SNP Alliance
The National Voice for Special Needs and Medicare-Medicaid Plans
A National Nonprofit Leadership Organization

VIA ELECTRONIC SUBMISSION: https://www.regulations.gov/

February 13, 2023

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Deputy Administrator and Director
Center for Medicare Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Re: CMS-4201; Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

INTRODUCTION

The Special Needs Plan (SNP) Alliance is a national, non-profit leadership association addressing the needs of high- risk and high-cost populations through specialized managed care. We represent 26 health plans offering over 550 plan benefit packages (PBPs) and 175 contracts through special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs). These plans have over 3 million beneficiaries enrolled in 47 states and the District of Columbia—totaling more than 55% of the national SNP and MMP enrollment. Our primary goals are to improve the quality of service and care outcomes for complex populations and to advance integration for those dually eligible for Medicare and Medicaid.

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

Sincerely,

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II. Implementation of Certain Provisions of the Bipartisan Budget Act of 2018, the Consolidated Appropriations Act, 2021, and the Inflation Reduction Act of 2022

A. Applying D-SNP Look-Alike Requirements to Plan Benefit Package Segments (P. 79465): *The SNP Alliance supports CMS proposals regarding look-alike plans and the continued efforts to increase the number of dually eligible beneficiaries in D-SNPs.*

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

We appreciate CMS' incremental approach and the choice of the 80 percent threshold. This threshold has and is addressing the most obvious targeting of dually eligible individuals by non-SNP plans. It has also provided time to observe how plans respond and has allowed some non-SNP plans with enrollment of dual eligible individuals above 50 percent to continue to operate in markets where D-SNPs are not offered.

While we concur with the 80% at the present time, we do support a further decrease in the percentage threshold in upcoming years, as long as it can be done in ways that minimize disruptions to the members. Additionally, it is important to balance the challenge many D-SNPs are currently having with state procurements—resulting in increased numbers of those dually eligible advertently in general MA plans. **The SNP Alliance supports lowering the threshold** over the coming years, due in large part to the success of implementing the 80 percent threshold. We urge CMS to continue efforts to reduce incentives for non-SNP plans to focus enrollment efforts on dually eligible beneficiaries.

B. Part D Special Enrollment Period Change Based on CAA Medicare Enrollment Changes (P. 79466): *The SNP Alliance supports the proposal to align the timeframe for use of the Part D SEP*

C. Alignment of Part C and Part D Special Enrollment Periods with Medicare Exceptional Condition Enrollment (P. 79467): *The SNP Alliance supports the proposal to align Part C and Part D SEPs with Medicare Exceptional Condition Enrollment*

A priority of the SNP Alliance, to improve beneficiary experience by reducing confusion and differing and misaligned dates, has been to align various program dates, whether within Medicare or between

Medicare and Medicaid. The SNP Alliance supports all exceptional condition SEPs proposed in this section. **We strongly support the proposed exceptional SEP that would allow individuals when enrolling in premium Part A and/or Part B to be provided the opportunity to enroll in an MA plan or MA-PD plan.** This will provide Medicare beneficiaries with the opportunity to learn about and enroll in special needs plans. An ongoing issue for beneficiaries and stakeholders is the lack of understanding of the availability of these particular plans. This will provide another opportunity for CMS to provide beneficiaries with the very important choice of FFS versus Medicare Advantage, and Medicare Advantage versus SNPs.

D. Transitional Coverage and Retroactive Medicare Part D Coverage for Certain Low-Income Beneficiaries Through the Limited Income Newly Eligible Transition (LI NET) Program (P. 79469): *The SNP Alliance supports CMS proposals making the LI NET Program permanent.*

The LI NET demonstration has provided temporary, transitional Part D prescription drug coverage for LIS-eligible beneficiaries, including beneficiaries who are eligible for the Part D LIS but who are not yet enrolled in a Part D drug plan, or are enrolled in a plan but for whom coverage has not yet taken effect. A substantial number of special needs beneficiaries are LIS-eligible and have greatly benefited from the demonstration. The SNP Alliance not only supports permanency, but the criteria regarding eligibility, enrollment, benefits and beneficiary protections, and sponsor requirements as well. This proposal will simplify and expand access for the dually eligible population, in addition to the partially dual population, a population quite similar to those dually eligible.

E. Expanding Eligibility for Low-Income Subsidies Under Part D of the Medicare Program (P. 79478): *The SNP Alliance supports the CMS proposal to expand eligibility for low-income subsidies under Part D*

CMS proposes to expand eligibility for the full LIS subsidy group to individuals with incomes below 150 percent of the FPL and who meet either the resource standard in paragraph (3)(D) or paragraph (3)(E) of section 1860D-14(a) of the Act, beginning on or after January 1, 2024. This change will provide the full LIS subsidy for those who currently qualify for the partial subsidy. The SNP Alliance commends CMS for making this change, which will simplify eligibility and reduce confusion among beneficiaries by moving to a consistent standard for all LIS beneficiaries as well as increase the number of beneficiaries eligible for full LIS. It should also reduce current administrative processes needed for tracking multiple categories.

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

A. Health Equity in Medicare Advantage (P. 79479)

2. Ensuring Equitable Access to Medicare Advantage (P. 79479): *The SNP Alliance supports the proposed heading revision and identifying addition types of underserved groups*

The SNP Alliance joins CMS in its dedication to ensuring equitable access to Medicare Advantage and the priority of equity when looking at programs and health outcomes. This is of particular importance to SNP enrollees, who differ from populations enrolling in regular Medicare Advantage and FFS. **SNP enrollees, compared to non-SNP enrollees in MA and FFS, have higher rates of receiving help with 2 or more ADLs (27%), experience with serious mental illness (25%), no high school diploma (39%), and live in**

disadvantaged areas (47%). Additionally, SNP enrollees are more diverse compared to non-SNP MA and FFS beneficiaries, with 55% of enrollees being non-white. The proposal here to identify underserved groups will be of particular importance and benefit to special needs populations.

3. Medicare Advantage (MA) Provider Directories (P. 79480): _The SNP Alliance supports the proposal to include cultural and linguistic capabilities in provider directories. The SNP Alliance recommends a different approach for identifying providers via ability to offer medications for opioid use disorder (MOUD)._

CMS proposes to codify two regulatory requirements at § 422.111(b)(3)(i). Specifically, at § 438.10(h)(1)(vii) by adding the phrase "each provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office" to paragraph (b)(3)(i). The SNP Alliance agrees with CMS that information on providers' cultural and linguistic capabilities should be made available in provider directories. As noted earlier, SNP enrollees are more diverse in terms of race, ethnicity, language, and social risk factors. The SNP Alliance, based on experience of member plans collecting this data, has found that many providers fail to complete this information. **The SNP Alliance recommends that CMS assist providers with technical support, resources, or other tools and technology toward a standardized and effective way to identify language and cultural capabilities access offered by the provider, and to keep their information up to date.** The rule would clarify that plans are asked to encourage providers to increase/improve their language and cultural access and providers to report their cultural and linguistic capabilities to the plans within the first quarter of each year prior to plan bids and provider directory development.

