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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Submitted electronically to <http://www.regulations.gov>

Re: Comments on CMS-4203-NC

The Special Needs Plan Alliance (SNP Alliance) is the national non-profit leadership organization for Special Needs Plans and Medicare-Medicaid Plans. The SNP Alliance represents 26 health plan organizations with over 400 plan products, serving over 2.8 million enrolled beneficiaries (about 60% of all beneficiaries enrolled in SNPs). These special needs plans (SNPs) and Medicare-Medicaid plans are subsets of Medicare Advantage (MA) plans. SNPs are specifically authorized and designed to meet special care needs of Medicare beneficiary sub-groups. The plan types and subgroups include:

- **Chronic condition SNPs** (C-SNPs): serving persons with certain severe or disabling chronic conditions (e.g., HIV-AIDS, chronic heart failure, COPD, mental illness, etc.).
- **Institutional SNPs** (I-SNPs): serving persons residing in nursing homes or with comparable care needs in the community.
- **Dual eligible SNPs** (D-SNPs): serving persons covered by both Medicare and Medicaid.
- **Fully Integrated Dual Eligible SNPs** (FIDESNPs), **Highly Integrated Dual-Eligible SNPs** (HIDSNPs), and **Medicare-Medicaid Plans** (MMPs) – which are a specific type of D-SNP and provide both Medicare and Medicaid benefits, including long-term services and support.

Dually Eligible Population - A large proportion of the individuals enrolled in SNPs are dually-eligible for both Medicare and Medicaid and have high social risk issues. Nationally, dually-eligible individuals comprise about 11% of beneficiaries, but account for 30% of costs due to their condition and social risk complexity. See: [SNPA-Member-Profile-Brief-FINAL-June-30-2021.pdf \(snpalliance.org\)](#)

SNPS are regulated, evaluated, and paid on the same basis as other Medicare Advantage plans, and yet they are required to provide additional benefits and services to their target/special populations and to implement tailored care management according to unique Models of Care. While the SNP Alliance responds to this RFI focus on mining the best practices of special needs health plans and refining policies and regulations pertaining to SNPs to maximize the value and reduce barriers to achieving the goals set by Congress., we recognize that the foundation for SNPs begins with Medicare Advantage. MA provides the opportunity to coordinate care and offer flexibilities for benefits not available in fee-for-service Medicare. In exploring revisions to the MA program, the SNP Alliance cautions CMS to avoid unintended consequences with changes to MA that may result in greater disparities for those most at risk, including individuals enrolled in all types of SNPs.

Summary of RFI Responses

We are pleased to have this opportunity to provide our thoughts for improvements in the MA program, in particular those related to Special Needs Plans. Our remarks address selected questions posed in the RFI in the five domains:

- A. *Advancing Health Equity (P.3);*
- B. *Expanding Access: Coverage and Care (P.13);*
- C. *Driving Innovation to Promote Person-Centered Care (P.18);*
- D. *Supporting Affordability and Sustainability (P.21); and*
- E. *Engaging Partners (P. 26).*

A summary of our suggestions is offered first for each RFI question reviewed, followed by an addendum with overarching recommendations and in-depth analysis and information pertaining to more than one question beginning on page 31.

In our addendum we ask CMS to focus efforts on four overarching recommendations addressing key aspects of the MA program which promote or impede attention to diverse and special needs populations. These recommendations are directed toward the goal of improving policy, practice, and promoting innovation and effective evaluation as outlined below:

- I. Recognize the value of SNPs and support special populations enrolled through improved policy, payment, analysis, and reporting information**
- II. Provide incentives to increase the reach of SNPs so that duals and special needs populations can enjoy the enhanced care management and other benefits of these models**
- III. Improve quality measurement, case mix adjustment/risk models, and performance evaluation for special populations**
- IV. Reduce alignment hurdles between the Medicare and Medicaid programs for the dually eligible**

Please do not hesitate to contact us for further information. You may contact me, Dr. Phillips, at cphillips@snpalliance.org or Dr. Deborah Paone, Performance Evaluation Lead, at dpaone@snpalliance.org

Sincerely,



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

Summary Responses to RFI Questions

A. Advancing Health Equity

Question #1. What steps should CMS take to better ensure that all MA enrollees receive the care they need (groups delineated)?

AND

Question #11. How are MA plans currently using MA rebate dollars to advance health equity and address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

SNPs Attend to Diverse and High-SDOH Groups- The SNP Alliance has examined peer-review studies, expert committee reports, case studies, and other resources/references on social determinants of health and the impact these risk factors have on health outcomes. For the last six years our Annual Survey of plans has included questions about SNP efforts around comprehensive health assessment and Social Risk Screening with follow-up referral to services to identify and address the needs of special populations.

The diversity of language, chronic conditions, behavioral health and medical issues, age, gender identity, social risk issues and other factors means that SNPs—as a group of plans—serve a highly diverse population. Some plans specialize in frail elders who are at a nursing home level of care, some focus on people with HIV/AIDs, Complex/advanced Diabetes with Complications, some focus on people who are age 18-64 with physical disabilities, some plans have a high proportion of individuals in their enrolled population with mental/behavioral health and substance use disorders. Some SNPs work with those in palliative care toward the end of life. These plans have a high proportion of people who are low income, have low health literacy, and are experiencing environmental stress. For these individuals, having one or more social risk factor (such as lacking transportation, food security, housing, or being socially isolated with no family supports)—impacts the person’s health status and achievable health outcomes. Oftentimes special needs health plans see multiple SDOH risk factors in their enrolled populations, where these individuals are dealing with multiple diagnosed conditions as well as lacking social support and basic human needs. [SNPA-Member-Profile-Brief-FINAL-June-30-2021.pdf](#) (snpalliance.org) [snpa-briefing-paper-on-sdoh-paone-final-6172019.pdf](#) (snpalliance.org)

SNPs use multiple sources of data to identify enrollee characteristics and needs such as enrollment files, care management database, provider encounters, claims, the initial and annual Health Risk Assessment (HRA), and external data sources, such as Census data, American Community Survey, county health ranking, community health assessment information, state and county and municipal studies, heat mapping re: ER or other emergency usage (EMT) etc.

Under the SNP Model of Care standards includes a requirement for conducting a health risk assessment. This is one method for identifying enrollee characteristics such as race, ethnicity, language, literacy, etc., such as described the questions in this RFI around Health Equity. Special needs health plans request information about each member (beneficiary) in the enrollment process and conduct an initial and annual health risk assessment. Individuals may, of course, decline the assessment and answering questions about race, ethnicity, and other characteristics is always voluntary. If the individual is willing to answer these questions, then the plan can tailor care/support and conduct a review of care outcomes through analysis by specific enrollee group following service or annually. If the individual does not wish to answer such questions, the health plan continues to reach out to the individual through various member engagement strategies. SNPs have care management strategies such as utilizing community health workers, care managers, care navigators and outreach coordinators to tailor support.

Payment and policies around Special Supplemental Benefits for the Chronically Ill (SSBCI) could be revised to improve flexibility for SNPs in serving diverse populations with high SDOH needs to advance health equity goals. This would include allowing social risk issues that impact care to be included in the considerations for offering SSBCI. Currently SDOH risk factors can only be addressed if they maintain or improve health and these risk factors along cannot be used to provide supplemental services. Special needs and complex care beneficiaries have not accessed the Special Supplemental Benefits for the Chronically Ill or other primarily health-related benefits to the extent envisioned by Congress. Policymakers and CMS could provide better education, information, and incentives for these populations to enroll in SNPs and could support better integration across the Medicare and Medicaid programs, as well as provide better financing (outside of the quality bonus payment system) for SSBCI.

We believe CMS already has the authority to make many of the necessary changes to reduce barriers to health equity, and, together with Congressional support, can reduce structural inequities within the Medicare and Medicaid programs around the dually eligible population.

Action Steps:

- **Support SNPs** - Support MA high-dual plans with enhanced resources and policies
- **Support Best Practices** - Extend the best practices demonstrated by high-performing SNPs through supportive program policy, risk adjustment, quality measurement, and payment
- **Allow flexibility for HRA and Care Management practices by SNPs** – SNPs have been screening for SDOH risk factors for years and these are built into their Health Risk Assessments and care management processes.
- **Educate Consumers and Providers on Benefits** - Highlight the added benefits of SNPs (Model of Care, SSBCI) to all dually eligible and special needs beneficiaries and their providers; improve the Medicare Plan Finder
- **Align Feds and States** - Align State and Federal data definitions, screening, and care management requirements for the dually eligible

- ***Improve Data Standardization and Availability – For example, Create a National Database with Universal Definitions*** - Develop a national searchable beneficiary database on beneficiary characteristics including social risk factors, starting with the dually eligible population (with protections/permissions) which would be accessible by plans
- ***Improve Flexibility around SSBCI*** - Increase enrollee eligibility and benefit flexibility for SNPs and other high Dual plans to be able to offer more non-traditional services and do so proactively such as through Special Supplemental Benefits for the Chronically Ill (SSBCI)
- ***Increase Provider Incentives*** - Provide incentives to providers to target improvement for different groups in the policy, and payment systems of providers; consider a “specialized integrated care consultation visit” to encourage interdisciplinary team communication and coordination around SDOH risk factors impacting medical, behavioral health, and long-term services and supports.
- ***Support the Annual Wellness Visit*** - Increase support to providers around the Annual Wellness Visit as a key point of care within every beneficiary’s experience.
- ***Revise Quality Bonus Program*** - Revise approach to the Quality Bonus Payment (QBP) system for MA so that the approach does not exacerbate resource distribution inequities. The QBP has the potential to be a real lever for change. Help it reach that potential through quality payment incentives that recognize performance for people with the greatest vulnerabilities.
- ***Work Toward Meaningful Measures*** - Change measures, instruments, and methods of quality review to recognize and accommodate diverse and special populations.
- ***Improve Measure Alignment*** - Align measures across plans and providers, MA and ACO and other value-based options for specific beneficiary complexity groups.
- ***Improve or Replace Categorical Adjustment Index*** - Improve or replace the Categorical Adjustment Index using guidance from independent technical experts, such as the five technical reports provided by the *Committee on Accounting for Socioeconomic Status in Medicare Payment Programs* that examined the effect of social risk factors in Medicare quality measurement and value-based payment through the National Academies of Science, Engineering and Medicine (2016-2017).
- ***Separate into Plan Cohort Peer Groups*** - Separate High Dual Plans from Low Dual Plans and examine each group separately
- ***Add Beneficiary Complexity Index*** - Add Beneficiary Complexity Index or equivalent that includes frailty, palliative care, condition complexity, functional status and SDOH characteristics
- ***Modify Frailty Adjustment*** - Replace the Health Outcomes Survey (HOS) instrument for calculating level of frailty and applying a frailty adjustment for SNPs as the current instrument does not adequately capture frailty and the method substantially under-samples the most frail individuals as they find it difficult to participate in the survey.
- ***Add HIDE-SNPs*** - Provide Highly Integrated D-SNPs access to the frailty adjustment as accessed by Fully Integrated D-SNPs.
- ***Educate Providers in Working with Special Populations*** - CMS with States - Coordinate and integrate efforts to educate providers on best practices for different beneficiary groups, starting with the dually eligible.

- **Foster Learning Collaboratives** - CMS with States - Create learning collaboratives that capture insights and strategies that demonstrate improvement toward health equity goals.

Question #2. *What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?*

AND

Question #3. *What are effective approaches in MA for screening, documenting and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?*

AND

Question #7. *What food or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are most in need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically-tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.*

Special Needs Plans Work to Address Complex Medical, Behavioral, and Social Needs of their Diverse Populations Enrolled - SNPs are an innovation created by Congress in 2002 requiring specialized structures, processes, networks, and attention to high-need, at-risk populations. Over these last 20 years there has been slow but perceptible recognition in policy of the value of SNPs. More is needed, however, to make the most of the opportunity that SNPs offer and to learn from best practices discovered over these two decades.

SNPs use multiple sources of data to identify enrollee characteristics and needs such as enrollment files, care management database, provider encounters, claims, the initial and annual Health Risk Assessment (HRA), and external data sources, such as Census data, American Community Survey, county health ranking, community health assessment information, state and county and municipal studies, heat mapping re: ER or other emergency usage (EMT) etc.

Special needs health plans request information about each member (beneficiary) in the enrollment process and conduct an initial and annual health risk assessment. Individuals may, of course, decline the assessment and answering questions about race, ethnicity, and other characteristics is always voluntary. If the individual is willing to answer these questions, then the plan can tailor care/support and conduct a review of care outcomes through analysis by specific enrollee group following service or annually. If the individual does not wish to answer such questions, the health plan continues to reach out to the individual through various member engagement strategies.

SNPs have care management strategies such as utilizing community health workers, care managers, care navigators and outreach coordinators to tailor support.

Specialized, tailored care management, provider teams, and quality focus are important components of a care system for any dually eligible and high-risk individuals. These individuals have substantial risk issues and care coordination needs. We recommend that CMS work to better educate the public, targeting dually eligible individuals, about the value of these specialized components and of enrolling into integrated D-SNPs.

Payment and policies around Special Supplemental Benefits for the Chronically Ill (SSBCI) could be revised to improve flexibility for SNPs in serving diverse populations with high SDOH needs to advance health equity goals. This would include allowing social risk issues that impact care to be included in the considerations for offering SSBCI. Currently SDOH risk factors can only be addressed if they maintain or improve health and these risk factors alone cannot be used to provide supplemental services.

We believe CMS already has the authority to make many of the necessary changes to reduce barriers to health equity. Policymakers and CMS could provide better education, information, and incentives for these populations to enroll in SNPs and could supplement support for SSBCI through other adjustments outside of the Quality Bonus Payment program.

