

Special Needs ——— ————— Plan Alliance

March 1, 2024

VIA ELECTRONIC SUBMISSION:

<https://www.regulations.gov/>

RE: CMS-2024-006

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure,

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 621 plan benefit packages (PBPs). These plans have over four (4) million beneficiaries enrolled in 49 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) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. The SNP Alliance finds this notice to include a significant number of substantive changes. This set of proposed changes to payment policies will have a significant and negative impact to enrolled Medicare beneficiaries.

Because these changes are interrelated and complex, we are only beginning to understand the “whole picture,” and its impact on dual eligible individuals. The SNP Alliance retained an actuary to examine the impact of the Part C risk score model for payment year 2024 on SNP Alliance member organizations.¹ This report summarizes the impact of the new risk score model on SNP Alliance member organizations including the relative impact on different plan types and member cohorts. Two key findings from our analysis:

- The impact of the new risk score model will vary significantly by plan and by MA organization, it will generally have a less favorable impact on risk for D-SNPs compared to non-SNPs.

¹ [SNP Alliance - 2024 CMS-HCC Model Change Survey](#)

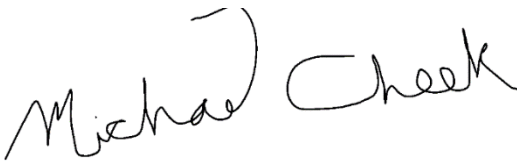
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- Among the five HCC model cohorts (new enrollee, non-dual, partial dual, full dual, institutionalized), the new risk model has the most negative impact on risk score for full and partial dual enrollees.

The SNP Alliance is committed to improving the care and the lives of those most vulnerable with high-risk and high-cost needs. We ask that CMS to examine the net effect of these changes and report on what the impact is for special populations enrolled in all types of special needs plans. Special needs plans have been authorized and established to address their needs. The quality measurement and Medicare payment system should be equitable, with thoughtful attention to making sure more resources are available to serving individuals who have social risk, medical complexity, behavioral health conditions, and long-term care needs –and who often have a life course of deficits to overcome.

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.

Sincerely,

A handwritten signature in black ink that reads "Michael Cheek". The signature is written in a cursive style with a large, stylized "M" and "C".

Michael Cheek
President & CEO
SNP Alliance
1666 Connecticut Avenue, N.W., Suite 250
Washington, DC 20009

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2025

Section B. 2025 Growth Percentage Estimates (Pages 15-16)

SNP Alliance Response:

The SNP Alliance is interested in understanding the assumptions and calculations leading to the estimate of the 2025 growth percentage to ensure adequate adjustments for the utilization trend in 2020 – 2023. In particular, we are interested in the long-term costs associated with COVID-19. While we appreciate CMS' inclusion of costs related to COVID-19 vaccination and changes in utilization in healthcare services, we request additional details necessary to evaluate whether the full impacts of costs associated with the pandemic have been included. It is critical that the growth percentage accurately capture the costs for providing care for people dually eligible for Medicare and Medicaid and older populations disproportionately impacted by the pandemic, as well as the additional hospital, testing, and vaccination costs associated with COVID-19.

The SNP Alliance is extremely concerned that the projected growth percentages for 2025 are inaccurate and do not fully account for the impact of overall utilization and inflation. Feedback from our membership suggests that the projected growth percentages do not align with what is going on in the industry and their direct experience. The projected growth percentages do not line up with what experts have publicly reported either. Specifically, the proposed effective growth rate is well below the Medicare Trustees' projected 5.80% growth in per beneficiary Medicare costs in 2025.² The CMS Office of the Actuary figures are also inconsistent with the effective growth rate, stating that Medicare spending per beneficiary growth is anticipated to be 5.60% in 2025.³

The SNP Alliance urges CMS to update the effective growth rate to reflect the documented increase more appropriately in Medicare utilization and costs.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2025

Section B4. Additional Adjustment to FFS per Capita Costs in Puerto Rico (Pages 28-37)

SNP Alliance Response:

² Centers for Medicare & Medicaid Services: 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2022): <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>

³ <https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf>

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The SNP Alliance encourages CMS to make additional adjustments to MA payments in Puerto Rico to account for the higher number of dually eligible beneficiaries and the unique local dynamics in the FFS and MA markets to ensure adequate payments. Additionally, the SNP Alliance supports the implementation of adjustments for dually eligible beneficiaries in Puerto Rico, including but not limited to Part B buy downs in D-SNP products to be part of the A/B bids and not as a supplemental benefit.

