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

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

March 6, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

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.

We appreciate the opportunity to respond to the **Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies**. For reasons we will articulate in the body of our comment letter, we oppose a number of these proposals. It is apparent that the impact, particularly to the special needs plans who were established to deal with the most complex needs individuals, will be disproportionately and dramatically greater than the estimates stated in the CMS Fact Sheet. The impact includes providers, many of whom are in value-based payment models with health plans, and beneficiaries who will see increased premiums (where allowed) and decreased supplemental benefits.

The SNP Alliance finds this notice to include a significant number of substantive changes, not all of which are transparent in the assumptions and modeling methodologies. While we understand the need to thoughtfully transition to the ICD-10 diagnoses, the proposed changes to coding have 4 significant impacts: 1) the mapping of the ICD-9 to ICD-10; 2) the constraining of certain codes; 3) the elimination of over 2200 codes; and 4) the restructuring of the HCC Condition Categories. Each of these has a cumulative effect on those plans who care for individuals with the highest concentration of these codes. Because these changes are interrelated and complex, and because with internal analysis many plans are seeing a far greater negative impact than what CMS projected, this warrants adequate time and detailed actuarial analysis to fully understand the "whole picture," the impact for those dually eligible, and time for full rulemaking with adequate time for stakeholder input.

Finally, this set of proposed changes to payment policies will have a significant and negative impact to enrolled Medicare beneficiaries. The SNP Alliance retained an actuary to do analysis of the impact on our SNP Alliance members. It is clear the impact disproportionally impacts those dually eligible and those enrolled in C-SNPs (who are also often dually eligible). While there is a wide range of impacts across plan types and geographies, the averages of impact don't tell the real story for individual beneficiaries. This will directly impact premiums and decrease or eliminate supplemental benefits. Many of these benefits are in place to improve health equity, access, and reduce disparities, and are directed to those with the greatest need and to provide supports and services above most states' Medicaid LTSS benefits. For states with integrated care for dual eligible beneficiaries, and that have agreements for certain supplemental benefits for this population, these benefits could also be negatively impacted. And for those beneficiaries who are low income, but above the threshold for Medicaid eligibility, these benefits may be the difference between remaining at home or requiring a higher level of care. All of these benefits serve to align with the CMS goal of advancing health equity and quality, reducing disparities, and increasing integrated care.

The SNP Alliance is committed to improving the care and the lives of those most vulnerable with high-risk and high-cost needs. Special Needs Plans have the highest use of HCC codes because they enroll populations with higher rates of chronic conditions with the most complex care needs. We are concerned the expectations put into the CY24 Proposed Rule for Medicare Parts C and D are misaligned with this strategy of eliminating key chronic condition codes and penalizing plans caring for those most in need. We encourage CMS to work with all stakeholders to assess the impacts these proposals will have on beneficiaries, especially vulnerable populations served by Special Needs Plans.

Respectfully,

Cheryl Phillips, MD

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SNP Alliance Advance Notice Comments by Section

Section A. Data and Assumptions Supporting USPCCs

SNP Alliance Response: The SNP Alliance recommends that CMS reduce the magnitude of this adjustment in 2024 by phasing in the adjustment to account for the removal of IME and DGME costs.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2024

Section A. MA Benchmark, Quality Bonus Payments, and Rebate

SNP Alliance Response: The SNP Alliance recommends that CMS exclude individuals with Part-A only coverage from the calculation of 2024 benchmarks. This is consistent with MedPAC recommendations to Congress.

A3. Quality Bonus Payment Percentage

SNP Alliance Response: The SNP Alliance supports the proposal.

Section B. Calculation of Fee for Service Cost

SNP Alliance Response: The SNP Alliance supports CMS continuing to adjust the calculation of benchmarks for Puerto Rico using only claims data for beneficiaries enrolled in both Parts A and B and encourages CMS to extend this policy to improve payment accuracy to advance care for all MA beneficiaries.

However, we continue to be concerned about the large disparity in payment rates between Puerto Rico and the States. We encourage CMS to establish a minimum MA AGA of 0.7 for Puerto Rico and to make such an adjustment non-budget neutral, to address anomalies in FFS data and better meet the needs of beneficiaries who are older, sicker, and who have fewer federal benefits.