Action Steps:

- ***Support Existing Innovation*** - SNPs are an example of an innovation authorized by Congress in 2002 that has matured and expanded. We recommend mining the best practices demonstrated by SNPs over the last 20 years in outreach and care management to special and diverse populations and increasing the reach of these programs through education and incentives to beneficiaries.
- ***Improve Beneficiary Use and Understanding of SNPs, the Medicare Plan Finder, Star Ratings, SSBCI*** – Improve information and education of beneficiaries, including more/better information about SNPs, SSBCI benefits and eligibility for these benefits, as well as additional filters and fields to compare health plans, improve required education and training for benefits counselors and brokers working directly with beneficiaries; audit a sample of counselors and brokers or build in self-audits or other protections to spot-check
- ***Support SNP Health Risk Assessment and Care management*** – SNPs are the only type of MA plan that create specialized Models of Care which are reviewed and audited by CMS for compliance. This includes an annual health risk assessment which includes SDOH screening for risk issues such as food insecurity, housing instability, social isolation, etc. There are extensive regulations and oversight of these specialized care management practices. We have several recommendations for improvement provided in this letter.
- ***Encourage Greater Beneficiary Participation in SNPs*** - More dually eligible and high-risk individuals might join and receive enhanced care management through SNPs if there was

- better understanding about the benefits and incentives to join when beneficiaries are making their choices among plans. We recommend outreach, education, and incentives.
- ***Improve Data Standardization and Access on Beneficiary Characteristics, (for example, Create a National Database with Universal Definitions)*** - Develop a national searchable beneficiary database on beneficiary characteristics including social risk factors, starting with the dually eligible population (with protections/permissions) which would be accessible by plans
 - ***Refine the MOC Guidelines*** - Additional Model of Care requirements for SNPs have been added over the last two years. We recommend a review of the requirements and processes to ensure that there is not excessive burden, duplication, or proscriptive standards that do not leave room for evidence and practice-informed improvement. For example, flexibility in addressing specialized group needs and characteristics through Health Risk Assessments, Care Management, Individualize Care Plans, Interdisciplinary Care Teams and Provider Training.
 - ***Publish Evidence & Best Practices*** - We recommend that the evidence supporting specific processes required in the Model of Care be made available. Education and dissemination of the evidence is particularly important to assist providers in seeing the value of the MOC requirements and plan expectations around screening, interdisciplinary teams, individualized care planning, and the role that health plans play in assisting their patients to achieve optimal health outcomes.
 - ***Conduct National Provider Training on MOC*** - Providers are expected to be trained on each health plan's model of care, although many of the standard factors and elements are common across Models of Care. Burden on providers could be reduced. We recommend an annual online provider-accessible review of the national guidelines be created by CMS, with ability of the provider to access plan-specific MOC trainings as a resource for plan-specific processes used and key contacts for follow up when needed.
 - ***Foster Plan, Community, and Provider SDOH Partnerships*** - SNPs work with cities/towns, medical/health care providers, community-based organizations, and other stakeholders in partnership to collaborate on improving access to food, housing, transportation and other needs. Payment and policies around SSBCI could be revised to improve flexibility for SNPs in serving diverse populations with high SDOH needs to advance health equity goals.
 - ***Provide Better Funding Support for SSBCI*** - A primary source of SSBCI funds is from quality bonus payments—this resource distribution method has been identified as being inherently flawed, particularly biased against MA plans with high need members.
 - ***Improve or Replace Categorical Adjustment Index*** - Update or replace the Categorical Adjustment Index using guidance from independent technical experts, such as the five technical reports provided by the *Committee on Accounting for Socioeconomic Status in Medicare Payment Programs* that examined the effect of social risk factors in Medicare quality measurement and value-based payment through the National Academies of Science, Engineering and Medicine (2016-2017).
 - ***Work Toward Meaningful Measures*** - Change measures, instruments, and methods of quality review to recognize and accommodate diverse and special populations.
 - ***Improve Measure Alignment*** - Align measures across plans and providers, MA and ACO and other value-based options for specific beneficiary complexity groups.

Question #6. *For MA plans and providers that partner with community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.*

- Yes, SNPs contract with CBOs, both national providers of services, such as Mom’s Meals, and local providers, such as local organizations including housing and food service organizations.

Action Steps:

- **Improve Beneficiaries’ Access to SNPs & SSBCI** - SNPs provide a wide range of SSBCI benefits pertaining to the following needs: food insecurity, housing instability, transportation issues, social isolation, language and interpretation challenges, lack of communication device, etc. In addition to services addressing these needs, some SNPs also provide home support services, in-home and adaptive equipment for functional limitations and disability related to health conditions, pest control, adult day health care, and restorative or pain relief therapy modalities, such as acupuncture. The challenge SNPs currently face is the restrictions within regulation on who can receive SSBCI. We have several recommendations to improve eligibility and benefit flexibility.
- **Foster Plan, Community, and Provider SDOH Partnerships** - SNPs work with cities/towns, medical/health care providers, community-based organizations, and other stakeholders in partnership to collaborate on improving access to food, housing, transportation and other needs. Payment and policies to foster such collaborations in serving diverse populations with high SDOH needs to advance health equity goals would facilitate and accelerate cross-sector aligned actions to address systemic and underlying issues that run deep and require sustained and comprehensive efforts to address.
- **Invest in CBO Infrastructure** - Single CBOs often do not have the ability to contract, share data, serve beneficiaries, and monitor quality performance. We provide offer ideas for addressing this infrastructure and capacity gap, starting with investment in these systems by Congress, HHS, CMS and other federal and state agencies.
- **Facilitate SDOH-related Referral to Services and Follow-up** - Referral and follow up would be greatly facilitated with a national, interactive, searchable standardized/universal database with digital application to search for community resources in all States. Incentives for entering and updating information could be provided to CBOs.

Question #8. *How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures reflect the quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?*

Focus on Special and Diverse Populations as a Target Group for Improving the Quality Measurement and Performance Reporting Systems –

Change measures, instruments, and methods of quality review to recognize and accommodate diverse and special populations. There are many opportunities for improvement and options to pursue (see Section III of this comment letter). We are concerned that the measures, methods, and underlying assumptions in various predictive models in MA Star Ratings are insufficient and have built in inequities that impact plans such as special needs health plans serving a high proportion of disabled/low-income/dually eligible individuals. The MA Quality Measurement system should not add to the inequities in resource allocation.

In a 2018 report by RAND based on their review of MA and Dually Eligible Beneficiaries they recommended:

*Use performance measures and instruments relevant for dually enrolled beneficiaries in quality reporting and value-based payment programs. **Existing instruments** (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]) and performance measures included in the MA Star Rating program **may not adequately account for improvements most important to dually enrolled beneficiaries** (e.g., daily functioning, quality of life), improvements in intermediate outcomes for which dually enrolled beneficiaries have worse starting values than other beneficiaries, or measure plans' achievement of care coordination or patient-centered care.*

Making these SNP specialized and tailored care management processes, providers, team models, outreach and quality improvement efforts available to dually eligible and high-risk individuals is an important action step. These individuals have substantial risk issues and care coordination needs. Congress recognized these are important components of a care system for any high-risk beneficiary. We recommend that CMS work to better educate the public, targeting dually eligible individuals, about the value of these specialized components and of enrolling into integrated D-SNPs.

Action Steps:

- ***Improve Beneficiaries Understanding of Star Ratings*** - Beneficiaries may see Star Ratings on the Medicare Plan Finder and may see the high star health plans promoting their Star Rating, but given the way Star Ratings are calculated, the Star level may not represent the level or quality of care the person would receive—since it is a very general summary of measure results and people. If a person has special needs and diverse characteristics, the Star Rating may not be relevant or comparable to what they experience.
- ***Clarify the Limitations of what the Star Rating means*** - The MA Star Ratings may not adequately reflect the quality of care for diverse, chronically ill, and special populations. The reasons include: the measures do not match the priority issues of special population groups, the measures have not been adequately tested in special population groups, the methods of data collection do not accommodate special population groups, the survey instruments (wording,

formatting, response options) are not designed to be completed by special population groups, or the contract may include multiple states and thus may not reflect the population of individuals enrolled in a given state.

- ***Pursue Opportunities for Improvement in MA Quality Measurement and Performance Evaluation*** - There are opportunities for improvement and options to pursue. See Section III of - this response letter.

Question #9. *How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?*

AND

Question #7. *What food or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are most in need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically-tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.*

SNPs have invested in chronic care expertise, internal structures and processes, innovation, member outreach, and communication connections to facilitate virtual interdisciplinary care management and accountability. This extends beyond traditional medical and behavioral health settings. Plans are trying to make these connections across providers and with LTSS.

Plans have worked with their communities, states, and providers for years to achieve their current care models. These structures, processes, and the resources plans have invested over the years to create them rely on a deep attention to and understanding of members' characteristics and community services. Finding multiple ways to proactively reach the member, establishing relationships, and connecting across settings, disciplines, and over time, are some of the ingredients of successful efforts. This happens only over time and with intentional sustained effort. This needs to be more fully resourced to extend these best practices to other special populations and improve beneficiary experience across regions of the country.

Action Steps:

- ***Make the Most of SNP Authorization*** -SNPs are an example of an innovation authorized by Congress in 2002 that has matured and expanded. SNPs provide the framework and structure for targeting, tailoring, and integrating care. We recommend greater support for this unique type of MA health plan through refinements in policy, payment, and regulation.
- ***Mine Best Practices of SNPs*** - We recommend mining the best practices demonstrated by SNPs over the last 20 years in outreach and care management to special and diverse

- populations and increasing the reach of these programs through education and incentives to beneficiaries.
- ***Rework Model of Care Requirements*** - SNPs are the only type of MA plan that create specialized Models of Care which are reviewed and audited by CMS for compliance. There are extensive regulations and oversight of these specialized care management practices. We have several recommendations for improvement to reduce, streamline, or re-work elements and factors required to reduce burden and allow for continuing best practices to emerge.
 - ***Increase Visibility and Understanding about SNPs among the Dually Eligible Population and those at high risk*** - More dually eligible and high-risk individuals might join SNPs if they had a better understanding about the benefits and incentives to join when beneficiaries are making their choices among plans.
 - ***Support SNPs in Identification and Care of People with High Social Risk*** - SNPs already identify social risk issues proactively and tailor care management methods to coalesce efforts around member needs – recent regulation has expanded these requirements. While the intent is good, the practical application of new requirements may represent a substantial cost and administrative burden on SNPs. Moreover, all people, regardless of what type of health plan they choose, should have attention paid to social determinant of health risk factors at least annually. We recommend:
 - Developing a national standard for social risk screening that would apply to all of Medicare and that could be used by States as well.
 - Improving or Replace the Categorical Adjustment Index
 - Improving Data Standardization and Availability – To support health equity goals, we recommend standardizing data standards and updating the model enrollment form to include key characteristics and data points. Interoperability across data systems should be a goal and settings should eventually include home and community-based services.
 - ***Improve Flexibility around SSBCI*** - Increase enrollee eligibility and benefit flexibility for SNPs and other high Dual plans to be able to offer food and nutrition services for people with food insecurity as a key risk factor impacting medical care/treatment and restricting the ability of the person to reach health goals, and to do so proactively through special payment or through Special Supplemental Benefits for the Chronically Ill (SSBCI).
 - ***Ease restrictions on C-SNPs & make this specialized health plan more accessible to beneficiaries - Annual Resubmission and Review of Model of Care*** – Congress has been asked to rescind the requirement for an annual submission and review of their Model of Care. Unlike other SNP types, C-SNPs are asked to annually submit and have reviewed their Model of Care – even if the plan scores highly on their previous MOC. This is a waste of resources of the plan and of CMS and NCQA. We recommend that C-SNPs be held to the same standard as other SNP types—with a MOC review that will then result in a 3-year, 2-year, or 1-year cycle—depending on the score received for that MOC submission
 - ***Support Specialized Care for Chronic Kidney Disease (CKD) Chronic Condition Special Needs Plans (C-SNPs)***: The care coordination offered by MA C-SNPs could help patients with Chronic Kidney Disease (CKD) better manage their disease and delay, or even avoid, the progression of the condition to End-Stage Renal Disease (ESRD). Therefore, we

encourage CMS to expand the list of C-SNP conditions to include patients with CKD Stages 3, 4, and 5.

Question #10. *How have MA plans and providers used algorithms to identify enrollees that need additional services or supports, such as care management or care coordination?*

To understand beneficiary needs, SNPs begin with outreach to the individual through many touchpoints and through continued analysis of information collected throughout the year. SNPs use multiple internal (plan collected) and external data sources to determine what variables are most important in targeting support, proactively promoting self-care practices, preventing decline or events, and alerting the plan and providers about triggers to avoid adverse health events. SNPs provide targeted care management for all members, based on their risk and condition profile. Many FIDE-SNPs for example have a care manager assigned to every member, as they are all high risk. These algorithms have been developed and refined over many years and are continuously updated. The SNPs have enterprise-wide efforts to learn from a variety of internal subject matter experts and datasets, such as from Member Services, Clinical Services, Care Management, Quality, Data Analytics, Population Health, Compliance—so that the one-to-one member contacts as well the aggregate data can inform strategies for outreach, care coordination, provider relations, quality improvement, and member satisfaction.

Action Steps:

- ***Improve Data Standardization and Access on Beneficiary Characteristics, (for example, create a National Database with Universal Definitions)*** - Develop a national searchable beneficiary database on beneficiary characteristics including social risk factors, starting with the dually eligible population (with protections/permissions) which would be accessible by plans
- ***Support SNP Health Risk Assessment and Care management*** – SNPs are the only type of MA plan that create specialized Models of Care which are reviewed and audited by CMS for compliance. There are extensive regulations and oversight of these specialized care management practices. We have several recommendations for improvement provided in this letter.
- ***Promote evidence-informed targeting and response*** - Provide evidence-informed algorithms based on research and practice that yield best practices as they evolve—regarding effective targeting and response to address complex and high-social risk populations.

B. Expand Access: Coverage and Care

Question #1. *What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?*

AND

Question #8. *How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits and how could access be improved?*

Beneficiaries utilize a number of methods for choosing options around health care coverage. This includes talking with benefit and enrollment counselors—individuals who are trained to answer questions about Medicare and Medicaid and guide people through health plan options available to them in their state. They may also talk with family or friends, their physician, or may review the websites of health plans in their areas, follow up on local advertising, or receive fliers and other informational material in the mail directly from health plans. Beneficiaries also may access BenefitsCheckUp® an online service managed by the National Council on Aging, their State Department of Health/Human Services website, or the Medicare Plan Finder. CMS oversees the Medicare Plan Finder. We have several suggestions (under Section III of this letter) for improving the Medicare Plan Finder.