Section G. CMS-HCC Risk Adjustment Model for CY 2025 (Pages 51-52)

CMS Proposal: In the 2024 Rate Announcement, CMS finalized an updated risk adjustment model, referred to as the 2024 CMS-HCC model, with the intention to phase it in over three years, with full implementation of the model in payment year 2026.⁴ The 2024 CMS-HCC model included important technical updates to improve the predictive accuracy of the model. These updates help to ensure that higher payments are available to plans that serve beneficiaries who are expected to be more costly.

For CY 2025, CMS proposes to continue to phase in the implementation of the 2024 CMS-HCC risk adjustment model, as described in the CY 2024 Rate Announcement. Specifically, CMS proposes to calculate risk scores for CY 2025 using the sum of:

- 33 percent of the risk score calculated with the 2020 CMS-HCC model and
- 67 percent of the risk score calculated with the 2024 CMS-HCC model

CMS has concluded that continuing to implement the 2024 CMS-HCC model is necessary and appropriate after analyzing the impacts of the model and analyzing the impacts on dual eligible beneficiaries and dual SNPs.

SNP Alliance Response:

The SNP Alliance supports the continued implementation of the 2024 CMS-HCC model. Understanding that the CMS-HCC model will improve payment accuracy by using more recent data to reflect more recent cost and utilization patterns. Continued phase in of the updated model ensures MA payments more accurately reflect more recent relative cost. Additionally, updating the 2024 CMS-HCC risk adjustment model with HCCs developed using ICD-10 codes aligns the model with the rest of the health care system, which has been using ICD-10 since 2015.

We are concerned that CMS' removal of over 2,000 HCC codes from the Part C risk model last year particularly impacts those with behavioral health conditions. Depression is common but often under-treated. It is associated with exacerbation of many chronic conditions and affects self-care practices. No compelling clinical argument for removal of these codes has been offered. This has affected the risk model and individuals with these conditions. We recommend that CMS add back the following codes: major depressive disorder, recurrent, mild (F33.0) and major depressive disorder, single episode, mild (F32.0) into the risk model starting in CY 2026. Additionally, we suggest that CMS conduct ongoing provider education given the significant changes to the Part C risk model.

In addition, the SNP Alliance wants to express our concern about the impact of the calculated risk score for special needs plans. The SNP Alliance commissioned a report by Milliman to examine the impact of the Part C risk score model for payment year 2024. The analysis of SNP Alliance member organization risk score data from CMS suggests that while the impact of the new risk score model will vary

⁴ [Announcement of Calendar Year \(CY\) 2024 Medicare Advantage \(MA\) Capitation Rates and Part C and Part D Payment Policies.](#)

significantly by plan and by MA organization, **it will generally have a less favorable impact on risk scores (i.e., decrease risk scores more or increase risk scores less) for D-SNPs compared to non-SNPs.**

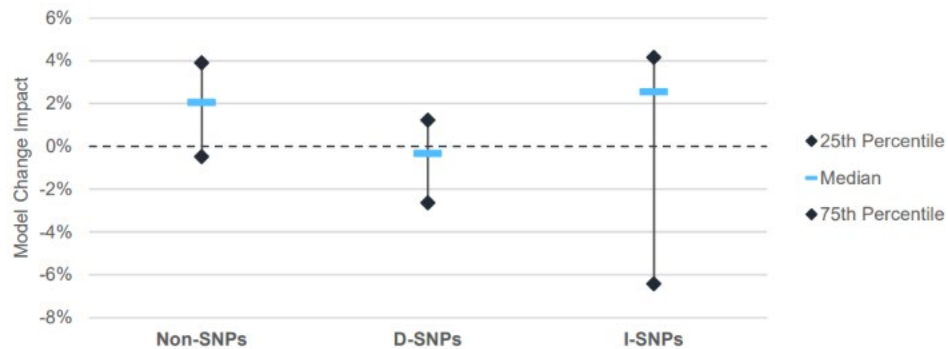


Figure 1

Figure 1 shows the median change to average risk scores for D-SNPs (including Medicare-Medicaid Plans, or MMPs) is -0.3% under the 2024 model; whereas the median change to average risk score for non-SNPs is +2.1%. The impact for D-SNPs ranges from -2.6% at the 25th percentile to +1.2% at the 75th percentile of plans. The impact for non-SNPs ranges from -0.5% at the 25th percentile to +3.9% at the 75th percentile of plans. The analysis also examined I-SNPs which had a wide range impact from -6.5% at the 25th percentile to +3.9% at the 75th percentile of plans.