Section G. CMS-HCC Risk Adjustment Model for CY 2024

CMS Proposal: *For CY 2024, CMS proposes to implement a revised version of the CMS-HCC risk adjustment model. This proposed model has the same structure as the 2020 CMS-HCC risk adjustment model currently used for payment in that it has eight model segments as first implemented for payment for CY 201718 and condition count variables as first implemented for payment for CY 2020. It incorporates the following technical updates: (1) updated data years used for model calibration, (2) updated denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, and (3) a clinical reclassification of the hierarchical condition categories (HCCs) using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. In addition, as part of the clinical reclassification, CMS conducted an assessment on conditions that are coded more frequently in MA relative to FFS. This assessment is consistent with Principle 10 of CMS's longstanding model principles, described in more detail initially in the December 2000 report titled, "Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment (Final Report)." As a result of this assessment, in addition to the technical updates, the proposed model includes additional constraints and the removal of several HCCs in order to reduce the impact on risk scores of MA coding variation from FFS. Refer to Table II-4 below for a list of HCC* *differences between the current and proposed CMS-HCC risk adjustment models. We propose to use this revised CMS-HCC model in Part C payment for aged/disabled beneficiaries enrolled in MA plans beginning with payment year 2024*.

SNP Alliance Response: The SNP Alliance has identified four distinct and separately impactful coding change concerns:

1. **Mapping from ICD-9 to ICD-10**
   The SNP Alliance has long supported accurate coding and understands the goal of transitioning to ICD-10 codes. However, this mapping comes with a decrease in the number of ICD-10 codes that map to the proposed CY 2024 HCCs. Under the current model, CMS utilizes 9,797 codes, compared to 7,770 in the proposed model. These changes will be discussed more below, but it is clear that neither plans or providers can adequately evaluate and create operational changes based on a 30-day payment notice while also providing for adequate timing for bid submissions.

2. **Constraining of Codes**
   In addition to the shift to ICD-10, this proposed risk model also constrains key chronic care codes for diabetes (36, 337, 38) and those codes for heart failure (224, 225, 226). Both are essential chronic conditions, often presenting first to primary care providers. The use of these codes is important to provide direction for further investigation and intervention.

3. **Elimination of Codes**
   There are 2269 net fewer codes in the ICD 10 mapping. Diabetes has 86 fewer ICD-10 codes, major depression has 402 fewer, and vascular disease 293 fewer. The result of which (using the diabetes example) is that a greater proportion of diabetics will be diagnosed with unspecified or no complications based on the updated ICD mapping and thus artificially reduce the coding risk adjustment despite their need for increased interventions and treatments.

   Additionally, the proposal eliminates codes that are frequently used in clinical practice because they are based on the information the clinician has on hand and are needed for additional chronic care management. These include protein-calorie malnutrition (HCC 47), which is particularly important for institutional level of care enrollees and/or HIV/AIDS patients; Angina Pectoris codes (HCC 230), which are used when patients present, or are known to have CAD – but the treating provider may not have all the details as to the exact specific branch of the coronary artery involved; and Peripheral Vascular Disease with Intermittent Claudication (HCC 265). These deletions all serve to depress the HCC weights for many with serious chronic disease burden, and such codes are needed for additional chronic care management.

   One dramatic example of this coding change is the impact to C-SNPs providing care to HIV/AIDs individuals. While the statement we have heard is that risk for HIV patients is now moved to Part D, this does not apply to those individuals who are aging with HIV/AIDS and who have multiple co-morbid, functional, and drug-related affects, including malnutrition, polyneuropathy, thrombocytopenia, vascular disease, major depression and drug/alcohol use. The reported impact of one SNP Alliance member serving this population is approximately a 20%

cut to revenue. This will directly impact services that are essential to keeping these members in the community.

Lastly, another impact not stated in the CMS proposed rule is the elimination of some of the rare and chronic, genetic, or metabolic condition codes that require substantial resources for management in the younger SNP population. These include rare anemias, endocrine abnormalities, disorders of metabolism, and genetic conditions of metabolism, all of which are serious and costly conditions for those affected. If this was done due to discrepancies in coding practice as compared to Medicare FFS, it is most likely these types of conditions are, in fact, underrepresented in the Medicare FFS population—accounting for that discrepancy.

4. **Restructuring of HCCs**
   In addition to the above 3 significant changes, the HCC condition categories have been restructured. This alone is significant enough to warrant formal rule-making and significant beneficiary, provider and payor comment. While one might debate any of these HCC risk adjustment changes in isolation, the total impact to coding, operations and provider practice is far more significant and impactful, resulting in difficulties to incorporate into system changes, education, and actuarial analysis for the PY 2024 bid submission. The fact that many plans are seeing significant negative impact would imply that perhaps the modeling looked at the broad populations of general MA. An actuarial analysis of a large sample SNP Alliance member plans revealed a majority of the special needs plans, particularly those serving a higher proportion of members dually eligible, saw a negative impact several-fold greater than predicted by CMS.