- ***Improve Beneficiary Use and Understanding of SNPs, the Medicare Plan Finder, Star Ratings, SSBCI*** – Improve information and education of beneficiaries, including more/better information about SNPs, SSBCI benefits and eligibility for these benefits, as well as additional filters and fields to compare health plans, improve required education and training for benefits counselors and brokers working directly with beneficiaries; audit a sample of counselors and brokers or build in self-audits or other protections to spot-check.
- ***Support SNP Health Risk Assessment and Care management*** – SNPs are the only type of MA plan that create specialized Models of Care which are reviewed and audited by CMS for compliance. This includes an annual health risk assessment which includes SDOH screening for risk issues such as food insecurity, housing instability, social isolation, etc. There are extensive regulations and oversight of these specialized care management practices. Beneficiaries with special needs find value in the plan care management processes, which include assessment, care planning, interdisciplinary teams, and specialized provider networks.
- ***Use Demonstration Authority to Test Expansion*** - *The current MA financial structure allows health plans to fund supplemental benefits through rebates. The Center for Medicare & Medicaid Innovation (CMMI) could use their demonstration authority to test the expansion of access to supplemental benefits by increasing the rebate percentages for plans offering SSBCI benefits, which would enable plans to go even further in addressing SDOH.*

Question #5. *What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?*

SNP Alliance Response

Telehealth plays an important role in providing access to care, especially for beneficiaries in special needs plans, who have higher rates of chronic conditions and behavioral health needs and therefore require more usage of telehealth services. More specifically, audio-only telehealth services are needed for beneficiaries for a variety of reasons, such as limited access to broadband, functional limitations with audio-video services, inability to access in-person health services on a regular basis due to distance or extraordinary

circumstances such as pandemics and public health emergencies (PHEs) and the shortage of behavioral health providers, especially in rural areas. During the Covid-19 Public Health Emergency audio-only telehealth services have been instrumental in maintaining needed levels of care for beneficiaries with access issues. Unfortunately, health plans, due to current rules regulating audio-only telehealth services, have not been able to capture diagnoses from audio-only telehealth services—negatively impacting beneficiaries and health plans.

The SNP Alliance supports risk adjustment of diagnoses captured during audio-only telehealth services, but with certain guardrails. The guardrail of highest importance is that diagnoses should only be captured in risk adjustment via audio-only telehealth services when the beneficiary is an existing patient and has had a previous in-person assessment. With this guardrail, access to health services will be improved for beneficiaries and ensure in-person and audio-video assessments and services are not unnecessarily replaced by audio-only telehealth services.

Additionally, the SNP Alliance looks forward to the future opportunities to advance digital connectivity and equity offered by the Broadband Equity, Access, and Deployment (BEAD) provisions of the Infrastructure Investment and Jobs Act (IIJA). We recommend CMS continue to partner with agencies such as the National Telecommunications and Information Administration (NTIA) as they support states broadband strategies, and with the Federal Communication Commission (FCC) in support of the Affordable Connectivity Program (ACP) to eligible individuals. In recognition that connectivity infrastructure will take time to build and implement, we encourage CMS to also pursue options that increase Medicare beneficiaries' connection to and use of digital tools, such as supporting cellular devices programs and incorporating digital literacy so beneficiaries can maximize the opportunities of digital health services.

***Question #6.** What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces with which MA could better align?*

SNP Alliance Response

The SNP Alliance would like to take this opportunity address key public policy issues and concerns about flaws in current network adequacy requirements with respect to their appropriateness for I-SNP members. 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 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.

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

1. We recommend 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.

Question #10. *How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?*

SNP Alliance Response

While improper payment rates in Medicare declined between fiscal year 2018 and 2020, improper payment estimates were still estimated to be in the billions, and the U.S. Government Accountability Office identified prior authorization as a critical tool to address the issue of improper payments made to providers. Prior authorization is also a critical element of care coordination, helping to ensure patient treatment is safe, medically necessary, high value, and appropriate. We encourage an ongoing dialogue with CMS about the importance of prior authorization in the delivery of value-based care to beneficiaries to ensure MA continues to deliver the high-quality care and value that patients and consumers deserve.

We would like to offer some comments in response to the Office of the Inspector General's (OIG's) recent report on Medicare Advantage Organization Denials of Prior Authorization Requests. Much has already been said of the small sample size that was extrapolated across all of Medicare Advantage, and that the report neglected to point out that most MA members have never had any issue with denied authorizations. But an equally significant concern we have is the implied assumption that specific services meeting Medicare coverage rules are automatically "medically necessary." Having a service covered by Medicare does not mean that it is always appropriate for that individual—at that time, or in the setting requested. Denial for a requested service should not be automatically equated with a denial of care. Special Needs Plans must focus on assuring needed and covered services are made available to their members, and part of that responsibility is ensuring that beneficiaries are receiving necessary and proper services—not any and all services that can sometimes be harmful to the beneficiary.

While it is out of the scope of authority for the OIG or the SNP Alliance to determine appropriateness of any requested service, the report did not acknowledge past (and current) concerns regarding overutilization of unnecessary services. Again, while we cannot opine on each case provided as an example, merely meeting the Medicare criteria for a given service does not determine the appropriateness of that service for that individual. We would agree with the OIG report that increased transparency of criteria used is important for both providers and patients.

The SNP Alliance, on behalf of our member health plans and the beneficiaries they serve, request that as this issue is explored further by CMS, in addition to the broader understanding of the value of prior authorization review, the role of denials beyond simply cost containment, and the overall satisfaction of members in special needs plans, is considered. While both under-utilization and over-utilization of treatments is not in the individual's best interest, making final determinations from 18% of 500 reviews (for a total of 90 reports) should not be used to determine the appeals and review processes for the more than 26 million people currently enrolled in Medicare Advantage health plans.

C. Drive Innovation to Promote Person-Centered Care

***Question #1.** What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?*

SNP Alliance Response

As CMS begins to transition the FAI demonstration plans (Medicare Medicaid Plans-MMPs) into DSNP platforms, it is essential that CMS assure DSNPs can continue to merge funds at the plan level to provide a more seamless experience for dually eligible members and the providers serving them.

There is considerable experience in some of the early (legacy) demonstrations serving dually eligible individuals with value-based arrangements with providers that merge Medicare and Medicaid funds to create coordinated care or health care home type models across primary care and LTSS services. For example, some plans delegate care coordination, primary care and LTSS case management to clinics, "health care homes" or "care systems" that employ physicians, NPs/PAs and social workers to manage clinical care along with care coordination of home and community-based services and may pay for these services on a PMPM or sub-capitated basis. These entities may also participate in gain/risk sharing or performance payment models which may extend to additional services beyond receiving direct payments for physician and care coordination services. While specific encounter data for each Medicare and Medicaid service is still required by both CMS and the State, such models are dependent on integrated payment approaches and processing an integrated set of claims, rather than differentiating Medicare from Medicaid services at the time of payment.

In order to continue these current arrangements and to expand this sort of innovation across Medicare and Medicaid and acute, primary and LTSS services and providers, it is essential that CMS continues to provide clear guidance to claims process auditors that integration of Medicare and Medicaid claims adjudication is allowed. If requested by auditors, such DSNPs could provide plan-specific documentation regarding the methodology used for the allocation of expenditures between Medicare and Medicaid by service category. This approach has been part of CMS' Administrative Alignment demonstration in Minnesota for many years and should be recognized for all DSNPs in order to expand and encourage VBP arrangements that can integrate financing and funding sources at the care delivery level.

***Question #7.** What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreement to support improved health information exchange for use cases relevant to MA plans and providers?*

SNP Alliance Response

To further improve efficient and secure data movement across healthcare stakeholders, we encourage continued support and advancement of CMS and Office of the National Coordinator for Health Information Technology (ONC) interoperability initiatives. This includes involving all relevant healthcare stakeholders in the data exchange provisions, such as payer-to-payer data exchange, and advancing the use of Fast Healthcare for Interoperability Resources (FHIR). Aligned standards across the industry will enable relevant stakeholders to send and receive healthcare data in an efficient, secure way with reduced burden.

In addition, the lack of data sharing interferes with improving coordination and integration of Medicare and Medicaid benefits for dually eligible individuals because there is no consistent requirement or approach to sharing of enrollment information between coordination only DSNPs and state Medicaid agencies. Therefore, DSNPs may not know where their members are receiving Medicaid services, and Medicaid plans or providers may not know where their members are getting Medicare services. While states have files that should indicate where dual individuals are enrolled for Medicare, data from those files may not be shared with Medicaid providers. We have repeatedly recommended that CMS develop a more consistent process that would require that states provide Medicaid enrollment information to DSNPs to enable them to carry out their coordination functions in applicable rule requirements, and it is also important that Medicaid providers have a clear source of information on Medicare coverage for dually eligible individuals.

Further, though coordination only DSNPs are required to share some data about hospital and nursing facility admissions and discharges for some portion of their enrollees as defined by the state, there continues to be a 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. 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. In addition, such data exchanges may not include important information from HCBS providers, who are often too small or lack capacity to participate in various new interoperability initiatives and electronic record exchanges. We recommend that CMS assist in developing mechanisms for this participation and encourage states to include D-SNPs and HCBS providers in such data exchange methodologies.

To that point, we are aware of a creative approach in use for sharing on data 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 innovative 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 Medicaid 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 contact: Tom Gossett – Director, Business Integration & Alignment, MN DHS
tom.l.gossett@state.mn.us

Question #9. *What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?*

SNP Alliance Response

CMS should consider use of 1115A authority in combination with current DSNP authorities in order to facilitate the continued integration of Medicare and Medicaid services as MMPs transition to DSNPs in a number of states. Such authority could assure that all current protections apply to dually eligible individuals enrolled in these plans, while allowing specific waivers of Medicare or Medicaid operational requirements that thwart or complicate integration within the parameters of a few defined pathway options for states and provide some additional flexibility to accommodate some of the differences among states.

As mentioned earlier, CMS should also consider testing additional sources of information for the FIDE SNP frailty adjustment, to correspond more closely to that utilized in the PACE model. In order to receive a frailty adjustment FIDE SNPs must have a similar score level to PACE. PACE frailty scores are based solely on community dwelling members who meet Medicaid Nursing Facility Level of Care (NFLOC) standards and criteria. These standards are set by each state participating in PACE. However, in some

states FIDE SNP frailty scores do not reflect only the enrolled NFLOC community dwelling members because the state may require that the FIDE SNP must also enroll members who do not meet NFLOC requirements. While the NFLOC standards set by the state are the same for both PACE and the FIDE SNP, the enrollment categories of enrollees included may be quite different. When states choose to include a range of Medicaid eligibility categories including non-NFLOC community dwelling members in their FIDE SNP enrollment parameters, this results in an apples to oranges frailty score comparison between PACE and FIDE SNPs. Since states have clear data on community dwelling NFLOC members, CMS should consider developing a refined methodology based on actual state HCBS eligibility data for all community dwelling FIDE SNP members meeting NFLOC criteria.

D. Supporting Affordability and Sustainability

Question #1. *What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?*

Special needs health plans rely on rebate dollars through CMS to fund special supplemental benefits for the chronically ill and other supplemental health benefits. These rebate dollars depend in part on the quality Star rating the plan achieves through the MA Quality Measurement System, yet there is no tailoring of the quality measures or scoring for plans that serve a high proportion of special needs and diverse populations. This has the unintended effect of restricting resources to the very plans and beneficiaries that need them most.

Action Steps:

- ***Revise the Quality Bonus Program*** - Revise approach to the Quality Bonus Payment (QBP) system for MA so that the approach does not exacerbate resource distribution inequities. The QBP has the potential to be a real lever for change. Help it reach that potential through quality payment incentives that recognize performance for people with the greatest vulnerabilities.
- ***Improve or Replace the Categorical Adjustment Index*** - Update or replace the Categorical Adjustment Index using guidance from independent technical experts, such as the five technical reports provided by the *Committee on Accounting for Socioeconomic Status in Medicare Payment Programs* that examined the effect of social risk factors in Medicare quality measurement and value-based payment through the National Academies of Science, Engineering and Medicine (2016-2017).
- ***Utilize Plan Cohort Peer Groups*** - Separate High Dual Plans from Low Dual Plans and examine each group separately
- ***Add a Beneficiary Complexity Index*** - Add Beneficiary Complexity Index or equivalent that includes frailty, palliative care, condition complexity, functional status and SDOH characteristics
- ***Address Beneficiary Survey Limitations*** - Address limitations in instruments and methods around the Health Outcomes Survey (HOS) and the Consumer Assessment of

Healthcare Providers Survey (CAHPS) to accommodate and recognize diverse and special needs populations

- ***Develop Tailored Measure Sets*** - Provide for tailored measure sets – or allow for measure equivalency so that the set of measures used for special ad diverse populations match their needs, priorities, and characteristics
- ***Set Minimum Standards for Measure Testing in MA*** - Set forth minimum standards for measure testing for use in the Medicare and Medicaid programs
- ***Improve Frailty Adjustment*** - Replace the Health Outcomes Survey (HOS) instrument for calculating level of frailty and applying a frailty adjustment for SNPs, include both FIDE-SNPs and HIDE-SNPs ability to access a frailty adjuster
- ***Improve SSBCI Flexibility*** - Increase enrollee eligibility and benefit flexibility for SNPs and other high Dual plans to be able to offer non-traditional services proactively such as through Special Supplemental Benefits for the Chronically Ill (SSBCI)
- ***Provide Incentives to Providers to serve High Risk and Special Populations e.g., via a “Specialized Integrated Care Consultation”*** - Provide incentives to providers to target improvement for different groups in the policy, and payment systems to providers, such as a “specialized annual integrated care consultation visit” that would include an interdisciplinary virtual team visit that is reimbursed and that includes attention to how social risk factors and other issues faced by the patient impact medical, behavioral health, and long-term services and supports access and treatment/care.
- ***Support the Annual Wellness Visit*** - Increase support to providers around the Annual Wellness Visit as a key point of care within every beneficiary’s experience.