The SNP Alliance agrees with CMS that provider directories need to be a resource for beneficiaries with substance use disorder, but we recommend a different approach than proposed. The prescribing of MOUD is an area that is quickly evolving, particularly with the recent enactment of Section 1262 of the 2023 Omnibus Appropriations bill, which removed the federal requirement for practitioners to submit a Notice of Intent (i.e., have a waiver commonly referred to as an "X-Waiver") to prescribe medications, like buprenorphine, for the treatment of opioid use disorder. Due to all licensed practitioners now being able to prescribe MOUD, a specific network adequacy test for MOUD prescribers would be duplicative; the network adequacy test could essentially be attached to all licensed prescribers.

Additionally, because the SAMHSA Locator identifies individual practitioners rather than practices, some suboxone providers have elected not to be included on the locator tool so as not to be overwhelmed by calls. We are concerned that including a flag for providers waived to treat patients with medications for opioid use disorder (MOUD) in payer provider directories will exacerbate this problem. **The SNP Alliance thinks a more appropriate method is to identify, and make searchable based on, addiction specialty.**

4. Digital Health Education for Medicare Advantage (MA) Enrollees Using Telehealth (P. 79482): _The SNP Alliance supports the intent of these new requirements, however, we see digital health literacy training and telehealth access as largely dependent on providers and under their purview._

CMS notes there are barriers to accessing telehealth services and there is a need to improve such access to address health equity goals. CMS currently does not have requirements for MA organizations around digital health literacy and proposes to add requirements for MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy. This will include assisting them to access any medically necessary covered telehealth benefits. CMS is proposing an amendment around continuity of care requirements, to "ensure continuity of care and integration of services through arrangements with contracted providers" by adding a new paragraph (9) which would "require MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered benefits that are furnished when the enrollee and provider are not in the same location using electronic exchange." This would apply to all MA organizations offering coordinated care plans. CMS is also contemplating this requirement to apply to all MA plans.

The SNP Alliance supports the intent of these new requirements to improve access to telehealth care, improve digital health literacy, and reduce disparities toward health equity goals. We are also supportive of improving all individuals access and ability to use telehealth benefits. However, we see digital health literacy training and telehealth access as largely dependent on providers and under their purview. It is part of their scope of service to their patients. Plans can play a supportive role in encouraging use by their members of the providers' services. We offer additional thoughts for consideration below.

SNP Alliance Recommendation: First, we recommend CMS focus this effort on improving provider capacity. The language should be reworded to clarify that health plans are expected to guide members/beneficiaries to providers to gain access to the providers' patient information portals, electronic health records, and telehealth access platforms. CMS should clarify that if these services are offered to any of their patients, then the provider must address language, literacy, and digital health access to their patients, as appropriate. Plans can play a supportive and instructive role to guide members (patients) to the provider's digital health portal. This would require providers to share that information (patient and telehealth portal platforms links) with the health plan and for the provider to keep that information updated.

We also recommend that CMS work with plans and providers over the next few years to develop standards and reporting metrics. Experience with digital health education is needed before performance can be measured.

The SNP Alliance offers several related considerations which are important as CMS addresses the goal of equal access (the underlying intent):

- **Standardization** – Does CMS have a standardized or best practice definition of who has "low health literacy or access" and what content should be covered in a universal health literacy course or education that would be offered by any entity? This would be helpful for both plans and providers in identifying who needs help and what are best practices in education/training for improving digital health literacy.

- **Identification of "low health literacy"–** We assume this is a self-report determination by the individual. How and when should identification of individuals/plan members who have low digital health literacy or access occur? This would be the first step in addressing the process toward improving literacy to access telehealth benefits.

- **Barriers** - How to define barriers? For example, the barrier to telehealth could be lack of access to broadband/Wi-F or lack of access to a smart phone/device rather than the person's inability to use devices or comfort level in using telehealth portals. Are health plans expected to address these hardware/technology barriers as part of digital health literacy support? Some plans are adding this additional benefit in special supplemental benefits for the chronically ill, where the person meets the definition of "chronically ill." Is this what CMS envisions? If a barrier is language rather than technology—how would this be handled so that patient portals to medical records and patient portals to telehealth platforms are translated? This is not under the jurisdiction or control of the health plans to translate the provider's patient electronic portal or their telehealth service provider—rather the provider portal should already have a way for the patient to indicate need for translation services. We understand that this is standard in many patient portals.

- **Variation** - How would CMS envision addressing the variation in electronic portals and electronic personal health records or telehealth platforms that are used by providers in the health plan's network? Providers have their own patient health record access portals and often contract with telehealth platforms—these differ across providers and health systems. We recommend that CMS work with providers on standards for ensuring their patients have the digital health literacy to access their patient electronic records and to access the provider's telehealth portal. A generic set of instructions from the health plan would have to be so general to accommodate the variety of portals and platforms that it makes it marginally useful.

- **Continuity of care** - We believe continuity of care is important for all beneficiaries and access to telehealth services is part of the set of services that providers now typically offer their patients. This is especially important in rural areas and in behavioral health services, where there may not be sufficient provider locations or capacity to serve the population in person. This continuity of care requirement is important—we suggest that CMS guide providers with best practice and technical assistance to help the providers make progress in ensuring their telehealth and related patient portal services are culturally and linguistically robust.

- Caregiver Support - Often times it is not the individual enrolled member, but their family and/or direct caregivers that are utilizing the digital platform. Thus, there may be times when such education should be directed to appropriate caregivers (e.g.: home care worker who is assisting the individual with their telehealth interactions). Perhaps CMS can offer some additional guidance as to how such digital literacy assessments should be applied to these situations.

We can think of several touchpoints where the individual could be asked about their "digital health literacy," asking the beneficiary if they can access patient portals and telehealth platforms, including:

1. **Enrollment into the plan** - At time of plan enrollment members could be asked if they have access to Wi-Fi/broadband and if they have received instructions from their provider on how to access the provider's patient portal [health plan then alerts/refers to provider]. This would have to be woven into the enrollment process. Is this the CMS intent? This would have to be a requirement for all MA plans.
2. **Primary provider visit** – Whether at time of primary care or physician office visit, when the individual requests an appointment, or at time of the encounter/visit/interaction with a provider, the provider would be responsible for helping their patients access their own electronic patient portal. Therefore, this would shift from an MA requirement, to a provider requirement.
3. **When patient requests a telehealth visit** – The provider office should provide additional guidance including training and educational opportunities for improving digital health literacy and accessing telehealth services through their telehealth provider/vendor. This would be a provider requirement of service to Medicare beneficiaries—offering support to their patients for

full access to the service—as they do with other medical services and treatments. This would be an additional accessibility requirement to which providers adhere.

5. Quality Improvement Program (P. 79486): *The SNP Alliance supports the increased focus on health equity, however, we request more guidance from CMS regarding measuring disparity reduction, such as the use of the Health Equity Summary Score (HESS) Dashboard for targeted population sub-groups.*

CMS proposes to amend the MA Quality Improvement program regulations to incorporate one or more activities into their overall QI program to reduce disparities in health and health care. The SNP Alliance supports the increased focus on health equity, however, we request more guidance from CMS regarding measuring disparity reduction, such as the use of the Health Equity Summary Score (HESS) Dashboard for targeted population sub-groups. We would like CMS to publish the HESS and its research and findings to date about the HESS so that stakeholders could review and provide comment. We also request that the results from CMS' recent survey about the HESS and its utility, feasibility, ease-of-use, be published. If or when the HESS is ready for use, CMS could stipulate a score or targeted proportional improvement which, if met, would signal health equity improvement activity has been done and targeted results achieved. This could be set so that each plan is targeting improvement based on its own benchmark, rather than having every plan compared in a group average.