Summary Result: Presently, SNP enrollees have greater access to supplemental benefits, a necessity due to their increased social risk factors and higher rates of chronic conditions. The actuarial analysis from a majority of SNP Alliance members reinforces the negative impact on D-SNPs and C-SNPs, consistent with other recent published reports. While D-SNPs, overall, saw a negative reduction in payment, this impact was several-fold greater for C-SNPs, many of whom are also servicing duals. Given that a number of the SNP Alliance members are reporting a negative impact of $700-$800 per member per year, this will directly impact the ability to provide much needed supplemental benefits and special supplemental benefits for the chronically ill (SSBCI). Many of these benefits are providing essential services (non-medical transportation, in-home care, nutritional support, interventions to address social isolation) for those with greatest risk of health disparities and social risk factors. Even more concerning is the reality that such cuts will make some SNP plans nonviable in a given market. Should these plans no longer exist, these beneficiaries will no longer have the model of care or care coordination that is now built into the special needs plans and who will default back to a general MA plan or original FFS Medicare. Furthermore, several states are working with D-SNP, HIDE and FIDE plans to identify needed supplemental benefits and SSBCI. These benefits, and thus these state relationships, would also be jeopardized.

Lastly, the SNP Alliance recognizes this will have a direct impact on the provider community and potentially beneficiary access to services. CMS has been clear in its commitment to advance models of value-based payment with physicians and other providers. Our SNP Alliance members have actively advanced that goal through several VBD models, including shared risk and full risk delegation. Providers, especially primary care providers, are already facing significant workforce challenges and other payment pressures. This will further add to those serving the highest risk and most complex beneficiaries—for whom these cuts have the greatest impact. CMS is already aware of some of the regional challenges those dually eligible have in accessing healthcare. This will compound that challenge.

The SNP Alliance requests additional modeling from CMS regarding the impact to those enrolled members who are dually eligible, as well as an analysis of impact for special needs plans by SNP type: D-SNP (including breakout of HIDE and FIDE, and C-SNP), where the concentration of these codes is likely much higher, and thus the risk adjustment change is anticipated to be much greater. This could be accomplished through the creation of a technical expert panel to analyze how the proposed modifications will impact different subgroups and plan types. Lastly, a future Advance Notice should re-propose any model updates based on the work of the Technical Expert Panel.

We urge CMS not to proceed with the proposed changes to the Part C CMS-HCC risk adjustment model and to provide a longer opportunity (minimum of 60 days) to evaluate the proposed changes to allow for increased beneficiary, provider, and plan review and input.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

SNP Alliance Response: The decrease in Frailty Adjustment by more than 15% is an additional impact to those FIDE plans serving a significant number of individuals who are at a nursing home level of care. It is part of the cumulative downward pressure on those plans serving enrollees with the most need. A shift of this degree implies a disproportionate impact to those FIDE SNP plans who serve complex needs members. Furthermore, since the FIDE-SNPs calculations use the updated HCC model and PACE calculations are based on the 2017 HCC model, can CMS explain the potential impact on using disparate calculations for this comparison?

The SNP Alliance requests additional transparency as to how this calculation change was determined and whether it took into account the impact of the HCC proposed changes on FIDE SNPs with a population served most likely to have the deleted or changed HCC groups.

Section K. Normalization Factors

SNP Alliance Response: The SNP Alliance supports exclusion of 2021 risk score data from the calculation and, given the variation in state and county-level COVID-19 impacts and responses during CY 2021, further recommend that CMS take a more nuanced approach to inclusion of 2022 risk adjustment data by eliminating outlier markets, where low utilization caused by the COVID-19 pandemic persisted into CY 2021, from the calculation. We urge CMS not to move forward with the proposed model changes for 2024 and to therefore continue using the current Part C risk model and corresponding normalization factor.

Attachment IV. Updates for Part C and D Star Ratings

SNP Alliance Response: Given the extensive and multiple changes to Star Ratings and MA quality measurement, we recommend that CMS provide a summarization and hold stakeholder calls, as well as update the CMS website.

Table IV-1: 2024 Star Ratings Measures

CMS issued the 2024 Star Ratings Measure Table with weights, improvement measure designation and CAI measures delineated, including finalizing the addition of the Transitions of Care and Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions measures to be added to the 2024 Star Ratings. We have comments on the TOC, and HOS-derived measures.