Question #2. *What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?*

Over six years ago in their 2016 Report to Congress, the Assistant Secretary for Planning & Evaluation found that dual-eligible status was a valid proxy for high social determinant of health risk factors, and that such factors had a negative effect on outcomes. Furthermore, they found that the measurement system did not adequately adjust for high social risk factors and appeared to have unintended negative effects on organizations that served a high proportion of these individuals. ASPE’s Report to Congress (U.S. Department of Health and Human Services, 2016; See: [Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs | ASPE \(hhs.gov\)](#)) had three key recommendations:

- (1) Measure and report quality ***specifically for beneficiaries with social risk factors;***
- (2) Set high, fair quality standards for all beneficiaries and ***consider adjustment of measures for social risk factors based on empirical relationships and to improve adjustment for health status;***
- (3) Reward and support better outcomes through targeted financial incentives within value-based purchasing programs to ***reward achievement or improvement for beneficiaries with social risk factors.***

Similar recommendations for action were offered by RAND from their analysis of MA plans and addressing social determinants (commissioned by HHS/CMS):

[Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies | RAND](#)

The SNP Alliance has previously offered recommendations to CMS/HHS pertaining to an interim approach to adjust measure scoring to help address systemic inequities. The Categorical Adjustment Index (CAI) was set up seven years ago by CMS in response to Congress calling for better SES/SDOH adjustment in the MA Quality Measurement System. The CAI is a complicated method that sets up 10 levels (groupings) of health plans for DE/LIS status and 5 levels for Disabled. Since inception, the top level of DE/LIS (Level 10) was set extremely high—Level 10 requires that 100% of all individuals enrolled in the health plan must be dually eligible and/or receive a low-income subsidy. Special needs health plans that exclusively serve dual members have reported that they run into a challenge with reaching the 100% CAI level 10 because some of their members may not be determined Medicaid eligible for part of the year due to changes or delays or other administrative processes performed by the State. Therefore, SNPs may not be able to access Level 10 in the CAI even though they are exclusively serving dually eligible members. The difference between the CAI adjustments at Level 10 and Level 9 can be significant in terms of impact. This restricts access to resources and dampens the usefulness of the CAI.

Special needs health plans rely on rebate dollars through CMS to fund special supplemental benefits for the chronically ill and other supplemental health benefits. These rebate dollars depend in part on the quality Star rating the plan achieves through the MA Quality Measurement System, yet there is no tailoring of the quality measures or scoring for plans that serve a high proportion of special needs and diverse populations. This has the unintended effect of restricting resources to the very plans and beneficiaries that need them most.

Action Steps:

- ***Target Dually Eligible, Disabled, Low Income*** - Begin by targeting people who are dually eligible, disabled, and/or low income to test the current case mix, risk adjustment, and predictive models and then begin adding additional variables such as frailty, functional status limitations, language, literacy, race, ethnicity, poverty level in the region--to see what additional explanatory power is found. This analysis will help guide revisions to the current methods of quality measurement, payment, and regulations. This may reveal multiple opportunities to improve such policies toward a more equitable system.
- ***Improve Data Standardization and Availability***

- **Utilize Plan Cohort Peer Groups** - Separate High Dual Plans from Low Dual Plans and examine each group separately
- **Add Beneficiary Complexity Index** - Add Beneficiary Complexity Index or equivalent
- **Address Beneficiary Survey Limitations** - Address limitations in instruments and methods around the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers Survey (CAHPS) to accommodate and recognize diverse and special needs populations
- **Develop Tailored Measure Sets** - Provide for tailored measure sets – or allow for measure equivalency so that the set of measures used for special ad diverse populations match their needs, priorities, and characteristics
- **Revise the QBP** - Revise approach to the Quality Bonus Payment (QBP) system for MA so that the approach does not exacerbate resource distribution inequities– The QBP has the potential to be a real lever for change. Help it reach that potential through quality payment incentives that recognize performance for people with the greatest vulnerabilities.
- **Revise or Replace the CAI** - Update or replace the Categorical Adjustment Index using guidance from independent technical experts, such as the five technical reports provided by the *Committee on Accounting for Socioeconomic Status in Medicare Payment Programs* that examined the effect of social risk factors in Medicare quality measurement and value-based payment through the National Academies of Science, Engineering and Medicine (2016-2017).
- **Report on to Congress on CAI Impact to Date** - Publish results on the impact for the Categorical Adjustment Index (CAI) in reaching/adjusting for high SDOH populations. It has been seven years. Congress and stakeholders deserve to know whether the method has been effective.
- **Set Timeline and Process for SDOH Adjustment Method that is Permanent** - CMS should also declare their plans to work with stakeholders toward a permanent solution with specific timeline and process.
- **Improve the Frailty Adjustment** – Replace or revise the Health Outcomes Survey (HOS) instrument for calculating level of frailty and applying a frailty adjustment for SNPs and include both FIDE-SNPs and HIDE-SNPs.

Question #5. *What are notable barriers to entry or other obstacles to competition within the MA market generally, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program?*

SNP Alliance Response

Plan consolidation can have a negative impact on entry and competition and is a significant concern for smaller plans. While consolidation allows for economies of scale overall, they tend to favor larger payers,

all the while providing fewer choices for beneficiaries in the market and creating upward pricing pressure due to providers negotiating rates with fewer payers.

To better understand vertical integration in health care systems and its impact on MA plans specifically, the SNP Alliance encourages CMS to collect and analyze data on the following factors:

- Number of beneficiaries covered by larger, integrated payers versus smaller, regional, or non-profit payers.
- Quality indicators, financial metrics, and patient satisfaction between the larger and smaller payers.
- Impact of geographic diversity of having smaller payers in a marketplace vs not — i.e., Does having smaller payers in a market increase geographic diversity and therefore access to care?
- Overall rate of enrollment in MA plans in areas of high payer diversity versus low payer diversity.

Question #6. *Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?*

SNP Alliance Response

In its recent 2023 Medicare rule, CMS indicates interest in an integrated MLR as utilized currently in MMPs, and how this feature might be applied to DSNPs, since the FAI demonstration will be phased out and may be transitioned to DSNP platform. The SNP Alliance recommends that CMS look at how to better align MLR cost reporting, definitions, and related requirements between Medicare and Medicaid and consider the lack of transparency and lack of 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 also suggest CMS will need to consider how the 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. CMS should consult plans and states as these concepts move forward. CMS could test some additional modeling and detail to see how such an approach can work under the D-SNP platform as soon as possible. CMS may need to consider changes to relevant state Medicaid requirements if needed to align definitions to make this feasible. CMMI authority could also be used to test such approaches in existing willing states and FIDE SNPs. The SNP Alliance would appreciate being involved in this ongoing effort.

E. Engage Partners

Question #4. *What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?*

SNP Alliance Response

The SNP Alliance greatly appreciates the work CMS/MMCO is doing to further enable integration of Medicare and Medicaid for individuals eligible for both programs (dually eligible individuals). The dually

eligible population contains the most diverse, complex and costly Medicare and Medicaid beneficiaries, and these beneficiaries face the most significant barriers and inequities in access to care in addition to the difficulties inherent in navigating two large, complex and separate systems of care. While enrollment of dually eligible individuals in DSNPs has grown to over 3 million, only about 10% of these enrollees are enrolled in programs that fully integrate care delivery. Further integration of service delivery and alignment of financing incentives are critical to facilitate improvement in access and equity for this group.

In its most recent rule CMS/MMCO clarifies direction for the future of current integration efforts by setting timelines for ending Medicare Medicaid Plans (MMPs) operating under the temporary demonstration status of the Financial Alignment Initiative (FAI) and by providing pathways for states to better utilize the more permanent DSNP platform to continue integration efforts. We request that CMS continue to partner with states and health plans to identify Medicare and Medicaid financing integration approaches including using current demonstration authority to reduce administrative barriers and duplication under the DSNP platform in order to limit shifting costs between programs and increase financing of community-based Medicaid services. The SNP Alliance supports the direction of the recent CMS/MMCO changes but also wants to ensure that lessons learned and experiences from the FAI MMP efforts are incorporated and considered in state transition plans, including but not limited to infrastructure investments and changes needed to preserve a unified enrollment process, unified MOCs and care coordination functions, unified assessments, unified networks, additional QA measures and supplemental benefits as outlined below. We thank CMS for its recent memo “Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs” sent on August 25, 2022, which outlines opportunities and timelines for states to take advantage of changes offered under the new rules which will assist in further alignment of Medicare and Medicaid.

Communication:

Clear communication between CMS, the Medicare Medicaid Coordination Office (MMCO) states and DSNPs will be key to a smooth transition for individuals current served by the MMPs. In that regard, we offer the following additional recommendations:

- CMS/MMCO should encourage states to communicate with their MMPs as to their intentions to extend the MMPs through 2025 or end them in 2023, prior to the October deadline set for submitting their transition plans and CMS should ensure that these state transition plans including notice timeline expectations and draft notices for enrollees are publicly available.
- CMS/MMCO should issue further written guidance to MMPs and states prior to the October deadline to outline further details and expectations. It would be helpful if this guidance includes best practices based on history and experience of other states that have transitioned from the MMPs to DSNPs in recent years.
- We recommend that October transition plans should be considered conceptual until best practices and/or other guidance is available and that CMS/MMCO should clarify this point with states so that further administrative and operational details provided after this deadline can be incorporated.
- We expect that CMS/MMCO will need to consider additional rule making post the October deadline and if so, CMS should announce timelines for such as soon as possible.

Operational and Administrative Processes:

We also expect this transition will need to focus on nitty gritty operational and administrative processes and how to best manage and align them outside of the current FAI structures in order to be successful. A solid foundation for operations and administration would help support the next level of integration such as shared financing/savings models. These operational processes include:

- Oversight structures for ongoing coordination and communication between CMS, states and DSNPs:
 - As states lose some authority they had under the FAI and the MMPs move to separate contracts with states and CMS, we suggest that CMS consider a modified contract management team arrangement such as that used in the Minnesota Administrative Alignment demonstration which provides for regular meetings between states, MMCO and the Regional Office, including clarifying oversight roles and communications with DSNPs.
 - CMS should clarify the roles of DMAO and CMCS ongoing oversight of integrated programs including oversight structures within CMS and between MMCO and states and assure that opportunities for communication and collaboration on program improvements and growth will be addressed between the CMS internal entities.

- Enrollment processes:
 - CMS/MMCO should outline its vision for an overall aligned enrollment process including options for continued passive enrollment, any ongoing role for InfoCrossing (and if none, options for how that function can be replaced), cross walks, ongoing communications between state and DSNPs and Medicaid plans on enrollments and resolving enrollment issues, use of integrated forms, education and role of Medicaid enrollment brokers, coordination/alignment of effective dates, file sharing and file transfer processes (including potential HIPPA compliance considerations and challenges), sharing of LTSS HCBS waiver status and I/DD diagnoses, etc.
 - CMS/MMCO should ensure that steps are taken to provide a smooth passive enrollment transition for individuals from an MMP into a FIDE or HIDE SNP, recognizing that HIDE SNPs may not operate with exclusively aligned enrollment.
 - CMS/MMCO should also clarify how enrollment information will be shared/exchanged between plans and states, especially where Medicaid procurement may preclude fully aligned enrollment. Unaligned Coordination Only (CO) DSNPs will need to know where their DSNP members get Medicaid services.
 - CMS/MMCO should provide clearer and stronger guidance for states that encourages alignment of enrollments on an ongoing basis. Enrollment in two separate plans with conflicting financial incentives weakens any potential for improved coordination.
 - CMS/MMCO has outlined options for states to require DSNPs to operate under a single contract number within a single state. CMS/MMCO should further educate states about the importance and value of a single contract number and should clarify whether CMS will require that these transitions into FIDE SNPs via passive enrollment require a single

contract number within a state, in order to avoid problems with reporting and MOC provisions.

- Many SNPs, 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. 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.

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- Models of Care:
 - In these transitions from MMPs to DSNPs, CMS will need to pay particular attention to and provide additional guidance on integration issues around Models of Care, HRAs, MLTSS assessments and care coordination including barriers to unified care coordination and assessment, conflicting assessments and timelines, avoiding duplication of functions, and providing pathways to integrated MOCs. For example, due to the fact that MOCs are submitted at the contract level and audited by NCQA by H# and thus may cover multiple states and populations, there may be barriers to state additions proposed by CMS/MMCO to MOCs. States may be able to address more detail for these MOC suggestions in their SMACs with a broad reference to the SMAC details in the MOC. CMS/MMCO should provide extensive education to states and provide time for the significant effort that may be involved in such changes.
- Alignment of Quality Measurement and Data Reporting:
 - For the transitions from MMPs to DSNPs, we suggest CMS/MMCO also should consider alignment of quality assurance measures and reporting and tracking of performance outcomes across both Medicare and Medicaid (single contract numbers impact this area as well) including items and data for states and plans that cannot be captured under MA that were captured under MMPs and how gaps will be addressed, how HHR issues and contract level reporting issues may be addressed and what opportunities for new

approaches might arise from these new arrangements, such as a unified CAHPs as modeled in the MN Administrative Alignment demonstration.

- We recommend that CMS/MMCO also provide guidance on financial reporting, data sharing, encounter data, and adjustments to supplemental benefits (between states and DSNPs and with providers) for this transition.
- Incorporation of MLTSS and BH Services:
 - We recommend that CMS/MMCO consider the potential need for changes in network and IT interfaces needed for integration of MLTSS and BH program management as expected in the new rule.
- Medical Loss Ratios (MLRs):
 - With regard to the CMS rule discussion of how to consider integrated MLRs, we suggest CMS could provide guidance on how a separate merged Medicare-Medicaid MLR might function as a tool for states and plans to determine how to share savings under the DSNP platform. If CMS is considering this, the SNP Alliance recommends that CMS look at how to better align MLR cost reporting, definitions, and related requirements between Medicare and Medicaid and consider the lack of transparency and lack of 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 through an integrated MLR. CMS could also consider changes to relevant state Medicaid requirements if needed to align definitions to make this feasible.
 - We also suggest CMS will need to consider how the 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. CMS should test additional modeling and detail to see how such an approach can work under the D-SNP platform as soon as possible. CMMI authority could also be used to test such approaches in existing willing states and FIDE SNPs. CMS should consult plans and states as these concepts move forward. The SNP Alliance would appreciate being involved in this ongoing effort.
- Network Alignment:
 - The SNP Alliance recommends that CMS issue additional guidance to states and plans on how networks can continue to be aligned and could consider applying MMP features where useful. For example, MMPs have been allowed to utilize networks specifically designed for the dual population which may be a valuable approach especially for some smaller FIDE SNPs. CMS may also need to address how to facilitate smooth transitions to reduce disruption in access where enrollees may be transitioning to unaligned HIDE SNPs and how contract level vs PBP level network issues can be managed. CMS should also consider whether changes in Medicaid network requirements are needed to better align networks between programs.