Our analysis also showed the model disproportionately negatively impacts beneficiaries who partial or full dual eligible for Medicare and Medicaid. Figure 2 shows the median change in plan-level average risk scores under the 2024 model for non-institutionalized full dual and partial dual eligible beneficiaries is -1.5% and -2.5%.

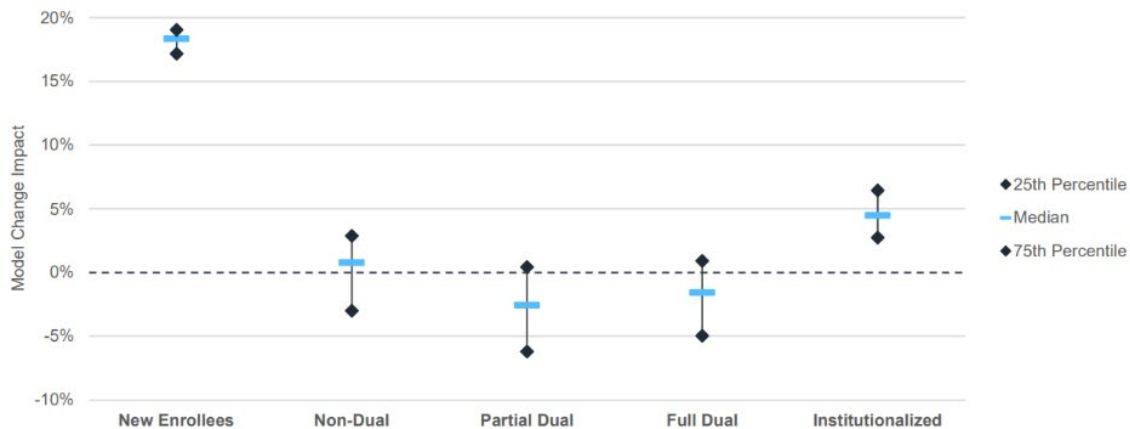


Figure 2

While CMS carefully considered and analyzed impacts on dually eligible enrollees and D-SNPs, our analysis is already showing that the 2024 CMS-HCC model will negatively affect dually eligible enrollees and vulnerable populations (e.g., minority individuals, those under the federal poverty level, or those with complex, chronic health conditions), and the plans that serve them (e.g., special needs plans that serve dually eligible individuals (D-SNPs)). As the leading voice for specialized health plans for those that need them most, the SNP Alliance must express concern that care for dually eligible individuals is not diminished and that the risk model will pay appropriately for these individuals and support the delivery of care necessary for these high-need individuals.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs (Pages 54-57)

CMS Proposal: CMS acknowledges that the CMS-HCC model may not explain all of the variation in expenditures for frail community populations. The purpose of the frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model.

Section 1894(d)(2) of the Act requires CMS to consider the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. In addition, section 1853(a)(1)(B)(iv) of the Act allows CMS to make an additional payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), if the average level of frailty in the FIDE SNP is similar to that in the PACE program. For PACE organizations and eligible FIDE SNPs, CMS make this adjustment by adding a frailty score to a beneficiary's risk score.

For CY 2025, CMS is proposing to continue using the frailty factors finalized in CY 2024 for FIDE-SNPs. CMS is proposing to blend the frailty score calculated for FIDE SNPs consistent with the phase-in of the 2024 CMS-HCC Model.

SNP Alliance Response:

The SNP Alliance would like CMS to clarify how using the updated 2024 HCC model will impact the FIDE-SNPs frailty adjustment calculations. We request more information about how this calculation change was determined and whether it considered the impact of the HCC proposed changes on FIDE-SNPs with a population served most likely to have the deleted or changed HCC groups. Current calculations are based on the 2017 HCC model, and the SNP Alliance foresees potential negative impact in the disparate calculations for this comparison. We note that in the last few years there has been a substantial decrease in the Frailty Adjustment, which impacts these fully integrated D-SNPs serving a substantial number of individuals at a nursing home level of care. This is contributing to a cumulative downward trend and has disproportionate impact on the most vulnerable dually eligible beneficiaries. See previous SNP Alliance comments in: [AN 2024](#).