SNP Alliance Response: The SNP Alliance recommends that the SNP-specific measures be counted in overall Star ratings and considered in the Health Equity Index.

Transitions of Care measure – The TOC measure is included in the 2024 Star Ratings.

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. 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.

SNP Alliance Response: We 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 from the Star Ratings.
3. Discussing with provider groups the feasibility and value for their coordination efforts of adding this to the provider measure set with additional best practice information and guidance provided by CMS to increase performance on timely information transfer and follow-up over time.

Health Outcomes Survey (HOS) Measures The HOS-derived longitudinal measures in Stars include *Maintaining or Improving Physical Health, Maintaining or Improving Mental Health,* and *Physical Functioning Activities of Daily Living.*

PCS and MCS Measures

SNP Alliance Response: The SNP Alliance does not support bringing back the PCS and MCS measures. These measures have not been adequately constructed/tested for comprehension to ensure accuracy, reliability, and validity among diverse populations are problematic as longitudinal measures, and do not offer usable information for quality improvement.

PFADL Measure

SNP Alliance Response: We recommend changes in the wording of one question used to generate the PFADL measure (see further discussion in this letter).

New HOS Measures

SNP Alliance Response: We do not support additional measures be derived from the HOS until the instrument is revised and retested among diverse population groups for validity, reliability, and accuracy. The instrument should also be available in more than 4 languages, and the methods for data collection should include online access.

Given the limitations in the Health Outcomes Survey, methods, measure result scoring, and other limitations, measure results derived from HOS 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 including language access, online access, and sampling, and measure calculation –engaging a wide group of diverse stakeholders to provide input. This should occur before adding to any performance evaluation, measurement program, or measure set that relies on this data source (HOS) to generate a measure result.

Please see our report just released that highlights challenges with HOS among diverse populations and offers recommendations: Ensuring-Equity-and-Fairness-in-MA-Quality-Measurement_Brief_Final.pdf (snpalliance.org)

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'. "

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

3. **PFADL Measure –** The measure misses an important opportunity to obtain information about how a plan and/or provider has enhanced the individual's ability to perform activities of daily living. We strongly recommend (at a minimum) changing the wording and adding an additional question around the item on activities of daily living to incorporate/include how the person is able to perform WITH ADAPATIVE EQUIPMENT OR ASSISTANCE – such support is critical and an important benefit provided to individuals with functional limitations. This is evidence of good care management and support—it does not make sense to exclude these important supports for daily living tasks.

CURRENT QUESTION: *Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?*

- *Bathing*
- *Dressing*
- *Eating*
- *Getting in/out of chair*
- *Walking*
- *Using the toilet*

☐ No, I do not have difficulty ☐ Yes, I have difficulty ☐ I am unable to do this activity

CHANGE TO or ADD: How well are you able to do the activities with special equipment or help from another person:

- ***Bathing***
- ***Dressing***
- ***Eating***
- ***Getting in/out of chair***
- ***Walking***
- ***Using the toilet***

☐ No, I do not have difficulty ☐ Yes, I have difficulty ☐ I am unable to do this activity

Add: *Did your health plan provide support, such as care management, or payment for adaptive equipment, that allows you to better perform these activities of daily living?*

☐ ***Yes***
☐ ***No***
☐ ***Don't Know***

2024 Star Ratings Program and the Categorical Adjustment Index (p. 99)

***SNP Alliance Response*:** We support the Categorical Adjustment Index but ask CMS to consider adding two measures: "Members Choosing to Leave the Plan" and "Complaints About the Health Plan" to the CAI measure set. We also recommend continued monitoring around how well the CAI is performing as intended to recognize the social risk issues and help adjust measure scoring for these individuals who predominate in special needs plan enrollment populations. We note the CAI was to be an interim strategy to recognize social risk impact on measure results.

Extreme and Uncontrollable Circumstances

***SNP Alliance Response*:** We recommend that CMS consider revisions to this policy to address when disasters or emergencies impact care delivery beyond the FEMA designated major disaster declaration in an individual assistance area. We also ask that CMS consider impact on self-report surveys such as HOS based on the date of the emergency/environmental circumstances and suspend use in the affected areas.