- Integrated Member/Customer Services:
 - MMPs have been set up to merge customer service operations to simplify member services. CMS/MMCO should provide guidance and resolve any issues in continuing this approach as MMPs transition to DSNPs.

- Grievance and Appeals:
 - Some issues for plans and states remain in moving MMPs to the DSNP Unified G&A processes. CMS should identify these barriers or issues and provide clarification to states and plans as to how these can be addressed.

- Additional Flexibilities from Medicaid CMCS:
 - CMS/MMCO should seek additional administrative flexibilities from MMCO, DMAO and from CMCS to align Medicare and Medicaid for this transition and beyond to all DSNPs to accommodate state processes while retaining some integrated features and efficiencies in order to avoid duplicative or burdensome administrative processes and promote some additional standardization for such processes across states.

CMS should also require CMCS to include and promote policies supporting dually eligible populations and integration with Medicare in the basic Medicaid program. For example, CMCS recently issued new toolkits for Medicaid LTSS and BH and Medicaid Managed Care, it was extremely disappointing that integration for duals and even the availability of related Medicare services is not even mentioned in these toolkits. CMS/MMCO should consider how it can rectify some of the silo-based activities by incorporating where appropriate, Medicaid policy and administrative suggestions for Medicaid support of integration as listed in a recent report compiled by ATI. <https://atiadvisory.com/advancing-medicare-medicaid-integration-through-medicaid-programs-a-policy-roadmap/>

Addendum and Overarching Recommendations

I. Recognize the Value of Special Needs Plans

Special Needs Plans Work to Address Complex Medical, Behavioral, and Social Needs of their Diverse Populations Enrolled - SNPs are an innovation created by Congress in 2002 requiring specialized structures, processes, networks, and attention to high-need, at-risk populations. Over these last 20 years there has been slow but perceptible recognition in policy of the value of SNPs. More is needed, however, to make the most of the opportunity that SNPs offer and to learn from best practices discovered over these two decades.

Special population groups include *younger people with physical disabilities* (age 18-64), people with *severe complex and disabling conditions* (e.g., ALS, Parkinson's, advanced renal disease, COPD, AIDs-HIV, etc.), and *frail elderly persons* with cognitive, functional, and disease-related impairments. [SNPA-Member-Profile-Brief-FINAL-June-30-2021.pdf](#) (snpalliance.org)

These individuals often require community long- term services and supports, behavioral health services, specialty medical, pharmaceutical, and condition-focused care, as well as other assistance to address their complex needs. SNPs work to coordinate an extensive service array with specialized provider networks. The health plan works to integrate and coordinate the two separate programs — Medicare and Medicaid — each with different rules governing how plans and providers may interact with the beneficiary and what can be offered.

Sustained commitment including time and resources dedicated to these people with complex medical, behavioral and social needs is bedrock to achieving care and quality goals. The medical, mental health, and social needs are deeply intertwined and interact with each other. Integrated approaches such as tested within SNPs have demonstrated successes on which to build.

SNPs have invested in chronic care expertise, internal structures and processes, innovation, member outreach, and communication connections to facilitate virtual interdisciplinary care management and accountability. This is extending beyond traditional medical and behavioral health settings. Plans are trying to make these connections across providers and with LTSS.

Plans have worked with their communities, states, and providers for years to achieve their current care models. These structures, processes, and the resources plans have invested over the years to create them rely on a deep attention to and understanding of members' characteristics and community services. Finding multiple ways to proactively reach the member, establishing relationships, and connecting across settings, disciplines, and over time, are some of the ingredients of successful efforts. This happens only over time and with intentional sustained effort. This needs to be more fully resourced to extend these best practices to other special populations and improve beneficiary experience across regions of the country.

SNPs have been enhancing their supplemental health and special supplemental benefits for their members to need for supportive and non-medical services. Within their enhanced benefit packages, most SNPs offer coverage for medical meals, medical transportation,

Evaluation of fully integrated SNPs have shown that they improve health outcomes through better coordination and integration of care, expanded health and social services benefits, and a focus on preventing condition decline.

The SNP Alliance strongly supports health equity goals. We see a connection between better understanding of social risk factors and complexity characteristics of an individual to know what barriers the person faces in achieving optimal health. From an individual-level understanding, this can inform macro-level change—to move toward achieving better health equity at a population level.

Actions CMS Can Take to Recognize Special Populations in Medicare Advantage

Action Steps:

- ***Target Dually-Eligible Beneficiaries*** - Attend to recommendations of the National Academies of Science, Engineering and Medicine Committee (five reports provided to Congress) to examine the impact of social risk factors and determine if the effect on quality measurement and payment for Medicare Value-Based Payment programs. After three years of study and analysis, the NASEM experts provided tangible recommendations, starting with a focus on people who are dually eligible for Medicare and Medicaid as a proxy for people with a high level of social determinant of health risk factors. The Committee determined that the current system of measuring, scoring, reporting, and providing quality bonuses is inherently biased against providers and plans that serve a high proportion of dually eligible individuals and the system must be adjusted. They particularly focused on the need for adjustments to the quality measurement and bonus payment incentive system.
- ***Identify High-Dual Health Plans*** – CMS could indicate two groups of plans that are “high dual” in terms of proportion of enrolled population –with (1) from 51-75% and then (2) from 76-100% of members who are dually-eligible. These two groups of health plans have demonstrated their focus on the high-SDOH and high-risk populations. These populations are more diverse in race, ethnicity, language, and other characteristics than the general Medicare beneficiary population and should be a first priority of interest when targeting resources to reduce health disparities.
- ***Add a Beneficiary Complexity Index*** – One way to enhance identification and resource allocation in MA is to add a method for recognizing complex needs and characteristics that require additional resources for SNPs and other MA plans with a high proportion of at-risk and high-need individuals enrolled. This would elevate the approach from simply grouping all dually-eligible people in one group—to being able to segment into additional

groups, based on complexity of characteristics that impact their health status. This would help target resources and improve the usefulness of information collected by CMS.

We call this a “beneficiary complexity index.” Such a standardized index could proactively identify complexity issues, such as frailty, significant functional impairment or disability, palliative or advanced illness status, multiple chronic conditions, social determinant of health risk factors, behavioral health and long-term services and supports. Grouping people based on their actual needs and characteristics would allow the Medicare program to adjust payment so that resources flow more effectively. People with multiple, complex, interacting conditions are most vulnerable to adverse events. These are the people who most need enhanced management, non-traditional services, expanded outreach, tailored engagement strategies, and ongoing support to manage between programs, services, and settings and reach health outcome goals. Such an index would also be very valuable in evaluating and comparing outcomes/performance. It would provide better information toward performance monitoring, quality scoring, and quality improvement.

- ***Enhance benefit flexibility and access to special supplemental benefits for SNPs***
Payment and policies around Special Supplemental Benefits for the Chronically Ill (SSBCI) could be revised to improve flexibility for SNPs in serving diverse populations with high SDOH needs to advance health equity goals. This would include allowing social risk issues that impact care to be included in the considerations for offering SSBCI. Currently SDOH risk factors can only be addressed if they maintain or improve health and these risk factors alone cannot be used to provide supplemental services. To enhance outreach and service to enrollees with high social risk, we support H.R.4074 Addressing Social Determinants in MA Act of 2021.

In addition, a primary source of SSBCI funds is from quality bonus payments—this resource distribution method has been identified as being inherently flawed and particularly biased against MA plans with high need members. We recommend adding a beneficiary complexity index or other case-mix adjustment index that would guide resource allocation. As stated above, this index would be used in quality measurement and performance evaluation so that SNPs and other high-dual plans would not be disadvantaged because of the composition and characteristics of their enrolled members. The QBP has the potential to be a real lever for change. Help it reach that potential through quality payment incentives that recognize performance for people with the greatest vulnerabilities.

- ***Replace Use of HOS or Improve Methods for Defining Frailty for the Frailty Adjustment*** – We discuss the issues with use of the Health Outcomes Survey as a data

source for identifying people who are frail and their level of frailty further under Section III. of this response. We recommend improving the identification of frailty for adjustment and including both FIDE-SNPs and HIDE-SNPs as being able to access this adjustment.

II. Provide Incentives to Increase Reach of SNPs for the Dually eligible and Special needs beneficiaries

SNPs Have Unique and Comprehensive Extra Statutory and Regulatory Requirements -

By design, special needs plans have additional legislative and regulatory requirements to:

- **focus on chronic care populations,**
- **identify beneficiary needs proactively** at time of enrollment,
- **craft tailored specialty models of care with structure and processes** that can address the complex and multi-dimensional needs of the special populations enrolled, and
- **measure and report on special quality of care elements over and above general MA measures** under the Medicare Star Ratings program.

Special needs and complex care beneficiaries have not accessed these benefits through enrolling in special needs health plans with integrated Medicare and Medicaid services to the extent envisioned by Congress. Policymakers and CMS could provide better education, information, and incentives for these populations to enroll in SNPs and could support better integration across the Medicare and Medicaid programs. Some of the benefits for stakeholders, especially beneficiaries, would be that:

- SNPs specialize in diverse and high-SDOH population groups
- SDOH and other risk screening is conducted at enrollment and at least annually as part of a comprehensive health assessment to better understand the current needs and issues facing the individual
- SNPs are the only type of health plan that follow a tailored Model of Care that is reviewed and audited by CMS, with comprehensive care management components, such as individualized care plans, and an interdisciplinary team
- Independent researchers looking at best practices of health plans in addressing SDOH and dually eligible populations found four examples, and all are special needs plans
- SNPs have developed partnerships and contracts with communities, community-based organizations, and with national service providers to help address SDOH risk issues within their enrolled members.
- SNPs are utilizing the opportunity to provide Special Supplemental Benefits for the Chronically Ill as best they can to serve high-risk members, but there are restrictions on this opportunity that could be eased by CMS.

SNPs Attend to Diverse and High-SDOH Groups- The SNP Alliance has been examining (for several years) peer-review studies, expert committee reports, case studies, and other resources/references on social determinants of health and the impact these risk factors have on health outcomes. Our Annual Survey of members has included questions about SNP efforts around comprehensive health assessment and Social Risk Screening with follow-up referral to services to identify and address the needs of special populations.

The diversity of language, chronic conditions, behavioral health and medical issues, age, gender identity, social risk issues and other factors means that SNPs—as a group of plans—serve a highly diverse population. Some plans specialize in frail elders who are at a nursing home level of care, some focus on people with HIV/AIDs, Complex/advanced Diabetes with Complications, some focus on people who are age 18-64 with physical disabilities, some plans have a high proportion of individuals in their enrolled population with mental/behavioral health and substance use disorders. Some SNPs work with those in palliative care toward the end of life.

Many plans have a high proportion of people who are low income, have low health literacy, and are experiencing environmental stress. For these individuals, having one or more social risk factor (such as lacking transportation, food security, housing, or being socially isolated with no family supports)—impacts the person’s health status and achievable health outcomes. Oftentimes special needs health plans see multiple SDOH risk factors in their enrolled populations, where these individuals are dealing with multiple diagnosed conditions as well as lacking social support and basic human needs. [SNPA-Member-Profile-Brief-FINAL-June-30-2021.pdf \(snpalliance.org\)](#)
[snpa-briefing-paper-on-sdoh-paone-final-6172019.pdf \(snpalliance.org\)](#)

Monitoring Needs and Targeting Response - To understand beneficiary needs, SNPs begin with outreach to the individual through many touchpoints and through continued analysis of information collected throughout the year. SNPs use multiple internal (plan collected) and external data sources to determine what variables are most important in targeting support, proactively promoting self-care practices, preventing decline or events, and alerting the plan and providers about triggers to avoid adverse health events.

- At time of enrollment
- Through initial and annual health risk assessment including social risk screening
- Upon review of conditions, care plans, prior utilization, and claims
- Via the care manager assigned to the member
- Through outreach coordinators and community health workers
- In member outreach such as through screening and flu shot reminders
- When the enrollee calls the health plan
- Through review of encounter and other provider data and information

- In quality-of-care reviews by the health plan around specific groups, condition issues, or other QI targets

As mentioned, SNPs use multiple sources of data to identify enrollee characteristics and needs such as enrollment files, care management database, provider encounters, claims, the initial and annual Health Risk Assessment (HRA), and external data sources, such as Census data, American Community Survey, county health ranking, community health assessment information, state and county and municipal studies, heat mapping re: ER or other emergency usage (EMT) etc.

Under the SNP Model of Care standards includes a requirement for conducting a health risk assessment. This is one method for identifying enrollee characteristics such as race, ethnicity, language, literacy, etc., such as described the questions in this RFI around Health Equity. Special needs health plans request information about each member (beneficiary) in the enrollment process and conduct an initial and annual health risk assessment. Individuals may, of course, decline the assessment and answering questions about race, ethnicity, and other characteristics is always voluntary. If the individual is willing to answer these questions, then the plan can tailor care/support and conduct a review of care outcomes through analysis by specific enrollee group following service or annually. If the individual does not wish to answer such questions, the health plan continues to reach out to the individual through various member engagement strategies. SNPs have care management strategies such as utilizing community health workers, care managers, care navigators and outreach coordinators to tailor support.

Algorithms Use Additional Data to Tailor Care - Data sets that health plans can access outside of directly asking the member about these characteristics that are used to create a more comprehensive member profile and tailor care through algorithms and predictive models include:

- Census data, particularly accessing the 9-digit zip code data tied to the member's home address – would help identify the rural, suburban, or urban characteristic
- State Medicaid data for those individuals who are listed as eligible and enrolled in Medicaid and also identified as being enrolled in the health plan – would help identify those who are dually-eligible for Medicaid and Medicare
- Medicare administrative data – giving reason for Medicare eligibility – would identify people who enrolled in Medicare by reason of a disability

CMS could work with State Medicaid offices to provide a standard set of data points on beneficiary characteristics (including racial categories and definitions) and provide funding to support a standardized, searchable database with firewalls and privacy protections, but that has tiered levels of permissions allowing plans and others to access data fields for tailoring care, providing care management, and working on quality improvement.