We recommend that CMS consider allowing FIDE-SNPs to survey only those members who are at a nursing home level of care. We also suggest that another instrument, not HOS, be used or that the HOS instrument be modified so that the functional status and other items used to generate a frailty score are from validated instruments and scales that have been designed to measure frailty. Finally, we recommend that alternative frailty indexes or approaches be modeled.

Section K. Normalization Factors (Pages 58-68)

SNP Alliance Response:

The SNP Alliance supports CMS continuing to examine the inclusion of data years impacted by the pandemic. Re-evaluating the methodology would most accurately account for the FFS average risk score trend that has been occurring since the beginning of the pandemic.

However, the SNP Alliance recommends that CMS take a more nuanced approach to inclusion risk adjustment data. While we do not believe the proposed methodology will improve the CMS-HCC normalization factor setting process, we understand CMS' interest in accurately accounting for the FFS average risk score trend since the beginning of the pandemic.

Based on feedback from our membership, we are suggesting that CMS consider an alternative approach that better reflects the pre-COVID risk score experience. We encourage CMS to ensure the pre-COVID risk score trend is adequately reflective of abnormal COVID data and post-COVID data. One possible approach is to treat 2023 as a COVID year in its model methodology (weighing 2023 as a 0 instead of 1) or implement a sliding weight variable scale that assumes 2023 is somewhere in between a COVID and non-COVID year.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2025

Section A. Annual Adjustments to Medicare Part D Benefit Parameters in 2025 (Pages 73-85)

SNP Alliance Response:

CMS annually updates the Part D benefit parameters and any changes to the payment methodology for the Part D benefit. For 2025, changes that the SNP Alliance supports include:

- The coverage gap phase will be eliminated and defined standard Part D prescription drug coverage will consist of a three-phase benefit. As such, there will be no initial coverage limit and the initial coverage phase will extend to the maximum annual OOP threshold, at which point the catastrophic phase will begin.
- The annual OOP threshold is statutorily set at \$2,000 rather than updated using the Annual Percentage Increase (API).⁵

⁵ Section 1860D-2(b)(6) of the Act defines the API as “the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify.”

The SNP Alliance acknowledges the updates to parameters for the Low-Income Subsidy (LIS) benefit. The LIS benefit provides Part D cost-sharing assistance to certain low-income Medicare Part D Beneficiaries. Medicare Part D beneficiaries who are eligible for full Medicaid benefits, recipients of Supplemental Security Income (SSI) or eligible for a Medicare Savings Programs as a Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualifying Individual under a State’s Medicaid plan (see § 423.773(c)(1)(iii)) are deemed automatically eligible for the full subsidy and do not have to separately apply for the LIS benefit. Other Medicare Part D beneficiaries must apply for the LIS benefit and may receive the full subsidy if they meet certain income and asset requirements, as described in section 1860D-14(a)(3)(E) of the Act.

Programs like LIS are invaluable to low-income populations like dual eligibles; however, the SNP Alliance must acknowledge that prescription drug costs are rising faster than cost of living adjustments for Supplemental Security Income and low-income Medicare beneficiaries are becoming more and more reliant on OTC allowances, prescription drug cards, and manufacturers rebate programs to access the medications they need.

Section G. RxHCC Risk Adjustment Model (Pages 91-103)

SNP Alliance Response:

The prescription drug hierarchical condition category (RxHCC) risk adjustment model is used to help ensure that payments to Part D plans reflect the plans’ expected drug costs given their enrolled population. The RxHCC is also used to predict plan spending in a future year when the benefit will be different.

The SNP Alliance supports CMS’ proposed calibrated changes to the model using 2021 diagnoses and 2022 expenditure data. This is a change from 2023 and 2024, when 2018 diagnoses and 2019 expenditure data were used. Using the most recent complete data available outweighs concerns about the impact of COVID-19 on model coefficients.