Changes to Existing Star Ratings Measures for the 2023 Measurement Year and Beyond (p. 102)

Table IV-4: Preliminary Adult Universal Foundation Measures

The SNP Alliance supports fair, equitable, accurate quality measurement and reporting. We applaud CMS' interest in aligning performance metrics and policy across the Medicare and Medicaid programs and support this important effort. CMS' initial effort to create a "universal foundation" of measures is appreciated. We provide further comments and recommendations to improve upon this initial step to better tie to health equity goals and recognize the importance differences between population subgroups and among plans.

SNP Alliance Recommendation**:** We recommend a smaller core set of measures aligned across Medicare, Medicaid, settings/services, with a few additional measures tailored to the characteristics of the population to drive meaningful quality improvement. We would like to work with CMS to move toward a more meaningful set of quality measures for specific population groups—such as groups with complex medical progressive conditions, high social risk vulnerabilities with concomitant medical and behavioral health conditions, and frail individuals living in institutional settings, and persons who became eligible for Medicare due to physical disabilities.

Everyone agrees there are too many measures, and some are less meaningful to certain subgroups than others. Moreover, comparisons of outcomes when there is great diversity of social risk issues and complexity of conditions without adequate case-mix adjustment is unfair and can perpetuate disparities. This approach adds burden without value and can cause unintended harm. We continue to voice the perspective that dually eligible/disabled/low-income, high social risk, complex chronic care populations are a diverse group needing focused attention in the quality measurement space.

SNP Alliance Recommendation**:** We recommend CMS consider a smaller set of "universal measures" to start. A core set of 5 or 6 measures which have the same measure specifications and are used across the Medicare and Medicaid programs and within provider settings/services could form a base.

SNP Alliance Recommendation**:** We urge CMS to consider additional sets tied to subgroup characteristics that represent meaningful areas for assessing outcomes in quality of life, functional status, and physical and mental health and that are aligned —the same—for both the Medicare and Medicaid programs, and for entities such as health plans and ACOs working with integrated care models—could serve to replace some of the general measures that do not apply as well to some subgroups.

The tailored/customized sets of measures and/or customized weights on existing measures could be tested for usability and value using stated criteria, and then added to the core set after study/determining utility. These additional measures would be applied to population subgroups to better reflect key population characteristics impacting health and condition management.

A smaller universal core set coupled with tailored additional measures would promote meaningful measurement and performance evaluation across programs and settings. We believe this approach could help in recognizing what matters to these different populations. The tailored set would be used across settings, services, and programs where the measure is relevant to the population group and care/support is provided in that setting or entity. This is to promote the goal of aligning and driving quality improvement efforts across programs and settings. We need benchmarks and targets that are relevant and that offer the opportunity to demonstrate best practice and quality improvement.

***SNP Alliance Recommendation*: Case Mix –** Another area for improvement in the MA quality measurement/performance evaluation approach is in the case-mix variables used to adjust for condition characteristics which affect measure results independent of provider or plan actions. **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. With additional information about the enrollment characteristics of plans, all stakeholders would be better able to interpret the measure results—measure by measure, and as a whole.

<u>Universal Foundation Measure Set</u> – We offer additional comments on the universal foundation measures:

- **<u>Health Equity Goals</u>** - **We recommend that CMS ensure diverse stakeholder input on this core set to ensure that health equity, fairness, and relevance goals are met.**

- **<u>Criteria for Selecting and for Evaluating</u> –We request that CMS provide stated criteria with processes and weighting (where relevant) that the Agency has used for selecting the universal foundation measure set.** Stated criteria with weights/processes allows others to replicate and evaluation. This promotes the goal of ensuring transparency and allows CMS to obtain important feedback/information from stakeholders. We also recommend criteria or standards be outlined for how to evaluate how the measure set is performing. Known, objective criteria will be needed both now, and in the future, to guide how/when to cull or add to this measure set and evaluate whether it is achieving intended goals.

- **<u>Test for HE and Effect Prior to Implementation</u>** – We recommend that CMS conduct additional modeling for each measure proposed in the universal set first to determine if there are uneven effects on plans with high DE/disabled/LIS profiles.

- **<u>Specific Measures in the Universal Foundation Set</u> –** We recommend scaling the initial universal set down and then adding as experience is gained. We also recommend that CMS only select measures which have been adequately tested and validated in diverse (language, ethnicity, literacy) and high social risk populations. This is particularly important with any self-report measures, such as in CAHPS.
    - ***Adult Immunization Status.*** **(HEDIS) - We recommend that the adult immunization measure be withdrawn or CMS consider alternatives including receipt of a single vaccine.** As noted, there are discrepancies between HEDIS and CAHPS data and electronic data sources on immunization status. Immunization status data available to the health plan can be incomplete as individuals may receive vaccines in community settings without an insurance claim. This includes faith community locations, community centers, and other nonprofit service and advocacy organizations. The other unfortunate consideration is current resistance among some individuals to getting vaccinations—

therefore beneficiary refusal is a reality in the current environment. This needs to be noted in exclusion criteria in the measure.