Multi-Cultural Outreach, Enhanced Services – SNPs focus on people with high levels of social risk who also have medical, behavioral health, and long-term services and supports needs and are

often from non-Majority population groups. SNPs utilize multi-lingual staff and community health workers, peer counselors, community navigators and others who are from the communities to facilitate outreach to diverse members. The engagement and connection with members is very important.

To address the multi-dimensional needs, SNPs have built partnerships with community-based and non-medical, non-traditional services. SNPs refer to community services to meet the needs of diverse members. It is common for plans to engage with community organizations.

CMS should work with States and build or contract for an interactive, searchable standardized/universal digital application of community resources for use in all States, that can be accessed via a mobile app or an online searchable database, so that this application would be accessible to plans, providers, and beneficiaries—each with a tailored portal and sign-in process. Such a repository would contain information on community resources, with standard fields and categories and capability for the user to filter and customize their search and understand eligibility or other requirements to access these resources. This repository and database/app could highlight how the services can be tailored to people with diverse needs (for example the multi-lingual and multi-cultural staff competencies, service to people with physical or mental disabilities, accommodation of the physical environment, etc. Such a tool/repository would greatly facilitate connecting people to tailored services.

Action Step:

- ***Improve Data Standardization and Access on Beneficiary Characteristics, (for example, create a National Database with Universal Definitions)*** - Develop a national searchable beneficiary database on beneficiary characteristics including social risk factors, starting with the dually eligible population (with protections/permissions) which would be accessible by plans
- ***Enhanced Health Risk Assessment and Care management*** – SNPs are the only type of MA plan that create specialized Models of Care which are reviewed and audited by CMS for compliance. There are extensive regulations and oversight of these specialized care management practices. We have several recommendations for improvement provided in this letter.
- ***Promote evidence-informed targeting and response*** - Provide evidence-informed algorithms based on research and practice on what variables and what responses to risk issues yield the best outcomes. Publish and disseminate best practices as they evolve—regarding effective targeting and response to address complex and high-social risk populations.

Risk Screening is part of the Initial and Annual Health Risk Assessment for SNPs

The SNP Alliance has canvassed health plans through surveys, calls, and other communication to determine the current state of health risk assessment, plans' use of validated tools, practices around screening and follow-up, and challenges.

Take aways from our surveys and discussions with SNPs are:

- Most plans use a variety of validated items from several screening instruments.
- Some plans have more than one HRA form (more than one version) and processes for different beneficiary groups/plan products.
- SNPs indicated they currently screen for SDOH/social risk factors as well as many other condition and functional issues. They target SDOH risk issues which most often arise in their enrolled populations. Key issues include poverty, social isolation, low health literacy, food insecurity, and unstable housing.
- Given new regulatory requirements SNPs will need to revise their HRAs and revise instruments/forms, processes by contractors if the plan delegates this function. This will be costly and time intensive. SNPs request assistance and time to complete these changes and ask for minimal changes over time so that the tool and processes do not have to be changed frequently.
- Challenges in directly collecting via the HRA and conducting other screening or using screening information collected by others include:
 - Member cannot be reached (for HRA)
 - Member refuses questions or stops assessment
 - Providers not using the 'z' codes in ICD-10
 - Sources of data unreliable on race, ethnicity, and language (R/E/L).
 - State, Feds and other agencies use different R/E/L categories – not consistent
 - Screening instrument required by the State is not valid, out of date, has gaps or does not sync with SDOH data definitions

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 - 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 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 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., Accountable Health Communities Screening tool (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.”

Crosswalk 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.

Action Steps/Ideas:

- ***Beneficiary Use and Understanding of SNPs, the Medicare Plan Finder, Star Ratings, SSBCI*** – Improve information and education of beneficiaries, service counselors, and brokers, including more/better information about SNPs, SSBCI benefits and eligibility for these benefits, filters and fields to compare health plans based on beneficiary characteristics, and better explanation of the meaning of Star Ratings with drill-down opportunity to see what geographic area the plan ratings cover and how many people with similar characteristics are enrolled in that plan.
- ***Beneficiary incentives*** - CMS could provide beneficiary incentives to completing the annual health risk assessment to all SNP enrolled members and provide additional public information showing the value of participating in an annual health assessment.
- ***Release of Information at Enrollment and Annual Thereafter*** - CMS could incorporate a Consent for Release of Information into the MA enrollment process, so that health plans would have permission of the individual to collect race, ethnicity, and other characteristics and to use this information to tailor care through an assigned care manager. CMS could request Medicare beneficiaries to annually review and verify or update their own beneficiary profile and indicate the health plan, ACO, or other entities that have permission to review/access this profile information.
- ***Harmonize SDOH Items Across Health Risk Assessments***—CMS could work with experts to conduct a crosswalk 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.
- ***Support Providers with Specialized Annual Integrated Care Consultation Team Visit*** - CMS could incorporate the health risk assessment including SDOH risk scoring into a “specialized integrated care consultation visit” for dually eligible beneficiaries where providers would be able to spend additional time with high need patients and interact virtually with other interdisciplinary team members that would include attention to how social risk factors and other issues faced by the patient impact medical, behavioral health, and long-term services and supports access and treatment/care.

The table (next page) provides detail on the top priority social risk issues faced by special need members as indicated by SNPs surveyed by the SNP Alliance.

SDOH Risk Factors Observed in Special Needs Populations – Survey Data (2016-2021)	
SDOH Factor	Brief Summary
Poverty	Living in poverty is the number one risk factor reported every year.
Lack of social supports/social isolation including living alone	This factor substantially and rapidly increased as a result of COVID –since all sectors of society were affected, so much was closed—thereby greatly exacerbating isolation.
Food insecurity	This factor substantially and rapidly increased as a result of COVID; people could not get to or pay for groceries and Meals on Wheels or other food programs were closed.
Housing instability	This is always a significant risk factor year to year in special needs populations, and continues to be a challenge, especially for people with physical disabilities and/or mental/behavioral health issues.
Lack of regular transportation	This factor substantially and rapidly increased as a result of COVID as public transportation became more limited and friend/volunteer transportation was greatly curtailed as people were worried about getting the virus from others
Lack of regular communication device (e.g., trac phone out of minutes; no smart phone/computer)	This became a much bigger risk factor as so many things switched to virtual during COVID.
Lack of mental health services/resources, and/or living in an area with a lack of preventive/primary care services	This is a substantial issue for many people in rural or low-resourced urban areas. This factor increased due to COVID-- the eventual rise in telehealth did not reach many of the high SDOH groups of special needs health plans because many of these people do not have smart devices with cameras or lack access to wifi/broadband or computers. Libraries were closed as well. Clinics were closed. Much was put off – making the chronic conditions and disease stages worse.
Low health literacy	As things switched to virtual, not understanding the physician’s directions or the disease course or self-care advice becomes more of a substantial risk factor.
Non-English speaking, non-native born	As things switched to virtual, not understanding the language became more of a risk factor—also translation/interpreter services were more limited and could not be in person.

Model of Care Requirements are Comprehensive and Only Apply to SNPs - Special needs health plans are the only type of Medicare Advantage (MA) health plan that write, submit, have reviewed/scored, and follow a Model of Care that outlines their care management processes and structures around four key domains:

1. Population
2. Care Management
3. Provider Network
4. Quality Improvement

Specialized, tailored care management, provider team, and quality focus are important components of a care system for any dually eligible and high-risk individuals. These individuals have substantial risk issues and care coordination needs. We recommend that CMS work to better educate the public, targeting dually eligible individuals, about the value of these specialized components and of enrolling into integrated D-SNPs.

The specialized Models of Care are reviewed and audited by CMS for compliance. There are extensive regulations and oversight of these specialized care management practices. We have several recommendations for improvement.

Recently there have been additional requirements added to the MOC, for example around the Health Risk Assessment. We recommend that the requirements be reviewed as a whole to consider where duplication and unnecessary proscriptive language can be reduced. For example regarding HRAs, we recommend that CMS: (1) support work already being done by SNPs, (2) allow for targeting the most important social risk factors –such as social isolation, not a prescribed list that may/may not align with the special needs group enrolled in that SNP, (3) allowing SNPs to use their screening, assessments, care management data, provider inputted information, and other data sources to populate the profile including the HRA for that individual as these richer data sources offer more context and deeper information about needs, priorities, and preferences, (4) consider that SNPs must respect the wishes of people not to share their SDOH risk needs with their health plan and therefore may refuse the HRA—if other sources and data collectors are allowed (and with the permission of the member to share with their plan care manager), the necessary information can be worked into the care plan even if through a non-linear or proscriptive pathway.

Action Steps:

- ***Streamline MOC requirements*** - Additional Model of Care requirements have been added in the last year. A review of the requirements and processes is needed to ensure that there is not excessive burden, duplication, and proscriptive standards that do not leave room for evidence and practice informed improvement.
- ***Provide Evidence of Effectiveness of Required Standards/Processes*** - We also recommend that the evidence supporting specific processes be made available—

particularly to assist providers in seeing the value of the expectations around screening, interdisciplinary teams, individualized care planning, and the role that health plans play in assisting their patients to achieve optimal health outcomes.

- ***Collect and Share Best Practices*** – CMS and NCQA could play a key role in gathering and sharing information on best practices for the following required processes: (1) Health Risk Assessment, (2) Individualized Care Planning, (3) Interdisciplinary Team Coordination and Collaboration, (4) Provider Training and Engagement, (5) Quality Improvement Interventions for Special Population Groups (including benchmarks).
- ***Harmonize Review Cycle for all SNP Types***- Currently, all SNP types except C-SNPs submit their MOCs for review and, based on that review, receive either a 3, 2, or 1 -year approval. C-SNPs have to submit annually. For MOCs submitted by C-SNPs that have achieved a high MOC score and have demonstrated effectiveness, this is a waste of resources for the health plans and for NCQA/CMS. Congress should be asked to rescind this requirement to bring it in line with the review cycle of the other SNP types.

SNPs Demonstrate Best Practices - Best practices case examples from SNPs on outreach, care management, and tailoring care for improved outcomes to people with health disparities and high social risk issues are provided in a report commissioned by CMS and conducted by an independent research team at RAND. Researchers examined four managed care organizations with exemplary care models and demonstrated results. All of the case study examples described are special needs plans. All are member plans of the SNP Alliance. This supports our assertion that special needs health plans offer important learning to the field on addressing social risk issues. As discussed, social risk factors are more common in the special needs and Medicare-Medicaid dually eligible populations that are the priority focus of these plans.¹

These four special needs health plans are great examples of organizations making the most of their specialty focus on chronic care populations and utilizing their extensive expertise as they continue their work to address the social aspects of health integrated with the medical/clinical care, mental health services, and long-term services and supports needed by these individuals. We recommend a full read of this report. See: [Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies | RAND](#)

¹ US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (2018). *Addressing Social Determinant of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans*. Research Report Phase II conducted by RAND researchers: Sorbero, Kranz, Bouskill, Ross, Palimaru, and Meyer. October.

SDOH and CBO Partnerships - SNPs have expertise and long-standing partnerships with organizations including national and local CBOs in many areas re: SDOH needs. SNPs contract with CBOs, both national providers of services, such as Mom’s Meals™, Aunt Bertha™, and local providers, such as local organizations such as housing and food service organizations.

While local and smaller providers have the advantage of knowing their communities very well, they are disadvantaged by not having the capacity, infrastructure, or processes to serve enrolled SNP members. This pertains to their organizational readiness and ability to: contract with managed care organizations, serve within set timeframes and geographic areas, track and report services provided in standardized formats, submit claims, cover costs while awaiting claims paid, monitor and report on quality measures.

Challenges are many for CBOs. This will require a substantial effort and infusion of resources to improve the ability/readiness of CBOs especially around contracting, capacity, performance monitoring, data tracking, data transfer, and standardization for consistency in service.

Action Steps:

- ***Invest in CBO Readiness*** - We recommend that CMS/States help regional CBOs coalesce into single contracting entity to cover many more people and much wider area—single CBOs often do not have the ability to contract, share data, serve beneficiaries, and monitor quality performance-- as the requirements specify health plans must guarantee/safeguard. In addition, the administrative burden of annually contracting with hundreds of small CBOs is high—there is not feasible infrastructure or readiness at present time. Therefore, the national service providers often are able to move into this space.
- ***Provide Standards for Interoperability of Information for CBOs*** - The level of infrastructure readiness within most CBOs on closed loop referrals is low – HHS/Congress needs to assist CBOs to develop this infrastructure and acumen and processes. We recommend providing standards, guidance, funding and technical assistance to CBOs to adopt a standardized data set with interoperability in database systems that connects with healthcare electronic medical record systems (EMRs) and allows for direct data transfer to health plans. Build CBO capacity in this area. Consider the way that Meaningful Use was developed within EMRs. Encounters completed, costs, member experience and rating/response should be data elements collected and reported in a standard format.
- ***Feds and States Work Together to Build a National Repository*** - Regarding referrals to community services for SDOH and related needs, CMS should work with States and build/contract to build an interactive, searchable standardized/universal database or digital application for searching for community resources, for use in all States. Such an application should be accessible via a mobile device with application and through a website offering an online searchable database, so that this application would be

accessible to plans, providers, and beneficiaries—each with a tailored portal and sign-in process. Such a repository should contain information on community resources, with standard fields and categories, with functionality for the user to filter and customize their search and understand eligibility or other requirements to access these resources. This repository and database/app should highlight how the services can be tailored to people with diverse needs (for example the multi-lingual and multi-cultural staff competencies, service to people with physical or mental disabilities, accommodation of the physical environment, etc.) Such a tool/repository would greatly facilitate connecting people to tailored services in a consistent way. The CBO providers would be responsible for updating their own information at least annually.

Similar recommendations for action from RAND in their analysis of how MA plans are addressing social determinants (commissioned by HHS/CMS) include:

[Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies | RAND](#)

Reward and Support Better Outcomes: Build a Supportive Environment Support community resources and links at a local level.