B. Behavioral Health in Medicare Advantage (MA) (P. 79488)

2. Behavioral Health Specialties in Medicare Advantage (MA) Networks (P. 79488): *The SNP Alliance supports the addition of three new provider specialty types, proposed time and distance standards, and 10-percentage point credit.*

Beneficiaries with special needs have higher rates of behavioral health risks and conditions. D-SNPs have worked to meet the needs of beneficiaries and CMS integration requirements to ensure their enrollees have access to behavioral health specialists. While the SNP Alliance supports the addition of three new provider specialty types, with respect to the addition of "clinical social worker" as a specialty subject to network adequacy standards, we urge CMS to clarify that all disciplines that fit within this category (i.e., licensed independent social workers and LCSWs) would be included.

Additionally, and unfortunately, there are significant behavioral health provider shortages, a problem that is particularly acute in more rural areas as these provider types tend to congregate in urban areas. To help ease these shortages and the burden it places on current providers, **the SNP Alliance therefore urges CMS to increase the telehealth credit for BH specialties and take steps to support the expansion of telehealth for these services.**

3. Behavioral Health Services in Medicare Advantage (MA) (P. 79491): *The SNP Alliance supports the addition of behavioral health services to the types of services which MA organizations must have programs in place and its proposed definition for "emergency medical condition."*

CMS is proposing to add behavioral health services to the types of services for which MA organizations must have programs in place to ensure continuity of care and integration of services. The SNP Alliance supports this proposal, due in large part to SNP enrollees having higher rates of behavioral health needs and complex care conditions, such as addiction and depression. The SNP Alliance believes continuity of care is important for all beneficiaries, especially for behavioral health services. We concur with CMS that MA enrollees must receive medically necessary services in a medical emergency, and that includes both physical and behavioral health. Inserting “, mental or physical,” after the word “condition” and before the work “manifesting” will ensure that emergency medical conditions are easily interpreted as such and the needs of beneficiaries are indeed met.

4. Medicare Advantage (MA) Access to Services: Appointment Wait Time Standards (P. 79491): *The SNP Alliance does not support the proposal to codify primary care appointment wait time standards and to extend those standards to behavioral health services.*

CMS is appropriately concerned about the wait times beneficiaries encounter for both primary care and behavioral health services. While the SNP Alliance supports CMS’ efforts to ensure consumers do not have a significant wait for key services, there are many variables that make it challenging to precisely track and adhere to wait times. **The SNP Alliance recommends using a more flexible standard that enables health plans to adhere to requirements or provide a justification about why the standards are not possible to achieve and works on a mitigation strategy with CMS to ensure access through in-person or telehealth options.**

There is currently a national shortage of behavioral health and substance use disorder providers that MAOs cannot always resolve. These specific wait time metrics and requirements could have negative impacts on consumers, including reducing choice for consumers as MAOs reduce their footprint or cancel expansions due to the inability to achieve new wait time standards.

C. Medicare Advantage (MA) Network Adequacy: Access to Services (P. 79493): *The SNP Alliance supports the proposal to codify longstanding policy for coordinated care plans to arrange for any medically necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee’s medical needs.*

D. Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (P. 79494): *The SNP Alliance supports the proposals but with modifications.*

CMS is proposing to split enrollee notification requirements based on two types of provider terminations and provider terminations that are not behavioral health, substance use disorder or primary care. For provider terminations with-cause, CMS proposes to maintain its "good faith effort" standard for timely notification enrollees. For provider terminations without-cause, CMS proposes to remove its "good faith effort" standard since the timeline for notification should be within MAO control to provide notice.

The SNP Alliance joins CMS in its effort to ensure beneficiaries are notified appropriately and expeditiously when a provider is leaving the network. Unfortunately, SNPs often experience providers not providing sufficient notice to the MAOs, which results in not meeting CMS timeframes for beneficiary notification. **The SNP Alliance recommends CMS modify its proposal, so the “good faith” standard remains in effect if the provider (instead of the MAO) is the party terminating the contract.**

An issue faced particularly by SNPs is the high volume of behavioral health providers who shift in and out of networks. This constant churn, in addition to the increase in provider termination notifications, would be administratively difficult and potentially lead to beneficiary confusion. The SNP Alliance and its members believe notification is integral for proper care management of these beneficiaries with complex care needs, but due to the complexity regarding behavioral health providers in particular, and the often occurrence of MAOs not being notified by providers regarding contract termination, the current proposal would prove burdensome to plans and potentially confusing to beneficiaries. **The SNP Alliance thinks the "good faith" standard works for both plans and beneficiaries, in addition to CMS.**

Additionally, CMS is proposing to expand the scope of notification requirements to all enrollees who have ever been patients of a terminating primary care provider and behavioral health provider—not just those enrollees who are patients seen on a regular basis by the terminating provider. The SNP Alliance supports this objective to ensure beneficiaries receive timely notices of contract terminations for all providers. We are simultaneously concerned the resulting "unlimited lookback" and increase in notices from the plan will not only dilute the impact of notices, but cause confusion to beneficiaries receiving contract termination notices regarding providers they have not seen in years. **The SNP Alliance does not support the "unlimited lookback" and instead recommends CMS specify the lookback period and implement a lookback period that would not result in beneficiaries receiving contract termination notices about providers the beneficiaries have not seen in multiple years.**

E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (P. 79497)

2. Coverage Criteria for Basic Benefits (P. 79499): *The SNP Alliance has concerns and seeks clarification on the proposal, but opposes the proposal as written.*

The proposal by CMS appears to be moving toward conforming Medicare Advantage policy to Medicare FFS. When Congress created Medicare Part C in 1997, goals included offering beneficiaries an improved option that would be different from traditional Medicare, including the use of medical management. The SNP Alliance supports the need to have Medicare benefits be aligned between Original Medicare and MA. However, the utilization management of those benefits assumes review for medical necessity and appropriateness to avoid unnecessary services, services of inappropriate duration, or services that many not be indicated for appropriate for a given individual. This process should also be in line with the related CMS requirements for transparency in the authorization and denial process.

3. Appropriate Use of Prior Authorization (P. 79503): *The SNP Alliance supports the proposals while believing there is a purpose and role for prior authorization.*

The SNP Alliance agrees with CMS that the use of prior authorization should be limited as proposed in the rule. Simultaneously, the application of health plan medical policy is one of the most effective ways to ensure the right care is provided at the right place at the right time. Experts have found that hundreds of billions of dollars are wasted every year in healthcare – and that beneficiaries often receive care that is costly, inappropriate, unneeded, or unnecessary. 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.

The SNP Alliance acknowledges that that the application of medical policies—such as in the case of prior authorizations—can create friction and frustration for providers and patients. This acknowledgement and understanding is why the **SNP Alliance supports the proposals here: they retain the medical**

purpose of prior authorization while ensuring that prior authorization does not stand in the way of needed care for beneficiaries.

Additionally, we urge CMS to clarify that MAOs continue to have the flexibility to be more generous than under the proposed policy. **Specifically, we seek confirmation that requiring supplemental benefits be "clinically appropriate" does not prevent a plan from approving a supplemental benefit based on functional or SDOH needs.**

4. Continuity of Care (P. 79504): *The SNP Alliance opposes these proposals.*

CMS proposes to require prior authorization approvals be valid for the entire "course of treatment". Requiring a prior authorization to be valid for the entire "course of treatment" is very broad and may create a situation where there is no clear time limitation and potentially no limitation on a provider continuing to furnish services experts would not consider tied to the original approval. Such a policy would increase waste in the healthcare system—in some cases for multiple years for a single patient. Of note, there is nothing in the proposed provision that would differentiate between diagnostics and therapy.