Section H. Normalization Factors for the RxHCC Models (Pages 104-110)

SNP Alliance Response:

CMS has historically used one normalization factor across both Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans. Eligible individuals form a single risk pool and can change between MA-PDP and PDP plans, making prospective plan-type normalization factors unsound.

There has been a shift in the market, however. Prescription drug enrollment (Part D) has increasingly shifted from standalone PDPs to MA-PD plans. In 2023, about 56 percent of Part D enrollment is in an MA-PD plan. This population shift necessitated the calculation of risk scores for PDPs and for MA-PD plans separately. We agree with CMS that there are fundamental differences between the risk scores of MA-PD plans and PDPs.

There is also a simultaneous movement in special needs plan (SNP) enrollment increasing. SNPs are included in risk adjustment and have substantially higher risk scores than non-SNP counterparts. SNPs are included in the normalization factor. Normalization drives notable increases in MA-PD premiums and decreases in PDP premiums, which are inconsistent with the actual trend in the MA-PD non-SNP risk

scores compared to the PDP risk scores. Including SNPs in normalization may actually be creating premium distortions.

Using separate normalization factors for MA-PDs and PDPs will generate risk scores that accurately reflect Part D costs. According to our membership, Part D costs are currently one of the most mercurial expenditures that health plans face when designing benefit packages.

We urge CMS to postpone the RxHCC proposed model changes for 2025. We understand the importance of separating PDP and MA-PD plans; however, with CMS not having a 2023 risk score for the RxHCC normalization factor calculation and not enough data for post-COVID pandemic risk scores available to evaluate the accuracy of the modeling, there is apt to be distortion in the normalization factors. If postponement is not an option, the SNP Alliance encourages a phase-in approach over a three-year to five-year period to minimize the impact to beneficiaries in 2025. The SNP Alliance would ask CMS for clarification whether underlying demographic or care delivery differences between the MA-PD and PDP market were taken into account in their assessment of the normalization factor differences?

Attachment IV. Updates for Part C and D Star Ratings

Part C and D Star Ratings (Pages 111- 140)

CMS Proposal: CMS provides information and updates in accordance with the Star Ratings regulations at §§ 422.164, 422.166, 423.184, and 423.186, with a list of measures for Part C and D including Improvement measures and Categorical Adjustment Index for the 2025 Star Ratings found in Table IV-1.

SNP Alliance Response:

There have been numerous changes affecting the quality measurement system over the last few years which have substantially revised the performance evaluation and Star Ratings for Medicare Advantage plans. The impacts of these changes are being felt and the ramifications are continuing to be revealed. Some specialized health plans serving unique populations, such as those with HIV-AIDs have had to close. Others are reducing their supplemental benefits and pulling back on offering some innovative benefits that have the potential to improve functional status and quality of daily life or address social risk deficits.

Thus, we urge CMS to examine the net effect of the changes and report on what the impact is for special populations enrolled in all types of special needs plans—since these plans have been authorized and established to address their needs. The quality measurement and Medicare payment system should be equitable, with thoughtful attention to making sure more resources are available to serving individuals who have social risk, medical complexity, behavioral health conditions, and long-term care needs—and who often have a life course of deficits to overcome. The Star Rating system, both in evaluating plan performance and in bringing quality bonus payments to the plan for building additional benefits into its service array—can be instrumental in helping to advance health equity goals.

We continue to be concerned about the measure focus and specifications around two measures: Transitions of Care and Care Coordination, as these measures pertain to provider actions around transfer of information and documentation of exchange/receipt of information by providers, which, while important, pertain to processes which are largely outside of the locus of control of health plans. We provide more information in this letter regarding the Care Coordination measure and have

previously discussed concerns with these two measures in our comments to the measure steward and to CMS when the measures were being proposed and developed. Our concerns remain. We hope that the measure steward will consider revisiting the measure concept(s) and develop/test new measures for health plans that help capture transitions of care and care coordination efforts that pertain to actions taken by the health plan.

Changes to Existing Star Ratings Measures for the 2025 Measurement Year and Beyond

Future Universal Foundation Star Rating Measures (Page 119-120)

CMS Proposal: As stated previously, CMS is moving toward a “Universal Foundation” of measures which will be aligned/consistent across all of the CMS quality programs. For this year, CMS will add two measures to the 2026 Display Page, based on this 2024 MY—the “Depression Screening & Follow-up for Adolescents and Adults” measure and the “Adult Immunization Status” measure. CMS is also submitting for consideration (MUC) the “Initiation and Engagement of Substance Use Disorder Treatment” measure.