MA plans mentioned trying to fill gaps in community-based resources to meet the needs of their members. Federal support for developing community resources as a public good could enhance the ability of MA plans to partner with communities. Some economists and thought leaders have suggested ways for stakeholders to contribute toward those community resources, such as through a bidding-based contribution system or rethinking how public spending (medical care versus public health versus social services) may have the greatest impact on health outcomes. Implement supportive state and federal policies.

III. Improve Quality Measurement and Performance Evaluation for Special Populations

We are concerned that the measures, methods, and underlying assumptions in various predictive models in MA Star Ratings are insufficient and have built in inequities that impact plans such as special needs health plans serving a high proportion of disabled/low-income/dually eligible individuals. The MA Quality Measurement system should not add to the inequities in resource allocation. If CMS remains committed to having only one set of measures, cut points, and ratings for all MA plans, then adjustments must be adequate to account for beneficiary characteristics and factors outside of plan control which impact measure results and affect quality bonus payments

and therefore access to rebate dollars to address health inequities. (Additional discussion of the Beneficiary Complexity Index on pg. 32.)

Beneficiary Use and Understanding of the Medicare Plan Finder Information, SSBCI and Star Ratings – Beneficiaries and those that counsel them need better information. We know that beneficiaries use a number of methods for choosing and comparing among options around health care coverage. This includes talking with benefit and enrollment counselors and/or health insurance brokers (individuals who are trained to answer questions about Medicare and Medicaid and guide people through health plan options available to them in their state). They may also talk with family or friends, their physicians, or may review the websites of health plans in their areas. They may read and follow up on local advertising and receive fliers and other informational material in the mail directly from health plans who they may call for telephone advice/assistance. Beneficiaries also may access BenefitsCheckUp® an online service managed by the National Council on Aging, their State Department of Health/Human Services website, or the Medicare Plan Finder. CMS oversees the Medicare Plan Finder. We have several suggestions for improving the Medicare Plan Finder to offer information in usable form for all levels of literacy and language, through graphics, animation, audio and video-enabled, and other formats online and accessible through smart phones, computers, and via toll-free calls. The information should be offered so that consumers can understand

- 1) Star Ratings and what they mean for them, given their own conditions and situation
- 2) How to compare plans in their region, particularly what benefits would be accessible to them under what conditions or restrictions
- 3) How to get independent advice and help

Beneficiaries can view Star Ratings on the Medicare Plan Finder and may see the high star health plans promoting their Star Rating, but given the way Star Ratings are calculated, the Star level may not represent the level or quality of care the person would receive.

The Star Rating reported is a general summary index of many measures. It can include people living across many regions of the country. It can include individuals who have few health issues and people with many chronic conditions. If a beneficiary has special needs and diverse characteristics, the Star Rating as a broad summary index may not be very relevant to this individual. Therefore, the MA Star Ratings may not adequately reflect the quality of care for diverse, chronically ill, and special populations. Reasons include:

- Measures in the Star Rating set may not match the priority issues of special population groups,
- Measures have not been adequately tested in special population groups
- The methods of data collection do not accommodate special population groups

- The survey instruments (wording, formatting, response options) are not designed for special population groups
- There are not enough people with specific characteristics in the sample, so that sub-group analysis cannot be done
- Small sub-population groups' results are masked as the results from other groups predominate and “wash out” the sub-group specific results—this is especially the case in plans with high enrollment and covering large geographic areas

Action Steps:

- ***Focus on Special and Diverse Populations as a Target Group for Improving the Quality Measurement and Performance Reporting Systems*** - We recommend changing measures, instruments, and methods of quality review to recognize and accommodate diverse and special populations. There are many opportunities for improvement and options to pursue including:
 - Improve measures—create tailored measure sets for specific sub-groups so that the measures more closely match their priority issues and use of healthcare services
 - Reduce number of measures
 - Align measures between MA and ACOs and other value-based programs (the same measure specifications, the same set)
 - Create core set of measures for dually eligible people and provide incentives for States to use these same measures their performance evaluation
 - Allow for tailoring/selection of relevant measures for different groups based on beneficiary characteristics/conditions
 - Ensure adequate testing of measures
 - Publish measure testing results
 - Improve surveys used in the measurement system
 - Improve accommodation and methods for data collection
 - Provide additional resources to reach hard-to-reach/engage groups and offer incentives
 - Publish results on best practices for high performance around specific beneficiary groups
 - Stratify into high dual and low dual health plans and publish/present results for these two different plan groups
 - Improve consumer education around special population measurement results and the value of integrated care management (SNPs to start)

- ***Align Measures*** Align measures across plans and providers, MA and ACO, and States and the federal government. Ensure that any value-based options for specific beneficiary complexity groups use a standard/core set of measures to evaluate and compare outcomes (CMS would need to lead this effort)
- ***Replace HOS*** - Replace the Health Outcomes Survey (HOS) instrument for calculating level of frailty and applying a frailty adjustment for SNPs as the current instrument does not adequately capture frailty and the method substantially under-samples the most frail individuals, as they find it difficult to participate in the survey.
- ***Stratify Measure Results and Report on Findings*** - SNP Alliance is very supportive of advancing health equity and improving the utility of measurement results to understand special population groups and help guide improvement efforts. We support stratification as recently proposed by CMS but note some recommendations:
 - (1) Add Dual, Disabled, Low Income Status and Language to Race & Ethnicity as a variable for stratification of quality measure results
 - (2) NCQA/CMS Transparency. Findings must be published and available anytime measures are stratified—accountability to stakeholders and improving knowledge is important. These data should not only be used internally within CMS and contracted organizations.
 - (3) Race and ethnicity data is not routinely available or transmitted to health plans by States or others collecting these data. Racial and ethnic categories in datasets are different. Harmonizing and providing the information to plans is important for ensuring accuracy and allowing plans to examine their own information. CMS must provide these data prior to stratification.
 - (4) In stratifying measure results to examine health equity targets, we recommend that CMS begin with measures where there is evidence of disparities with substantial gaps rather than narrow differences which do not rise to the test of clinical or statistical significance. We also recommend beginning with measures around health outcomes where there is at least emerging effective practice to address such disparities with targeted interventions based on the population sub-group.
 - (5) Effective practices require efforts across sectors—such as reducing housing instability--to impact outcomes and improve health equity. We recommend a way to tie provider and health plan measure results to community metrics and to provide ways for evaluating progress. A set of tools and guidance would help with consistent impact evaluation over time.

- (6) Show trends – it is very important to use a consistent means of evaluating changes in disparity gaps over time. The trends and patterns of change are instructional and should be used to guide improvement efforts.
 - (7) Information must be sound, accurate, valid and have utility and be able to inform improvement.
 - (8) If a beneficiary refuses SDOH screening or service/care or if other contextual reasons impacting the ability to meet option health outcomes for that person are noted—there should be some way of excluding these individuals in a sub-group analysis, so that more can be learned about hard-to-reach and hard-to-engage individuals for tailoring new ways of addressing their needs.
- ***Improve SDOH Adjustment Methods***- Overhaul, replace or re-tool the Categorical Adjustment Index (CAI) to better address the impact of socio-economic status on health outcomes and therefore on health plan Star Ratings.
 - Congress should request that HHS report on the observed impact of CAI method in reaching high dual/LIS/Disabled plans and their beneficiaries.
 - CMS should declare their intended process and timeline for a permanent solution, with involvement of stakeholders.
 - In the interim while we await a better approach, the CAI levels tied to case-mix should be modified to capture more people at high social risk levels. We recommend that the highest level (10) to be set in the range of 95-100% of enrollment DE/LIS.
 - ***Frailty Adjustment*** - Allow Highly Integrated D-SNPs (HIDE-SNPs) that provide Long-Term Services and Supports (LTSS) benefits to be eligible for the frailty adjustment.
 - ***Beneficiary Use and Understanding of SNPs, the Medicare Plan Finder, Star Ratings, SSBCI*** – Improve information and education of beneficiaries, service counselors, and insurance brokers, including more/better information about SNPs, SSBCI benefits and eligibility for these benefits, filters and fields to compare health plans based on beneficiary characteristics, and better explanation of the meaning of Star Ratings with drill-down opportunity to see what geographic area the plan ratings cover and how many people with similar characteristics are enrolled in that plan,

Similar recommendations for action were offered by RAND from their analysis of MA plans and addressing social determinants (commissioned by HHS/CMS):

[Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies | RAND](#)

Measure and Report Quality: Use Patient-Centered Performance Measures

*Use performance measures and instruments relevant for dually enrolled beneficiaries in quality reporting and value-based payment programs. Existing instruments (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]) and performance measures included in the MA Star Rating program **may not adequately account for improvements most important to dually enrolled beneficiaries** (e.g., daily functioning, quality of life), improvements in intermediate outcomes for which dually enrolled beneficiaries have worse starting values than other beneficiaries, or measure plans' achievement of care coordination or patient-centered care.*

Measures currently used only for SNPs and MMPs could be implemented more broadly in the MA Star Rating program to bring more attention to the different needs of dually enrolled beneficiaries in all MA plans.

Beneficiary Surveys Use in MA Performance Evaluation- The Alliance strongly supports obtaining consumer input about their health and about provider and health plan performance to better understand the person's experience of care.

CMS utilizes direct beneficiary-reported surveys within the quality measurement system, but there is room for improvement. Our comments address two surveys used extensively in the current MA system that are intended to capture the experience and self-report of the beneficiary. Improving these surveys and instruments as well as data collection, analysis, and reporting, will improve the accuracy and usefulness of the information. We recommend changes to the surveys and survey process. In addition to written and telephonic surveys, which are still bedrock, we recommend also getting creative around employing other methods, such as text and digital secure platforms for gathering beneficiary experience and being inclusive to accommodate the diverse dually eligible population. This is very important in terms of addressing inequity and health disparities.

CAHPS Survey - The CAHPS survey used in Medicare Advantage is collected from a sample of beneficiaries once a year and focuses on the beneficiary experience in receiving medical care and health care services.

Health Outcomes Survey (HOS) – The HOS survey is also collected from a sample of beneficiaries once a year and focuses on the person's self-report of health status around physical and mental health, physical activity, and other condition management areas, such as bladder control.

Related to the issue of “good fit” between the survey and the beneficiaries responding, there are several areas for improvement:

Action Steps:

- ***Reduce Hurdles for Special Groups*** – Some beneficiaries face substantial hurdles which restrict their engagement in surveys. Complexity characteristics already described highlight challenges groups with the highest complexity and social risk characteristics have with completing surveys. For example, practical issues impacting the person’s ability to complete a written or phone survey include no permanent address, limited access to phone service, speaks a language that is not accommodated in the survey, has low health literacy. Filling out a written survey and returning it or responding to a telephone survey is a higher burden for these beneficiaries. More resources should be provided to those responsible for distributing and managing these surveys to reach these groups. In addition, better methods and approaches should be used—and informed by the special needs and diverse groups who are intended respondents. The survey and the methods for getting the data are both important. Ask the beneficiaries if the survey and methods are understandable, will work for them, and how to change these, if they are not.
- ***Address Sample Inconsistencies Which Affect Results*** - There potential bias in the sample which affects the accuracy and usefulness of the information obtained. This can have real impact on plans and providers and may mean that the beneficiaries most experiencing health disparities are not equally in each sample collected. This inequality would suggest that it is not appropriate to compare across providers and plans—the sample profiles should be as similar as possible to compare results.

One major problem is that the response rate to these surveys is low and dropping. The HOS survey response rate reported is very low—Typically less than 20% of the random sample surveyed is in the final sample of responses received—and sometimes this is less than 10%. The CAHPS response rate has also been declining over the last decade—struggling to meet 40% and often lower. Therefore, from a statistical viewpoint, the accuracy of these samples to represent the enrolled MA beneficiaries’ condition management and experience of care is questionable. This is particularly worrisome for diverse, low income, disabled, and complex care individuals—as they may not be very well represented in many plans’ final samples.

Where a plan has relatively few high-risk members in their enrollment, the chance of one of these individuals getting the HOS or CAHPS survey to complete is low. However, when the plan enrolls only high-risk individuals, then anyone who receives the survey is facing the various condition and social complexities described earlier. Therefore, the profile or characteristics of the individuals in the two samples would be very different.

- ***Idea for Improvement in Sampling - Inclusion Criteria*** – One option to address this problem, CMS could set an inclusion standard to ensure that people with diverse and varied complexity characteristics are in every HOS and CAHPS sample in the same proportion. Then one could compare across plans because the complexity and beneficiary characteristics that might be driving the results are equally present in all the samples being studied.

- ***Improve Question Wording and Allow for Context in Responding*** – The survey instruments themselves need to be updated and revised for better utility and to accommodate and recognize the diversity of respondents taking the surveys.

For example, the broad scope of some questions in CAHPS introduces lack of clarity. In answering the question, the respondent does not identify an episode of care or provider of care. The wording with some of the CAHPS questions is non-specific and too broad. For example, asking the person to “Rate your provider” or “Rate your specialist” or “Rate all of your healthcare over the last six months” is non-specific and overly broad, especially for people who have many interactions with many providers over 6 months. A special needs plan beneficiary may see two or three specialists (e.g., endocrinologist, cardiologist, rheumatologist), and have other services, such as chiropractic care, dialysis, in six months for various conditions. The beneficiary may also see a behavioral health specialist, therapist, general primary care provider, and have a home visit from a nurse practitioner. How is this person able to rate all of these interactions via one question? Furthermore, how does the response given yield information to target improvement or explore further?

There should be some way the respondent can provide more information and give some context. Since providers that were seen are not identified, there is no usable information upon which to act. Additionally, some of the items are not under the health plan control, such as the time the person spends in the doctor’s waiting room.

- ***Idea for Improvement – Context and Wording Changes*** - We recommend that the items around rating the provider be more specific, that the provider or episode of care be indicated by the respondent, that the person be able to indicate the number and type of providers seen, and to also rank/rate the experience of care by each provider (assuming there are many). This way the respondent can be more specific as to what worked and as to the meaning of their rating. As CMS considers opportunities around changes in policy and programs, this is an area with specific action steps that could make a real difference. We can do better to capture beneficiary characteristics and their actual experience with specific providers and episodes of care. We can do better to obtain usable information for driving improvement.