It is also unclear whether an MA plan could conduct concurrent reviews for post-acute care; disallowing concurrent review in the post-acute setting would not ensure that the beneficiary was placed in the best setting. MA plans need to retain the ability to conduct concurrent reviews for post-acute care and rehabilitation, because there is a need to monitor the patient's condition. Additionally, disallowing post-acute concurrent review could potentially exhaust a beneficiary's benefits, leaving them with no remaining benefits when needed.

Additionally, CMS is proposing to require MAOs to have policies for using prior authorization that provide for a minimum 90-day transition period for any ongoing course(s) of treatment when an enrollee has enrolled in an MA plan after starting a course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider. This provision would also apply to beneficiaries who are new to Medicare. The SNP Alliance views the proposal as too broad. While we support continuity of care, the proposal does not allow for appropriate and reasonable prior authorization review, when indicated for services not critical or services that are out of network.

5. Mandate Annual Review of Utilization Management (UM) Policies by a UM Committee(P. 79505): *The SNP Alliance supports the proposal with recommendations and considerations*

The SNP Alliance agrees with CMS that it's good practice for MAOs to establish a UM Committee. UM Committees are needed to ensure criteria are rooted in the most current, evidence-based scientific literature. They also provide valuable insight for MAOs operating in multiple markets regarding any unique requirements of characteristics that warrant further consideration. We also support the concept of ensuring UM policies (including those for prior authorization) are reviewed regularly by individuals at the plan with diverse clinical experience and expertise. However, we also believe such a requirement should be applied in a way that is sufficient while minimizing duplication and administrative costs. This will be of considerable administrative cost to SNPs, who are disproportionately small and enroll beneficiaries with the highest and most complex needs.

We would like to note that NCQA accreditation already requires accredited plans to have qualified medical personnel review UM criteria and decisions. **Since NCQA accreditation already requires**

accredited plans to have qualified medical personnel review UM criteria and decisions, the SNP Alliance requests that CMS consider the administrative duplication brought by the NCQA accreditation requirement and the proposed UM Committee. We also recommend CMS maintain the flexibility for plans to define the structure and appropriate additional responsibilities of these committees. Not only will this provide plans the opportunity to tailor services to best address the needs of their populations, but it also ensures that plans can comply with other, similar requirements.

6. Additional Areas for Consideration and Comment (P. 79507)

a. Termination of Services in Post-Acute Care (P. 79507): *The SNP Alliance supports CMS' proposal to address potential early terminations of services in acute care settings.*

F. Request for Comment on the Rewards and Incentives Program Regulations for Part C Enrollees (P. 79508): *The SNP Alliance supports clarifying the definition of "cash equivalent" and more specific guidance on permissible gift card reward items.*

The SNP Alliance thinks "cash equivalent" is too broad and limits the ability to offer equitable rewards in big box stores that are sometimes the only retailers available to enrollees. SNPs would like to see CMS help support enrollees with rewards in various areas of risk factors such as food accessibility, clothing, etc., and large retailers that are accessible to enrollees. With current limitations plans are too restricted, especially in some rural areas that only have a big box store as the grocery store. Also, certain retailers and gift card restrictions do not make them available to all enrollees, especially depending on where they live and what access they have to technology.

N. Clarify Language Related to Submission of a Valid Application (P. 79519): *The SNP Alliance supports this provision and appreciates these clarifications.*

O. Updating Translation Standards for Required Materials and Content (P. 79521): *The SNP Alliance supports the purpose and spirit of the proposals but recommends a different and more iterative approach to reaching our shared goals of proper and equitable translation standards.*

The SNP Alliance fully appreciates and supports the reasoning for these proposals. We also believe in the importance of communicating with all enrollees in a way that is preferred. The proposals will be quite administratively and financially burdensome, especially given the implementation date of CY 2024. It takes considerable effort and time for a plan to translate the required materials into a different language or produce them in alternate formats. Some SNP Alliance members have estimated the required materials in §§422.2267(e) and 423.2267(e) to be over 200 materials requiring translations.

The SNP Alliance recommends the following to improve the proposal and ensure a smoother implementation of these much needed translation services:

1. CMS modify the 5% threshold report in HPMS to allow for entering multiple H#s and to include the actual percentage for the top 15 languages in a service area. This will allow plans to more easily monitor and prepare when getting close to a 5% threshold.
2. Consider a smaller subset of materials for translation and alternate format for the initial effective date, such as materials that do not contain PHI and are stable. For example, the Evidence of Coverage is the same for all enrollees of a plan and is produced once a year; an EOB is personalized to each individual's claims experience and produced monthly. If a smaller subset

is selected, we recommend an evaluation of use patterns and a survey of enrollees using translations and or alternate formats to identify other materials that would be of value.

3. In the event that the 5% threshold is met, consider making the translations effective or consider non-enforcement until the plan year that begins on or after the date that is one year after the date the 5% threshold is met. This mirrors timing requirements related to the effective date of changes to preventive services in 45 CFR § 147.130.
4. At least for a period of time, establish a good faith effort as regards enforcement.

The SNP Alliance strongly supports making SNP member individualized care plans (ICPs) accessible to all members but would like to note SNPs are the only type of MA plan with required individualized care plans (ICPs) for all beneficiaries as part of the requirements for a Model of Care, so this provision has an outsized impact on SNPs. We appreciate the intent of this proposal and agree language access is very important. We also agree that beneficiaries should be engaged and have their own care plan and be able to understand that care plan. However, this can be done verbally with the member without requiring that every ICP be translated in written form.

We are also concerned about the length of time it would take to have each individualized care plan translated and that the cost of translating all care plans on a standing basis would be prohibitive. Some SNP Alliance members estimate the cost to be roughly $1,000 per member to specially translate the care plan. If 1,000 SNP enrollees request translation services, that would cost more than $1million annually.

The SNP Alliance recommends that CMS modify the proposed requirement around ICPs, and that a two-step process be recognized as meeting the intent of the rule, which is to engage the individual in a language known so that the person is involved in and understands their ICP. The two-step process would require verbal translation and discussion first. Plans should offer verbal translation and discussion with the beneficiary on the individual's ICP in their preferred language (oral) first. Then, if the member requests a written copy, additional translation services are used to generate a written copy for the beneficiary.

CMS is also proposing to require that FIDE SNPs, HIDE SNPs, and applicable integrated plans (AIPs) as defined at § 422.561, translate required materials into any languages required by the Medicare translation standard at § 422.2267(a) plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts. The SNP Alliance has concerns with this proposal.

A disconnect exists between the standard Medicare language required and the Medicaid languages individual states require. This disconnect will result in confusion, overlapping requirements, and burden on FIDE SNPs, because state languages are more relevant to the particular duals served than the nationally standardized set of languages. For example, the state of Minnesota is required to translate documents into German, despite the very few German speakers in the state and many of the higher % languages like Somali and Oromo are not included by Medicare. Medicaid languages should supersede the Medicare languages to reduce burdens on both plans and consumers, and to better service the populations in each state.

P. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423) (P. 79455): *The SNP Alliance supports CMS for improving beneficiary protections but is concerned that some proposals will inadvertently create barriers to enroll, particularly for more vulnerable populations.*

The SNP Alliance supports CMS for improving beneficiary protections such as prohibiting contact at home unless an appointment at the time and place was previously scheduled. We are concerned that some of the proposals will inadvertently create barriers to enroll, particularly for more vulnerable populations. One of the proposals from CMS is to prohibit organizations from advertising benefits not available in a service area, unless doing so is unavoidable in a local market, such as advertising in a local newspaper that may be distributed outside a service area. To support MAO compliance with this requirement, **we urge CMS to provide additional clarification and examples of what is considered "unavoidable."**

Another proposal from CMS is to prohibit personal beneficiary data collected by a TPMO from being distributed to other TPMOs. The SNP Alliance supports this proposal, but **requests CMS to clarify that this does not prohibit TPMOs from sharing such information directly with MA plans and Part D sponsors.**

CMS is also proposing to require sponsoring organizations to have an agent and broker monitoring and oversight plan that ensures agents and brokers are adhering to CMS requirements and that the MA organization or Part D sponsor is actively monitoring and reporting agents and brokers to CMS who are not compliant with CMS requirements. While oversight is incredibly important, the burden on plans, especially small and mid-sized plans, would be significant. The SNP Alliance has significant concerns with the potential negative impact of the proposal to obtain a Scope of Appointment (SOA) at least 48 hours prior to the start of a personal marketing appointment. Not only does this impact members who may have an interest in enrolling quickly (i.e., they are close to the enrollment deadline and don't have 48 hours, they don't want to wait to finalize the conversation), but it can disproportionately hurt more vulnerable populations. It is also a health equity issue for people for whom these appointments are burdensome due to work schedules, dependent care, lack of transportation, etc. It is a burden to any population, especially those who may not be overly tech savvy and would need to sign a paper document once, only to wait 48 hours. **We urge CMS to allow a marketing appointment to happen within 48 hours if there is a documented beneficiary request for an earlier appointment.**

An additional proposal by CMS limits the validity of the BRC and SOA to six months following the date of signature. The proposed rule does clarify that, "if a beneficiary wants the agent tied to the SOA or BRC to continue contacting them beyond six months, the agent may secure and document that permission through a new SOA, BRC, or similar mechanism." **The SNP Alliance requests clarification that this proposal includes a verbal extension (with the requirement such verbal extension be documented).**

CMS is proposing to prohibit collection of beneficiary contact information at educational events. **The SNP Alliance understands CMS concerns regarding educational events, but we recommend CMS consider the burden placed on beneficiaries to conduct the initial outreach following an educational event, given the particular difficulties these special needs populations face.**

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies

A. Amending the Definition of Severe or Disabling Chronic Condition; Defining C-SNPs and Plan Types; and Codifying List of Chronic Conditions (P. 79560): *The SNP Alliance supports the proposals regarding C-SNPs but is concerned about potential groupings of chronic conditions.*

The SNP Alliance supports the expansion of qualifying chronic conditions to 21 conditions, and we support the expansion of CKD stages in C-SNPs. These additions and expansions more accurately reflect and capture the conditions special needs beneficiaries are experiencing. We commend CMS in its effort to ensure C-SNPs can meet the needs of beneficiaries which complex care needs and those who would benefit from C-SNPs are not left out. Additionally, further expansion of groupings should be done in ways to minimize beneficiary and provider confusion, and ensure conditions are clinically associated.

B. Defining Institutional Special Needs Plans and Codifying Beneficiary Protections (P. 79566): *The SNP Alliance supports the proposals with some concerns and request for clarification.*

The SNP Alliance appreciates CMS working to codify and operationalize existing definitions and plan types, to better distinguish types of I-SNPs and populations being served. We do seek clarification regarding the contracting requirements for Hybrid Institutional (HI) SNPs. The proposed definition says HI SNPs "must own or have a contractual arrangement with each institutionalized facility serving enrollees." It may not be possible to have a contract with a nursing home in a given rural area, or the existing single facility may be of low quality – and yet the members would have access to adjacent counties for service, and still benefit from the additional support and coordination offered by the I SNP.

F. Codification of Special Needs Plan Model of Care Scoring and Approval Policy (P. 79571): *The SNP Alliance appreciates codifying sub regulatory guidance but has concerns and recommendations.*

CMS is codifying sub regulatory guidance from Chapters 5 and 16b of the MMCM about current SNP MOC scoring protocols. The SNP Alliance appreciates codifying these rules, and notes that they will help address the confusion that has occurred among plans experiencing the need to modify their MOCs due to changes in practice or processes. However, we have some concerns and recommendations, including a more thorough review of the MOC Scoring Guidelines (for streamlining and to evaluate the process/value), a provision to be added to the MOC policy by CMS around environmental or industry substantial impact events that effects the ability of the plan to follow the written/reviewed MOC, attention to the off-cycle submission process and capacity of NCQA to allow for timely reviews.

Please find the recommendations regarding MOC scoring and approval policy below:

1. **MOC Scoring Guidelines & Review/Audit Processes** – Time for Evaluating – We appreciate and support the MOC. The MOC Scoring Guidelines have offered a thorough outline of expected structures and processes around care management to health plans. We believe having these guidelines has fostered attention to important elements of care management. However, the MOC regulations have been in place for more than a decade. We see this evaluation as being important to revise or reaffirm the MOC guidelines but also to update the evidence that supports specific factors/elements in the MOC guidelines. Such an evaluation could:
    - Reduce duplication, reduce the level of detail where there is redundancy within the MOC across factors/elements and/or where evidence shows the element/factor is NOT required to be present within a robust care management program)
    - Reevaluate the MOC submission, review, renewal and/or audit processes for efficiency, consistency, and effectiveness. This would need to involve study of time/costs and consistency across a sample of plans. We would appreciate some kind of review/analysis of the costs placed on SNPs and whether it has been increasing or decreasing and how to help achieve efficiencies, where possible, while maintaining regulatory compliance and keeping to the goals of Congressional intent.

This evaluation of the policy and practices by CMS/NCQA would help these agencies as well as plans to see if there are ways to streamline or improve.

2. **Recognize Major Environmental Shifts & Disasters** - We recommend that CMS consider the potential impact of environmental disasters or major shifts, such as in with the COVID-19 pandemic. A provision indicating acceptability of needing to vary processes from what is normally done and what is listed in the MOC during such a PHE is recommended.

3. **Revisiting Off-cycle submissions** - We are not convinced that the need for off-cycle submissions will be “infrequent” or “rare,” as the increasing number of requirements, industry developments, and ever-evolving best practices around health equity, care coordination, provider networks, and other emerging standards make it more likely that substantive changes will need to be made. Thus, SNPs are likely to find it necessary to more frequently submit an off-cycle review so that their MOCs remain current to structures, processes, practices, and programs that are operationalized for SNP members.

Therefore, we strongly recommend three actions:

1. **Clearly Define Substantive Change and Issue Criteria for Standard and Equal Determination/Decisions** - Revise/clarify the language around what is considered a “substantive change” as it remains unclear and plans with default to assuming they should submit. We appreciate the mailbox offered, but this is a one-at-at-time consideration and does not provide the transparency needed to ensure that all health plans are being treated consistently in this determination. Please provide better criteria which would not be open to subjective determination.

2. **CMS Audits** - Allow for some flexibility in CMS audits around MOC compliance, where the plan documents the deviations (purpose/extent) from the written/approved MOC when needed—as plans that read the change as “not-substantive” consistent with CMS criteria, should not be penalized for not submitting an off-cycle review.