- ***Screening for Depression and Follow Up Plan*** **(HEDIS) – We support additional behavioral health measures, such as this.** Depression is a serious, prevalent, and important condition for screening and follow-up. Screening and follow-up is a MIPS measure as well, so it aligns health plans with providers on this process measure. We note that the 2023 MIPS Clinical Quality Measure #134 has a slightly different specification that the HEDIS (NCQA) measure regarding follow up – where the MIPS measure is focused on the individual and requires a follow up plan documentation within 2 days of the encounter, while the HEDIS measure is focused on the population and requires follow up care within 30 days for those with a positive screen. **Therefore, we recommend that CMS address these issues and measure discrepancies be sorted out prior to application for "universal" use and alignment across Medicare and Medicaid and across plans and providers.**

- ***Screening for Social Drivers of Health/ Social Need Screening and Intervention (HEDIS)*-** **While SNPs are ahead of other types of health plans in screening for social risk issues, we believe it is premature to add this to a universal set at this time.** The NCQA measure specifications and the CMS screening requirements are not the same. More work is needed to elevate current social risk screening instruments used and required by States (Medicaid program requirements, which differ from state to state)—so that they meet the NCQA specifications for LOINC coding and validity/reliability standards. We all want to avoid burdening the beneficiary even further by having them have to answer questions through two different survey requirements by the federal and state governments on sensitive issues such as housing, food, transportation insecurity, and social isolation. In addition, there needs to be better clarity about who/when screening occurs and how/where the information is documented. There are important efforts by the National Quality Forum and other groups to support standardized social risk screening and encourage providers to document screening results and provide follow up to address the needs uncovered. However, the state of the art and practice is not mature yet. There is also a dearth of community organizations and services available to support and address the housing, food, and transportation needs uncovered. Accountability is diffuse. We have work to do to tie efforts together. Quality measurement can be one lever for aligning efforts—but to do so clarity is needed about expectations and responsible parties. We recommend that some of this foundational work be done before this is added to a universal set. Therefore, his measure should be withdrawn from the universal set until there is alignment in the measure specifications and clarity in answering the questions: who/when/how on screening, and who/what on follow up.

<u>Optional Exclusions for HEDIS Measures</u> (Part C)

SNP Alliance Response: **The SNP Alliance supports the rationale for making these exclusions mandatory as stated, but requests information about potential impact on measure results which may affect smaller plans that will not have enough data to report.**

Care for Older Adults (COA) – Pain Assessment (Part C)

SNP Alliance Response: **The SNP Alliance understands the reasoning offered for removing this, but we support keeping the measure as it is a good indicator for not only pain assessment, but pain management**. For example, it helps indicate progress toward reduction of opioids. We will also provide additional comment on the new measure proposed for chronic pain assessment and follow up.

COA – Functional Status Assessment and Medication Review (Part C)

SNP Alliance Response: **The SNP Alliance supports exploration by NCQA for modifying this measure;** however, additional data and analysis should be completed in consultation with the medical community and through formal rulemaking**. We also support application of functional status assessment for all older adults**. Limitations in function to perform activities of daily living impacts health, well-being, and condition management and is frequently under-addressed.

Diabetes Care – Eye Exam and Diabetes Care – Blood Sugar Controlled (Part C)

SNP Alliance Response: The SNP Alliance understands the rationale offered for changing this measure but requests consideration of potential impact and where the measure may need to be changed.

Specifically, we are concerned that the two-year lookback that requires the result of the exam for compliance in the year prior to measurement would be problematic. The diagnosis information necessary to meet the measure may not be present. and the Glucose Management Indicator is also problematic. Clinicians remark that GMI is not reflective of sustained glycemic control. The GMI is usually used as a screening/diagnostic tool. We recommend additional clinical subject matter expertise prior to making these changes.