Testing of Measures Used in MA Quality Measurement – Some of the measures used in MA Stars and quality measurement have not been adequately tested in diverse and disabled populations. We recommend that CMS set minimum standards for measure testing prior to being used in evaluating performance of health plans serving dually eligible, disabled, and special needs populations, and among diverse and non-English-speaking groups. The results of this testing should be made public so that providers, plans, and beneficiaries can see how the measure fares in terms of validity and accuracy across different groups.

Action Steps:

- **Minimum Standards** - CMS Should Set Minimum Standards for Measure Developers and Stewards around SDOH & Special Needs Populations - Minimum standards for measure developers and stewards would clarify the parameters needed prior to use in the MA quality program. This is especially important if the measures are applied to dually eligible and subpopulation groups who have different characteristics from the majority Medicare population in terms of social determinant of health risk factors, language, ethnicity, health beliefs, and other cultural differences. The dually eligible population represents the highest cost, most complex Medicare beneficiaries. Measure testing or re-testing is critical to ensure that the measure accurately portrays experience in the intended area of focus, and to reveal areas where adjustment is needed. We recommend the minimum standards include the following:
 - **Sampling** - a minimum sample size and diversity of the sample used for testing must include any diversity characteristics, if the measure is to be applied to that group of people. The study sample should explicitly include subgroups reflecting the enrollment from a variety of health plan types and regions, including language, age, race, ethnicity, and condition diversity. The sample should also have younger disabled individuals (18-64) and older adults with multiple chronic conditions, and in palliative care—if those groups will be in the measure pool. The sampling must also include people with significant social risk factors. The profile of the sample should be published/reported and how this sample compares to the Medicare, Medicaid, and dually eligible population at State and National levels.
 - **Variables Tested** - a minimum set of variables related to characteristics of people should be in the testing model, (this means that the sampling must have included methods to ensure sufficient proportions of people of various racial, ethnic, and gender diversity to allow for necessary statistical calculations). For the SNP population these would include people who are/have:
 - Low-income
 - dual-eligible
 - physically disabled
 - five or more chronic conditions
 - chronic behavioral health or substance use disorder
 - limited English proficiency
 - less than a high school education level
 - **Accommodation and Sound Methods of Administration** - the measure stewards need to ensure that the survey methods and administration adequately accommodate low-income, diverse, non-English speaking beneficiaries. Methods should not require beneficiaries to have cell phones, computers or Internet, or should offer ways to make

these technology devices available for easy access for survey completion. Surveys should be appropriately translated and interpreter support should be available.

- Transparency - the measure developers must publish their findings, including a description of their study design, statistical methods, data sources, variables included, and profile of characteristics of the testing sample. This findings report must be sufficient and available to allow other scientists and analysts in the field to replicate results, as per standard scientific principles.
- Dissemination - the measure developers must provide a summary report for disclosure to the general public so that findings are widely available in a form that is accessible and understandable to the lay public.

Improve Risk Adjustment and Incentives within the Quality Measurement and Value-Based Payment systems - Over six years ago in their 2016 Report to Congress, the Assistant Secretary for Planning & Evaluation found that dual-eligible status was a valid proxy for high social determinant of health risk factors, and that such factors had a negative effect on outcomes. Furthermore, they found that the measurement system did not adequately adjust for high social risk factors and appeared to have unintended negative effects on organizations that served a high proportion of these individuals. ASPE's Report to Congress (U.S. Department of Health and Human Services, 2016; See: [Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs | ASPE \(hhs.gov\)](#)) had three key recommendations:

- (1) Measure and report quality ***specifically for beneficiaries with social risk factors;***
- (2) Set high, fair quality standards for all beneficiaries and ***consider adjustment of measures for social risk factors based on empirical relationships and to improve adjustment for health status;***
- (3) Reward and support better outcomes through targeted financial incentives within value-based purchasing programs to ***reward achievement or improvement for beneficiaries with social risk factors.***

Similar recommendations for action were offered by RAND from their analysis of MA plans and addressing social determinants (commissioned by HHS/CMS):

[Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies | RAND](#)

Set High and Fair Standards: Account for Complexity and Social Risk in Performance Measures

Stratify, adjust, or otherwise account for clinical complexity and social needs of dually enrolled beneficiaries in performance measures. Dually enrolled beneficiaries are more likely to be low-income and have a higher burden of disease than other Medicare beneficiaries. MA plans reported support for adjustment for socioeconomic status or other SDOH for clinical measures included in the MA Star Rating program and other value-based purchasing programs to address the aspects of care outside the health plan's control and to account for the additional resources required to serve this population.

*CMS considers risk adjustment to be a component of the measure specification and, thus, the determination of need for risk adjustment is the responsibility of the measure developer. **Another approach would be the stratified distribution of bonuses from the MA Star Ratings program based on the percentage of dually enrolled beneficiaries, to prevent value-based purchasing programs from disadvantaging plans with large dually enrolled populations but retain incentives for quality improvement through reporting performance without adjustment beyond what is included in measure specifications.***

The SNP Alliance has previously offered recommendations to CMS/HHS pertaining to an interim approach to adjust measure scoring. The Categorical Adjustment Index (CAI) was set up seven years ago by CMS in response to Congress calling for better SES/SDOH adjustment in the MA Quality Measurement System. The CAI is a complicated method that sets up 10 levels (groupings) of health plans for DE/LIS status and 5 levels for Disabled. Since inception, the top level of DE/LIS (Level 10) was set extremely high—Level 10 requires that 100% of all individuals enrolled in the health plan must be dually eligible and/or receive a low-income subsidy. Special needs health plans that exclusively serve dual members have reported that they run into a challenge with reaching the 100% CAI level 10 because some of their members may not be determined Medicaid eligible for part of the year due to changes or delays or other administrative processes performed by the State. Therefore, SNPs may not be able to access Level 10 in the CAI even though they are exclusively serving dually eligible members. The difference between the CAI adjustments at Level 10 and Level 9 can be significant in terms of impact. This restricts access to resources and dampens the usefulness of the CAI.

Special needs health plans rely on rebate dollars through CMS to fund special supplemental benefits for the chronically ill and other supplemental health benefits. These rebate dollars depend in part on the quality Star rating the plan achieves through the MA Quality Measurement System, yet there is no tailoring of the quality measures or scoring for plans that serve a high proportion of special needs and diverse populations. This has the unintended effect of restricting resources to the very plans and beneficiaries that need them most.

Action Steps:

We recommend:

- ***Working Toward Meaningful Measures*** – Identify a more tailored set of measures with different methods that recognize diversity, social risk factors, behavioral health issues, and comorbidities. This core set should replace measures that are not as meaningful to these populations.
- ***Require Measure Testing Among Diverse Groups*** - Require measure developers to retest their measures to ensure they are valid and reliable for high SDOH, diverse, and complex chronic care populations.
- ***Replace or Upgrade Outdated Instruments and Improve Methods to Reach these Populations***
 - ***Replace/Revise HOS*** - Revise or replace the Health Outcomes Survey (HOS) to account for the increasingly diverse Medicare populations that include chronic degenerative conditions, physical disabilities, persistent behavioral health challenges, as well as those experiencing challenges related to social determinates of health such as poverty, lack of housing, or limited health/language literacy.
 - ***Improve CAHPS*** - Improve the CAHPS instrument and methods for engaging diverse and high risk/complex condition beneficiaries. Modify the wording and add ability for the respondent to indicate specific providers they are responding to in the survey. Otherwise, the information is less useful for identifying gaps, quality issues, etc.
- ***Stratify Results via Peer Group Cohorts of High and Low SDOH Plans*** - Stratify measure results of health plans into at least two groups of health plans for comparisons and quality benchmarks: High SDOH and Low SDOH plans. Provide additional resources for High SDOH plans (see Section I). These High SDOH plans have many members experiencing health and socio-economic disparities. Additional resources should be devoted to these individuals and that should be supported within policy and payment systems, including quality measurement systems.
- ***Improve Adjustment Methods***- Overhaul, replace or re-tool the Categorical Adjustment Index (CAI) to better address the impact of socio-economic status on health outcomes and therefore on health plan Star Ratings.
 - Congress should request that HHS report on the observed impact of CAI method in reaching high dual/LIS/Disabled plans and their beneficiaries.

- CMS should declare their intended process and timeline for a permanent solution, with involvement of stakeholders.
- In the interim while we await a better approach, the CAI levels tied to case-mix should be modified to capture more people at high social risk levels. We recommend that the highest level (10) to be set in the range of 95-100% of enrollment DE/LIS.
- **SNP SDOH Adjustment** - add a SNP adjustment to the payment rate
- **Improve Flexibility of SSBCI** - uncouple funding for SSBCI and other supplemental benefits from the Quality Bonus Program—and provide this funding separately, with high DE/Disabled/LI plans the recipients of this SSBCI funding.

Similar recommendations for action were offered by RAND from their analysis of MA plans and addressing social determinants (commissioned by HHS/CMS): [Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies | RAND](#)

Reward and Support Better Outcomes: Align Incentives for Care Interventions

Promote rigorous evaluations to identify interventions to address SDOH.

*MA plans reported addressing the SDOH of dually enrolled beneficiaries in a variety of ways, but few interventions and plan strategies had been rigorously evaluated. **More support for rigorous evaluations of these plan strategies will help plans identify those that are effective and financially viable as well as identify for which members and subpopulations these strategies are most effective.***

Share best practices and interventions among MA plans to address SDOH. Most strategies implemented by MA plans were developed or refined internally. For example, while all plans conducted health risk assessments, the approach for conducting these (e.g., in home, by phone) and the types of SDOH data collected varied. Mechanisms for MA plans to share their experiences developing and implementing interventions and strategies to meet the needs of dually enrolled beneficiaries and approaches to address barriers would facilitate the dissemination of best practices and more rapidly improve their care.

Design and implement value-based purchasing programs that are sensitive to and reward addressing SDOH. Dually enrolled beneficiaries are sicker and poorer on average than Medicare-only beneficiaries. Plans were concerned that the MA Star Rating program is not aligned with the needs of dually enrolled beneficiaries and were interested in seeing value-based purchasing programs that would reward the work plans do to address members' SDOH.

Approaches could include use of performance measures relevant for dually enrolled beneficiaries, bonuses based on high performance among dually enrolled beneficiaries, and bonuses based on a lack of within-contract disparities when comparing dually enrolled with other beneficiaries.

IV. Smooth Out Hurdles for Diverse Groups Enrolled in both Medicare and Medicaid (Dually Eligible Beneficiaries)

CMS Has the Authority to Adjust Policy and Regulations that are Barriers to Health Equity

Related to special populations, including those with disabilities, complex care needs, low health literacy, living at or below the poverty level, or speaking a language other than English, and the providers and plans that serve these groups, we believe CMS already has the authority to make necessary changes to reduce barriers to health equity

Action Steps:

- ***Address Programmatic Barriers to Integrating Care for High Need Individuals who are Dually-eligible*** - Remove barriers to care that arise from duplicative, conflicting, or complicated policies and procedures between the Medicare and Medicaid programs for dually eligible people. This group has some of the highest needs and greatest challenges with social determinants of health but is asked to navigate a complex and confusing tangle of requirements and rules that serves no one well. D-SNPs were authorized by Congress specifically for these populations, yet the regulatory barriers to integrated care remain in many states. We recommend that HHS and CMS use their full authority to eliminate barriers to integrated care for D-SNPs. There should be special attention paid to beneficiary experience in navigating between programs. This will be enlightening.

EXAMPLE: Model of Care – State/Federal Duplicity or Misalignment

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 issued by CMS for review by a national organization (NCQA) and for approval by CMS.

Recently, a Final Rule for D-SNPs indicated that States could use the Model of Care as a vehicle for coordinating care. We appreciate the intent but pointed out there are some practical issues and challenges requiring further regulatory guidance. We all hope to avoid having the problem of multiple State-issued additional requirements that do not sync with the federal requirements.

Health plans, providers, and beneficiaries may be caught in the middle. We offered a set of recommendations to CMS and re-state them here:

- Federal Requirements for Model of Care Supersede State Requirements as the MOC is a Medicare requirement which means that it is a national standard and consistent for all Medicare beneficiaries
- Incorporate Language that State requirements must defer to federal requirements. For example, around Model of Care, we request that CMS require that in setting forth state-specific requirements for a contract with a health plan, 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 in their State health plan contracting pertaining to unique aspects of their state Medicaid services or processes around care management and related activities (such as in the FAI or other demonstrations).
- CMS should educate, provide resources, and assist states to start with the MOC federal guidelines and produce a redline “add-only” State-issued MOC guidelines that highlights additions to the MOC and submit these to CMS for approval to ensure that their State contracting requirements do not conflict with national standards and requirements or that they are overly proscriptive impacting the health plan’s ability to follow effective care management strategies for all their members regardless of the state in which the person resides.
- Educating/Assisting NCQA - We further recommend that CMS submit these state-specific MOC documents to NCQA for their training of NCQA reviewers if these reviewers are supposed to review a combined State/Federal MOC document or if the plan is required to submit the State/Federal combined MOC document for review.
- Scoring the MOC – CMS must ensure that health plan MOCs ***are not scored differently based on in what State they operate*** nor rate the MOC lower if the plan is required to submit additional information for the State. 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.
- State-specific Requirements – It would be very important, as this D-SNP single contract was expanded, to have an accessible, searchable online repository of all of the MOC Federal-State versions that health plans would need to comply with—to maintain fidelity

to contract requirements. Many health plans cross states and serve people in multiple states. They need to follow effective care management practices and utilize their enterprise-wide databases, predictive models, staffing and training standards, quality improvement methods, data analytics, and other enterprise-wide internal systems to serve their beneficiary members consistently.

- **Untenable Number of Variations** - 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 statespecific 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. We note that the more each state individualizes the MOC requirements, the more this moves away from one national standard for Medicare beneficiaries and adds to complexity for plans, providers, and beneficiaries. This could quickly become untenable.
- **Alignment on MOC timeframes and related 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 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.

- National Crosswalk between State and Federal Requirements - Toward that end we recommend creating a national repository, cross-walking state and federal requirements including MOC and quality measures/methods—for clarity, transparency, training, efficiency, and quality improvement toward the goal of making this more viable as it is scaled nationally.

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