3. **Additional Off-Cycle Review Capacity & Set Timelines/Communication** - Increase the review capacity at NCQA to handle MOC reviews, especially off-cycle reviews in a timely, consistent, and effective way. There should be a standard response timeline with standard, consistent communication that is timely. The review should take no more than 30 days and the plans should be able to review the findings through an online portal.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

The SNP Alliance supports fair, equitable, accurate quality measurement and reporting and is encouraged by CMS’ interest in aligning performance metrics and policy across program. **We believe that CMS should advance a smaller set of core measures that are aligned across the Medicare and Medicaid programs for dually eligible beneficiaries.** (We see efforts to do this in the Advance Notice just issued and will comment on that in our subsequent letter).

C. Contract Ratings (P. 79614)

2. Contract Consolidations (P. 79614): *The SNP Alliance agrees and supports this provision.*

D. Adding, Updating, and Removing Measures (P. 79614)

1. Proposed Measure Removal (P. 79614)

A. Diabetes Care—Kidney Disease Monitoring (Part C) (P. 79614): *The SNP Alliance supports this rationale and this change.*

B. Medication Reconciliation Post-Discharge (Part C) (P. 79615): *The SNP Alliance supports the rationale offered by CMS and appreciates the removal of this measure, which is duplicative of the Transitions of Care measure, but continues to express reservations about the Transitions of Care measure being applied to health plans.*

The Transitions of Care measure is functionally a measure of the information exchange capability and timeliness of information from discharging provider to receiving provider. This does not measure health plan action or inaction. Therefore, we recommend that CMS provide additional support and technical assistance to inpatient and outpatient providers to improve their information exchange so that patients and their providers have the information needed for better continuity of care. This could be a focus for provider quality incentive payment, such as in MIPS. Health plans do not have control over providers' information transfer processes or systems.

Therefore, we again recommend:

1. Renaming the TOC measure to Transfer of Information by Providers or a similar name.
2. Removing this from the health plan measure set, and
3. Discussing with provider groups the feasibility of adding it to the provider measure set with additional best practice information and guidance to increase performance on timely information transfer and follow-up.

2. Proposed Measure Updates (P. 79615)

A. Colorectal Cancer Screening (Part C)—Substantive Change (P. 79615): *The SNP Alliance supports this measure change and the rationale to keep in line with clinical guidelines.*

B. Care for Older Adults—Functional Status Assessment (Part C)—Substantive Change (P. 79615): *The SNP Alliance agrees that an annual functional status assessment is very important for older adults but requests additional guidance and clarification.*

The SNP Alliance agrees that an annual functional status assessment is very important for older adults—whether they are enrolled in a special needs health plan or not. We note that functional status assessment of ADLs and IADLs may not be completed by a primary care provider within the Annual Wellness Visit, therefore we encourage recognition of such an assessment conducted by any clinician involved in the individual's care.

We note that the Advanced Notice mentions functional assessment. We will respond to that Notice, separately. For this proposed rule, we request that CMS ask NCQA to specify what criteria or definitions are used for delineating “standardized functional assessment tools.” What criteria meet the intention/requirement? As noted by CMS, there are already many screening and assessment tools available and in use, including those required by states in accordance with their state-specific eligibility requirements around functional status assessment. States require functional status assessment and updates in order to confirm level of care eligibility for the beneficiary to obtain access to Medicaid services in that state. We assume that the use of these state instruments is acceptable, and that documentation through the state assessment process is also acceptable, and that there is not an exhaustive list of approved tools currently published.

Finally, it would be helpful for CMS to provide a way for ongoing learning about how functional status assessment results should be linked to or lead to specific best practices that can be part of the plan and provider’s response. Such information from CMS helps drive best practice adoption of proven interventions for functional status improvement among both providers and plans and supports quality improvement.

C. Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins) (Part D)—Substantive Change (P. 79616): *The SNP Alliance supports adding a case-mix adjustment for socio-demographic risk factors and stratifying measure results to provide plans with more information for improving performance among different population sub-groups for these Part D medication measures.*

CMS has added the updated Part D Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins) measures (including non-substantive changes to the specifications) and proposes to case-mix risk adjust three measures for social-demographic risk status and stratifying by beneficiary-level characteristics and to remove these from the Categorical Adjustment Index (CAI).

We understand why these measures will be removed from the CAI, but ask CMS to please monitor and the report effects of such CAI changes on health plans with high enrollment of persons with social risk factors (dually eligible/low-income status/disabled) and complexity characteristics (chronically ill beneficiaries) to ensure that there is not unintended harm done by reducing the CAI adjustment for plans with a high proportion of these individuals enrolled.

We also request additional examination of the contracts that were impacted. In CMS’ analysis, 60-70% of contracts retained the same Star level after the change. However, did CMS review the impacted 30-40% of contracts where the Star measure changed? Did CMS analyze affected plans by MA enrollment profile or SNP vs general MA? Likewise, did CMS analyze by plan size of enrollment, geographic region (urban/rural, Area Deprivation Index) or other characteristics that might indicate need for changes in the methodology or reconsideration in order to ensure progress toward health equity goals? As CMS notes, having two years of data to recalculate effects will be helpful.
Please conduct this additional targeted analysis and report findings to share the results.

E. Measure Weights (P. 79623)

1. Patient Experience/Complaints and Access Measures (P. 79623): *The SNP Alliance agrees with this change and appreciates this effort to rebalance the measure weights across the MA Star measures.*

CMS is proposing to lower the weight of patient experience/complaints and access measures to 2 beginning with the 2026 Star Ratings covering the 2024 measurement period (2026 Star Ratings) to align efforts with other CMS quality measurement rules and the current CMS Quality Strategy, as well as to better balance the contribution of the different types of measures in the Star Ratings program.

The SNP Alliance agrees with this change and appreciates this effort to rebalance the measure weights across the MA Star measures. We had previously commented that the sharp increase in measure weights on these measures from 1.5 to 2 and then to 4 could have unintended negative consequences. We noted that these measures would represent nearly 60% of the total quality score for health plans and that seemed out of balance compared to other programs, such as hospital quality measurement. We appreciate that CMS has recognized this imbalance and made this change. **In considering measure weights and measure selection, especially in keeping with CMS' health equity goals, we have the following recommendations:**

1. **Balance of Process and Outcomes Measures -** Moving forward, we request that CMS consider additional stakeholder input regarding achieving a balance of process and outcome measures and the utility of each in performance evaluation and quality improvement.

2. **Criteria for Weighting Measures -** We request that CMS consider developing criteria with stakeholder input that will help ensure there is a fair and even approach to selecting and weighting quality measures. This will help guide measure weight changes in the future and help avoid year by year dramatic changes or program misalignment across settings and quality measurement programs under Medicare and Medicaid.

3. **Meaningful Measures -** We encourage CMS to incorporate stakeholder feedback on specific process and outcome measures that may be most meaningful to people with complex characteristics, such as multiple chronic conditions with both physical and mental health diagnoses, or high social risk issues. We recommend starting with individuals who are dually eligible.