Breast Cancer Screening (Part C)

SNP Alliance Response: **The SNP Alliance supports this change.**

Display Measures

Depression Screening and Follow-up (Part C)

SNP Alliance Response: **The SNP Alliance supports additional behavioral health measures, such as this, but requests modification to align with providers.** Depression is a serious, prevalent, and important condition for screening and follow-up. However, as noted above, the 2023 MIPS Clinical Quality Measure #134 has a slightly different specification that the HEDIS (NCQA) measure regarding follow up – where the MIPS measure is focused on the individual and requires a follow up plan documentation within 2 days of the encounter, while the HEDIS measure is focused on the population and requires follow up care within 30 days for those with a positive screen. **Therefore, we recommend that the NCQA measure consider how to align with the MIPS measure to promote and align the focus and quality improvement efforts across plan and provider.**

Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C)

SNP Alliance Response: **The SNP Alliance appreciates additional focus on behavioral health but have heard this measure may not be practical/feasible. We understand the rationale offered. However, we have heard from clinical and quality measurement experts that the measure is unrealistic**. Specifically, that individuals are reticent to reveal when they have not initiated/continued substance use disorder treatment and that providers don't have adequate resources to treat/manage. **We ask CMS to reconsider this measure and to consult with stakeholders, including SAMHSA, providers, and plans about possible alternative measures.**

<u>Timely Follow-up After Acute Exacerbations of Chronic Conditions</u> **(Part C)**

SNP Alliance Response: **The SNP Alliance understands and supports the rationale for timely follow-up, especially after ED and hospitalization.** However, we have several practical questions about the proposed measure, primarily around:

- Tracking/documentation – if the individual sees a provider within the time period for any reason, is that sufficient "follow up"?
- If the individual refuses follow-up, should this be noted and therefore the case excluded from the denominator?
- For a person with ongoing management of these conditions, where the principle provider is not able to see the patient within the timeframe—given scheduling or other barriers by the provider, how can/should the health plan intervene? How would the plan know that the timeframe was being missed? This does not seem to be within the purview/control of the health plan.

Because we believe this measure is duplicative of the FMC measure, we recommend that CMS complete an analysis on overlap between the measures and collaborate with stakeholders before inclusion of this measure on the Display Page.

<u>Adult Immunization Status (</u>Part C and D)

SNP Alliance Response: **The SNP Alliance supports immunization goals. However, there are several challenges with this measure as noted earlier which need to be overcome.** First, there can be discrepancies between HEDIS and CAHPS data and electronic data sources on immunization status. Immunization status data available to the health plan can be incomplete as individuals may receive vaccines in community settings without an insurance claim. This includes faith community locations, community centers, and other nonprofit service and advocacy organizations. The other unfortunate consideration is current resistance among some individuals to getting vaccinations—therefore beneficiary refusal is a reality in the current environment. This needs to be noted in exclusion criteria in the measure. Since having a regular primary care provider is often a precursor to good screening and immunization status, we recommend considering how to promote this goal as well as promoting full immunization status. **We recommend considering recognizing receipt of single vaccines in some way and excluding the individual from the denominator when the individual refuses immunizations.**

<u>Potential New Measure Concepts and Methodological Enhancements for Future Years</u>

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. 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.

SNP Alliance Response: 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.

<u>Health Equity Index Reward</u>

SNP Alliance Response: **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 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.

We 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 –** such measures 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 –** The HEI needs more testing and plans/stakeholders need more information prior to implementation. We suggest 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 on the HEI 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.

Eliminating Reward Factor

SNP Alliance Response: **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. We note that all of these changes have a cumulative impact—CMS needs to examine if the impact is disproportionately landing on health plans with high social risk/DE/disabled populations.

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**.**

Chronic Pain Assessment and Follow-up (Part C)

SNP Alliance Response: **The SNP Alliance supports examining chronic pain assessment and follow-up.** We look forward to having additional information on the measure specification and opportunity to comment.

Cross-Cutting: Sexual Orientation and Gender Identity for HEDIS Measures (Part C)

SNP Alliance Response: The SNP Alliance supports this effort.

<u>Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures</u> (Part C)

SNP Alliance Response: The SNP Alliance supports the rationale and the effort to reduce burden. We request that CMS share findings around effect of these changes, including potential for inclusion of false positives.

<u>Blood Pressure Control Measures (Part C)</u>

SNP Alliance Response: The SNP Alliance supports the rationale, but notes that recent scientific work by the National Quality Forum provides information useful for considering whether this measure needs to be adjusted for social risk factors. **We recommend that CMS obtain additional input from the medical community and go through a formal rulemaking process as these changes would be considered substantive.**

<u>Social Connection Screening and Intervention</u> (Part C)

SNP Alliance Response: The SNP Alliance recognizes the importance of social connections. **However, we do not support this measure as outlined.** We have concerns and questions about this as a measure. A few of the considerations include:

- What is an appropriate corresponding intervention if a person indicates loneliness and isolation?
- What if the individual does not want to connect/utilize the intervention(s) offered?
- Can electronic claims data capture the information needed for measure calculation?

