models, with some state approaches being more effective than others, especially in terms of meeting any expectations around use of required data for any kind of real time care coordination. One message we have heard from many is that it would be helpful if such provider information about discharges and admits was provided directly to the D-SNPs as well as to the state. We recommend that CMS encourage states to include D-SNPs in their data exchange methodologies.

To that point, at the most recent ADvancing States HCBS conference, we became aware of a creative approach in use for sharing data on admissions and discharges among providers, which may be useful to consider for further applicability to some states and plans. While it is not currently being used for integration requirement purposes (that state's D-SNPs are all FIDEs and have other means of sharing information for the time being), it might be instructive for others, especially because of its ability to include smaller HCBS providers, so we are taking this opportunity to highlight it. Below is a brief description and contact information for this program.

MN DHS Encounter Alert Service (EAS)

- Funded by CMS through an Advanced Planning Document (APD) with 90% federal dollars. The state's HIT team worked with the MN DHS Health Care Administration to contract with vendor Audacious Inquiry in September of 2017.
- EAS receives messages from treatment facilities in Minnesota and compares them to patient lists provided by subscribers. When one of the listed patients has an encounter at a participating facility, subscribers receive an alert containing details about that patient's encounter.
- EAS delivers HL7 standard "Admit, Discharge, Transfer" messages between registered Minnesota Medical Assistance (MA) providers to quickly and securely notify appropriate providers when a person moves through the system.
- MN's Goal is to have all registered providers of MA-funded services in the EAS
- Beneficiaries are served more effectively when HCBS providers participate in the EAS
- Small HCBS providers can access EAS (with proper consents in place) without needing Electronic Medical Record System
- Website: https://mneas.org/
- State contacts:

  Rolf Hage -Nursing Facility Rates & Policy, MN DHS rolf.hage@state.mn.us
  Tom Gossett – Director, Business Integration & Alignment, MN DHS tom.l.gossett@state.mn.us

Conclusion

The SNP Alliance is committed to quality, excellence and health equity 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—primarily 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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