4. **Core Small Measure Set -** We continue to voice the perspective that dually eligible/disabled/low-income, high social risk, complex chronic care populations need a different set of core measures than what is currently used in the MA Stars program. We would like to work with CMS to move toward a more meaningful set of quality measures for different population groups. We could envision a small core set of universal measures to form a base, with additional, tailored/customized sets of measures and/or weights which would better reflect population characteristics and help recognize what matters to these different populations. The core set could be used across settings and services where the measure is relevant to the population group. This would help align and drive improvement efforts and offer the opportunity to demonstrate best practice.

(We note that the need for a core measure set across programs is recognized by CMS in the Advance Notice. However, the focus is not on those with greatest health disparities—we believe a small core "universal set" is useful, but this does not address the issue of meaningful measures for vulnerable groups. We will comment further on that in our subsequent letter).

5. **Case Mix –** Finally we recommend that CMS consider additional characteristics (variables) in its case mix methodology used in quality measurement and performance evaluation. Characteristics such as functional status, frailty, social risk vulnerability level, palliative/advanced illness, complex chronic medical complexity, and behavioral health complexity are all important in identifying care needs, determine effective approaches for individualized care plans, setting achievable and meaningful outcome and improvement targets, and evaluating performance. We believe there are opportunities to improve the case mix indexes currently used.

F. Guardrails (P. 79625): *The SNP Alliance does not support this change as proposed.*

We understand and agree that the COVID-19 Public Health Emergency had profound impact on communities across the U.S. and that the PHE significantly reduced access across providers to preventive screenings, medical and behavioral health care, social services, diagnostics, treatment, follow-up care and other services. These changes, in turn, affected measure results for providers and plans, including the measures used in the MA Star Ratings program. However, CMS' proposal to remove these guardrails due to the experience shown during the PHE could have unintended negative consequences. The cut point guardrails were put in place for good reason—stability--which is still important.

In 2019 CMS proposed to modify the regulations at - §§ 422.166(a)(2)(i) and 423.186(a)(2)(i)) by adding two enhancements to the hierarchical clustering methodology used to set cut points to non-CAHPS Star measures. At that time, CMS discussed two important goals: (1) improve stability and (2) improve predictability for a health plan's cut points year-over-year. Unstable or unpredictable targets that vary substantially from year to year make it very hard for a plan to set quality improvement targets and make it difficult for plans that achieve positive change to receive recognition in the quality measurement program. If the end goal keeps shifting, it makes it hard to set a quality improvement target and to benchmark performance.

One enhancement that CMS applied at that time for implementation for the 2020 Star ratings was mean resampling which reduced the sensitivity of the clustering algorithm to outliers in measure scores across all MA plans. This reduced variation and improved stability of the cut points.
The second enhancement advanced by CMS was to apply a 5% guardrail for all measures that were in Part C and Part D Star Ratings for three years or more. This capped to 5% the allowable movement from the prior year's cut point for each of the five-star levels for each measure. This was promoted providing greater predictability in cut points, by measure.

These twin goals of stability and predictability remain important in quality measurement and in setting cut points (targets) and benchmarks year-over-year.

We do not support removing the guardrail provision beginning with 2026 Star Ratings. Rather, we recommend CMS consider three actions:

1. **Study Effect both ways -** Using at least three years of data (e.g., 2022, 2023, 2024), CMS should study the movement of cut point measure results with and without the 5% guardrail method and publish the results showing measure-specific and overall star rating effect of this method, and further,

2. **Analyze Impact on High-Risk Groups -** CMS should analyze and report on the effect of the removal of the guardrails on high dual/disabled/LIS enrollment plans to determine if there is a net positive impact on these at-risk populations enrolled in such plans or if the net effect is neutral or negative.

   Based on this analysis, CMS can make a determination in 2025 about options for guardrail method modification. This additional study could inform CMS on other options rather than complete elimination. For example, the guardrails could be placed on certain measures that have a more unstable pattern, or on measures that are more meaningful/relevant to the care and quality outcomes among high dual or at-risk populations. We suggest that the original intent and purpose of the guardrail application remain, and that CMS has the opportunity to study options and make a more informed decision with additional options at its disposal.

3. **Time/Sync Implementation** - Time any proposed changes in guardrail adjustment to take effect in 2027 which corresponds to other changes proposed in this rule, such as application of the Health Equity Index. As stated in earlier in this letter, we believe that studying and aligning inter-related provisions so that the net effect is known is important to CMS, stakeholders, and to achieving health equity goals.

G. Health Equity Index Reward (P. 79626): *The SNP Alliance supports this work and the proposed Health Equity Index but suggest some modifications and changes in the implementation of the HEI with additional ongoing study/analysis and other changes recommended. The SNP Alliance also does not support the proposal to eliminate the reward factor.*

CMS proposes to replace the current reward factor with a new Health Equity Index reward starting with the 2027 Star Ratings. The HEI would be based on performance related to a subset of enrollees with specified SRFs. There will be a lower threshold below which contracts are not eligible for the HEI. CMS proposes to initially include receipt of the LIS or being dually eligible (LIS/DE) with full or partial dual eligibility or having a disability as reason for Medicare eligibility (at any time within the measurement year) as the group of individuals considered to have a social risk factor and that this group would be used to calculate the HEI. CMS is also considering adding the area deprivation index category into the HEI and to exploring other SRFs to be added over time. Measures in the H.E.I would be announced annually.

The SNP Alliance fully supports the goal of reducing health disparities. We appreciate the efforts by CMS to focus additional attention and resources on individuals with social risk factors. The Health Equity Index-- and the proposed methodology to reward health plans demonstrating good performance for individuals with specified social risk factors --seems to have merit. We support the definition of the target population with both full and partial dually eligible individuals recognized. We appreciate that this for any time within the measurement year, particularly as some individuals experience administrative loss of eligibility due to lack of timely re-determination process rather than any actual reduction in eligibility. We also appreciate CMS recognizing the initial reason for Medicare eligibility to identify persons with a disability.

Recommendations -We support this work and the proposed Health Equity Index, but suggest some modifications and changes in the implementation of the HEI with additional ongoing study/analysis and other changes recommended:

1. **Reconsider exclusion of SNP-specific measures** – these are tailored to high DE/LIS/Disabled populations and these measures represent substantial investment in care management and services by SNPs—they are important for the health equity goals. Leaving them out reduces their importance and does not provide an opportunity to recognize excellence.

2. **Continue to model the effect of HEI prior to implementation** - using the next two years' data, by calculating the HEI each year between now and when it is in effect in 2027 to display/model the impact with and without the HEI. Study effect on high dual plans/populations. Based on the information presented in this proposed rule, we would expect that health plans with higher enrollment of persons with specified social risk factors will be advantaged by this reward factor. This should be demonstrated by CMS to stakeholders through additional modeling and use of MY data in 2023-2026 leading up to the implementation of the HEI reward factor. Specifically, we request modeling for D-SNPs and other SNP types with a high proportion of LIS/DE or disabled individuals to demonstrate the effect of the HEI reward as compared to contracts with lower proportions of LIS/DE or disabled members.

3. **Publish Results** of additional analysis prior to first year of implementation (no later than 2025) and immediately following first year of implementation (2027 Stars). This will ensure that CMS provides full transparency and that both individuals and plans are aware of the effects. This will assist stakeholders to determine impact of this HEI on each subgroup.

4. **Consider Effects Such as Marketing to Duals** -We've heard concern from a few plans about the possibility that some plans may more heavily market to dual members in order to have them enroll in non-D-SNP products in order to meet the threshold of having enough members to be eligible for the HEI--particularly given the proposed elimination of the reward factor. Has CMS contemplated this issue? Is this of concern?