<u>Broadening the Mental Health Conditions Assessed by Health Outcomes Survey</u> (HOS) (Part C)

SNP Alliance Response: The SNP Alliance agrees additional attention is needed on mental health, but we cannot support using the HOS as the source of any additional measures. HOS has significant limitations in the instrument, testing among diverse groups, methods of administration, sampling problems, case mix variables/data, predictive modeling, and scoring of measures. We agree that anxiety is very important and the condition should be addressed. However, using HOS will not provide any actionable information –as the above listed limitations of HOS and the very small sample of individuals yield very little usable information for quality improvement or performance evaluation. We recommend working with stakeholders to find better sources of information from which to craft an accurate, valid, reliable, and usable measure.

<u>Measuring Access to Mental Health Care on HOS</u> (Part C) –

SNP Alliance Response: The SNP Alliance agrees strongly that improving access to mental health care is important, but we cannot support using the HOS as the source of any additional measures given its significant limitations in the instrument, testing among diverse groups, methods of administration, sampling problems, case mix variables/data, predictive modeling, and scoring of measures. We agree that access to mental health care is critical. However, using HOS will not provide any actionable information –as the above listed limitations of HOS and the very small sample of individuals yield very little usable information for quality improvement or performance evaluation. We recommend working with stakeholders to find better sources of information from which to craft an accurate, valid, reliable, and usable measure.

Addressing Unmet Health-Related Social Needs on HOS (Part C)

SNP Alliance Response: The SNP Alliance agrees with a focus on unmet social needs, but **we cannot support using the HOS as the source of any additional measures. We strongly recommend replacing or substantially revising the HOS instrument, re-testing it in diverse populations, being more inclusive of language and ethnicity, improving methods of data collection, and greatly increasing sample size – before adding anything else to the HOS.** Assessing needs and response to social needs is very important but using HOS will not provide any actionable information –as the above listed limitations of HOS and the very small sample of individuals yield very little usable information for quality improvement or performance evaluation. We recommend working with stakeholders to find better sources of information from which to craft an accurate, valid, reliable, and usable measure.

CAHPS (Part C and D)

SNP Alliance Response: SNPA supports increasing the ways that individuals can respond to self-report surveys and participate in quality measurement. We appreciate the removal of the wait time question**. Regarding the CAHPS survey instrument and methods we believe the instrument is also due for some updating. Specifically, we recommend the following:**

- **All of Health Care –** We recommend revision to the item asking the respondent to rate "all of health care" without any specification of what provider or services they are rating,
- **Context –** We recommend adding opportunity for the respondent to indicate how the health plan contributed to care/service.
- **Regarding unfair treatment -** Again we recommend that some context be given and some way for the respondent to receive assistance, particularly if the situation is ongoing. This is concerning and should not be left unanswered.
- **Regarding Care Coordination –** Special needs plans provide care coordination as an integral part of the interdisciplinary care team. The individual member may not associate what happens in the doctor's office as "care coordination"—but rather how the health plan coordinates care across settings and services. This is more often the understanding of individuals and more often under the plan's actions. We recommend re-working the item and obtaining subject matter expertise.
- **Provider Practices vs. Care Coordination –** The question about doctors and nurses, tests, and labs—this relates to provider practices. This is not under the health plan's control. We recommend re-thinking the focus—this is not care coordination. We recommend re-working the item and obtaining subject matter expertise.

Attribution Clarity - The portion of the survey related to commenting on the providers' actions across all of the providers' they have seen/interacted with—should be attributed to the providers. The plan could be informed of the person's response on providers—but the results would not be attributed to the plan. Then the plan and the provider could work together to discuss improvement for their mutual 'client' –the individual.

Our reflection on CAHPS is that it may be time to clarify the focus and attribution for the respondent. If the purpose of CAHPS is to solicit the individual's assessment of their health plan's actions – that should be attributed to the health plan and clear to the person responding. **In general, we heartily endorse, and support continued work on ways and methods to engage individuals in quality measurement.**

Conclusion

The SNP Alliance appreciates the opportunity to comment on the CY24 Advanced Notice. While we do not support many of the proposals, we look forward to continuing our work with CMS to better serve beneficiaries enrolled in specialized managed care plans (SNPs and Medicare-Medicaid Plans) serving those with greatest needs.