SNP Alliance Response:

SNP Alliance appreciates the progress toward a universal foundation, aligned set of measures. We support aligning measures across programs. However, we do not have a clear picture of how the core set will be implemented across programs and settings and how it will be used in performance evaluation across the nation. Questions such as “Will the Universal Foundation measures be adopted as they are in their entirety by states or will variation be allowed?” have been raised.

As this effort continues to progress, we recommend that CMS engage stakeholders about the practical considerations in implementation of the UF measure set. We hope there will be sufficient guidance on how to collect the data, address data availability issues, and analyze and attribute measure results. We’d appreciate an iterative approach toward implementation so that we can all identify and strategize about these challenges, and we request that CMS and measure stewards report on these issues and challenges.

Also, regarding specific regions, provider types, or beneficiaries, we would like to understand whether challenges are experienced more in certain places or when certain characteristics are present. For example, are small practices, those in rural areas, more challenged? Is there a lack of capacity or infrastructure which affects data capture/transfer capability of community organizations? Is there a scarcity of mental health providers and this is affecting measure results?

We request CMS to ask measure stewards to publish their findings around these issues to better understand which providers or beneficiaries are more often unable to reach the measure target—and why. This transparency and dissemination of findings is important for guiding changes in approach/methods or practice to support improvement.

See our specific comments on the Depression, Immunization, and Substance Use Disorder measures:

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- **Regarding follow up from a positive depression screen** – We agree that depression is a serious condition and concern. Regarding the specifications and analysis of measure results, we encourage continued attention to the challenges providers have with having access to resources for patient referral when a positive screen is determined. There is also the issue of data privacy around mental health conditions. State laws are often more restrictive than HIPAA regarding exchange of patient information pertaining to mental health conditions. We also continue to hear about small practices and providers without robust data platforms/technology and/or capacity to screen and follow up within in a timely manner, and about scarcity of mental health resources in many communities. We are encouraged by recent studies in primary care practices⁶ however this requires concerted effort and resources at the clinic/provider setting.
- **Regarding immunization status** – We agree that vaccinations are extremely important. We continue to be concerned about the difficulty in obtaining accurate/current vaccination information. Challenges have been studied and reported, such as difficulty faced by immunizers in finding patient’s records on immunization status, inaccurate patient reporting, and lack of computerized vaccination registries.⁷ If immunizers do not have an easy way to find or monitor vaccination status, and self-reports are unreliable for some individuals—then the health plan, likewise, will have incomplete information. The other issue raised is patient/member refusal. With the increasing polarization in society about getting vaccines, individuals can be strident about their right of refusal. Individuals cannot be forced to comply. Therefore, we recommend that CMS and measure stewards provide some way of recognizing refusal and the lack of information availability in the measure specifications. Also, it would be immensely helpful for CMS and the measure steward to monitor these issues to determine if certain regions, characteristics of individuals, or other variables, such as income status—affect compliance, and what interventions or approach can counteract these forces or characteristics. The measure may need to be modified.
- **Regarding initiation and engagement of substance use disorder treatment** – We agree that SUD treatment and patient engagement is very important. In brief discussions we have heard about certain characteristics among the individuals with SUD who are less likely to engage. For example, those who have serious mental illness, were drug dependent, recently arrested, or had schizophrenia were less likely to complete an initial intake and/or to engage in treatment.⁸

Secondly, providers remark in some areas that there is a scarcity of SUD treatment services. There is also the issue of data privacy around mental health conditions. As mentioned, state laws are often more restrictive than HIPAA regarding exchange of patient information pertaining to mental health conditions. We would appreciate continued attention to these issues and the measure concept, specifications, and considerations As new information about effective strategies or best practices emerges around SUD engagement in treatment, follow-up strategies when faced with scarce mental health services, or data tracking and sharing that still complies with State privacy laws, please provide that information to the field.

⁶ [Improving Depression Screening in Primary Care: A Quality Improvement Initiative - PMC \(nih.gov\)](#)

⁷ [Immunization in the United States: Recommendations, Barriers, and Measures to Improve Compliance - PMC \(nih.gov\)](#)

⁸ [Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders - PubMed \(nih.gov\)](#)

Updates on Part C Measures (Pages 120-123)

SNP Alliance Response:

Breast Cancer Screening Measure: Regarding the BCS measure, we support the change to conform to USPSTF guidelines, however we request a slight modification of measure exclusion in specific circumstances.