As noted above, The SNP Alliance does not support eliminating the reward factor as proposed. Eliminating the reward factor could have outsize/disproportionate impact on special needs populations and plans that serve them. This is counter to health equity goals.

Recommendations: We recommend study of potential negative impact on high dual/LIS/disabled plans where the HEI will not counterbalance the loss of the reward factor. We also recommend synchronization with other changes, and delay of implementation until HEI impact is known. In addition, the reward factor is important for funding special supplemental benefits for people with chronic illness/conditions. How will the removal of this impact the benefits plans are able to offer? Please consider the following recommendations:

1. **Study Impact on HE populations** - This needs to be studied further in terms of the impact on high dual/disabled/LIS plans before the reward factor is eliminated. The net effect of these changes needs to be studied for populations that are most likely to experience disparities, using dual/LIS/disabled status as proxy.

2. **Synchronization** – This policy needs to be synchronized with other changes that are being proposed –the reward factor should not be eliminated until the HEI is implemented and the impact is fully understood.

3. **Delay and Phase-in** - At a minimum, delay implementation until after the HEI is implemented in 2027, as the information can guide CMS to ensure that there is not unintended harm to high-risk groups. Then, phase-in the change, so that rewards recognize high performance focusing on populations with high social risk issues.

4. **Categorical Adjustment Index** – Though not mentioned in this PR, we want to state our continued support for the Categorical Adjustment Index (CAI) and assume that will continue to be implemented. The CAI has increased in utility and value over time as an important adjustment to measures that are not already case-mix adjusted. We have appreciated the work of CMS on this.

H. Improvement Measure Hold Harmless (P. 79632): *The SNP Alliance does not support removing the hold harmless improvement provision for 4 and 4.5 Star plans.*

CMS is proposing to CMS drop 4 and 4.5 Star contracts from this provision and it will only apply to contracts with 5 stars beginning with the 2026 Star Ratings.

We do not support removing the hold harmless improvement provision for all 4 and 4.5 Star plans. We understand the logic about plans still having “room for improvement,” however, there are important considerations to take into account which we believe should modify what is proposed. (We will offer additional comments to CMS in the Advance Notice in a subsequent letter). Considerations include:

1. **Small plans** - First, plans with small enrollment are already challenged with obtaining 4.5 or 5 Stars as they may not have enough member volume to calculate the measure for some measures and therefore the full picture of their results is hidden. A small plan may be doing very well, but a specific measure cannot be calculated due to low denominator or lack of reliability of the data. This does not equate with poor performance. Every measure that is left out, where the plan is actually doing well, reduces the ability of that plan to demonstrate excellence and achieve a 5 Star rating.

2. **Effect on high-dual/LIS/disabled enrollment plans** - Second, CMS has not studied or reported on the impact for high dual/LIS/disabled enrollment plans. Does this regulation have uneven impact on certain plans based on their enrollment characteristics? Would it lower the resources available to high dual plans to offer care, support, services to at-risk or vulnerable groups? The Improvement factor is another important source of resources for funding special supplemental benefits for people with chronic illness/conditions. How would the removal of the improvement provision impact the plans that are offering expanded SSBCI and/or supplemental health benefits? We have heard from plans serving high proportion of duals/disabled/LIS members and those with other social risk issues that it is very hard to reach 4.5 Stars under the current MA quality measurement system. Removing this as an acceptable level of performance for recognized improvement would certainly have an outsize effect on these types of plans. Such unintended negative effect is counter to the goals around Health Equity and reducing health disparities.

3. **Consider excluding measures with extremely small differences between cut point thresholds when considering removal of the hold harmless provision** – We note that there are some measures in Stars where there is extremely small differences between 3, 4, and 5 Star levels with less than 4 percentage points between them. For example, looking at 2024 Stars, the Kidney Disease Monitoring measure, a 5-Star result is 97% achievement, where a 4 Star is 95% achievement, and a 3 Star is 93% achievement. Is this a difference without substantive meaning? Especially with small plans, a few members' results from their principal provider might affect the Star rating. Getting needed care is another measure with small differences between Star levels—a 5 Star is 84%, 4 Star is 82% and 3 Star is 80%. Depending on the CAHPS sample size and composition, results can be affected. We ask CMS to consider this issue.

Recommendations: The SNP Alliance offers the following options for modifying this proposal:

1. **Retain for High DE/LIS/Disabled/Small Plans** - Retain the hold harmless for 4- and 4.5-Star plans with a high proportion (80% or more) of dual eligible (full and partial)/low-income subsidy/disabled members, AND particularly for plans that have less than 5,000 members where the plan is targeting a special needs population.

2. **Study & Report Effect Prior to Implementation** - Study the impact of removal effects on high dual/LIS/disabled plans prior to implementation. Report on results and modify policy based on the analysis.

3. **Look at Two Years of Performance Data** - Maintain the hold harmless for 4.5 plans if the plan shows movement from 4.0 to 4.5 and it can secure that level for two consecutive years.

4. **Delay to Synchronize with other Changes -** Delay phase in of this provision until the HEI is implemented in 2027 as the impact will be better known (on plans with a substantial enrollment of individuals with social needs). Then consider a phased approach.

I. Extreme and Uncontrollable Circumstances (P. 79632)

2. Health Outcomes Survey (HOS) Measures (P. 79633): *The SNP Alliance does not support bringing back the PCS and MCS measures.*

Given the limitations in the Health Outcomes Survey, methods, measure result scoring, and other limitations, we do not support bringing back the PCS and MCS measures. These measures and the way they are derived have significant limitations—from the instrument to the survey methods, to the measure scoring. The samples of individuals from which the measure scores are calculated do not represent the diversity of the Medicare population, under-representing persons of color, and those with ethnic and linguistic diversity.

The SNP Alliance Recommends:

1. **Revise HOS & Retest Validity, Reliability, Accuracy among Target HE Populations -** We recommend revising the HOS instrument, methods, case-mix and predictive models, survey administration, and measure calculation with key stakeholder input. This should occur

before adding to any performance evaluation or measurement program that relies on this data source to generate a measure result.
Please see our report just released that highlights challenges with HOS among diverse populations and offers recommendations: Equity-and-Fairness-in-MA-Quality-Measurement-SNPA-ATI Feb 2023

2. **Suspend PCS and MCS Measures** - The PHE shone a light on the limitations of these HOS measures as used in MA Stars. They do not offer information that is representative of the people in SNPs, nor to guide quality improvement actions. The accuracy and utility of the PCS and MCS measures are questionable. These longitudinal measures should be retired/replaced or substantially revised to meet goals and standards around quality measurement. CMS's own language in this proposed rule states:

   ". . . goal within the Medicare+Choice program is to ensure that enrollees with limited English proficiency, education, or other socioeconomic disadvantages receive health care to which they are entitled and to provide services in a culturally competent manner. Therefore, CMS is updating their language § 422.112(a)(8) for clarification purposes by emphasizing that the policy applies to 'all enrollees'. "

   HOS does not reach "all enrollees" as it is now being used in MA quality measurement and Stars.

Conclusion

The SNP Alliance appreciates the opportunity to comment on these important proposed changes to the Contract Year 2024 Medicare parts C and D programs. We appreciate the person-centered focus that CMS has shown in this proposed rule to better address health access and equity. And while we support many of the recommendations, we have also identified areas that would benefit from further clarification. We are happy to have follow-up discussions, as helpful.