Specifically, we have heard from some plans that many of their younger members (under the age of 66) living in long term care facilities have significant complex medical conditions, but do not meet the I-SNP, Frailty, or Advanced Illness criteria. In these cases, just transporting the member out of the facility to have the mammography screening is overly taxing to the member. This places a burden on the individual and there are physical challenges with the screening itself. Additionally, members or their sponsors often refuse the screening because it may not align with their personal health goals or preferences. The plan is then faced with noncompliance because of the member exercising their right to refuse a service or treatment. These are individuals who do not meet the I-SNP or Frailty and Advanced Illness exclusion criteria (due to age), but have significant medical conditions with active treatment, or they reside in a nursing home even though they are younger than age 66. Plans have asked if there is some way to indicate member refusal of a mammography in the data capture or to extend the exclusion to age 40 if the person lives in a nursing facility and is enrolled in an I-SNP.

Diabetes Measure: We have heard from C-SNPs specializing in Diabetes that there is not sufficient information or detail around the CPT codes and condition categories, which is problematic.

Appeals: We understand the importance to the individual for timely review of a request for services or treatment. In discussing this measure change, we have heard from some plans that the reduced time to review cases may be challenging in some cases. This comes into play particularly in accessing and reviewing the large amount of information involved when the individual has multiple diseases, conditions, and other characteristics, which make it hard to get a full picture of the member's situation. We are not sure what a solution could be to this issue—timeliness and thoroughness are both important. We ask CMS to consider examining the measure results after this change—are some types of plans with certain membership characteristics more impacted than others?

Cross-Cutting: Identifying Chronic Conditions: We recommend considering characteristics of individuals which are at least equally important as diagnoses to understanding the individuals' health status and intervening. These characteristics include functional status, stage or severity of illness/disease, and frailty.

Cross-Cutting: Gender-Affirming Quality Measurement in HEDIS: We support this effort and applaud NCQA and CMS' action to ensure inclusive approaches. This aligns with health equity goals.

Care Coordination (Page 124)

SNP Alliance Response:

We appreciate work on this Care Coordination measure. We support changes in items about how doctors, nurses, or health care providers explain test results, however we see continued limitations

around this measure –in its limited perspective of care coordination, difficulty with the respondent having incomplete information, and potential inequities within the respondent group.

(1) Limited perspective - This “care coordination” composite measure focuses only on a small area of coordination—specifically on the actions of medical providers and their visit practice/communication styles and primarily within a personal exam setting. These things are important but do not fully address the components of care coordination. These items in CAHPS do not query the respondent about other important care coordination components, nor does it mention the actions of a care coordination or care manager who may be working with the respondent and actually be under the health plan’s employ or as a contracted staff. This care coordinator (outside the clinical walls) may actually be the primary individual who performs care coordination actions with/for the member/individual. This measure is focused primarily on clinician’s action within a clinical exam or medical setting. As CAHPS is worded, it does not query the individual about actions of the health plan. We recommend further work around capturing the health plan’s contribution to coordination of care.

(2) The respondent may not have difficulty in answering the question when they do not know the answer– For example, a patient may not know if/how the doctor reviewed the medical record prior to entering the exam room or what specialists’ notes were read. Physicians are encouraged not to look at a computer screen, but at the patient during the exam. Charting/review of record may happen prior to entering the exam room and after the visit.

(3) We recommend that CMS consider how a person accesses their test results and include this in their survey question(s). Often this is through electronic health patient portals. This may help identify gaps faced by people without access to the internet or secure/private computers or smartphones, as they will have less ability to access their own electronic health record to determine what kind of visit summary, test results, medication records, etc. that their physician/primary doctor has provided and what notes were included for the person’s medical team to review. This may mean that, if this person has not viewed their own record, they would not be aware of the coordination of items or information, as is being queried in this set of items within CAHPS.

Retirement of Star Rating Measures

Care for Older Adults-Pain Assessment (Pages 128-129)

SNP Alliance Response:

We have and will continue to support these changes for Care for Older Adults – Pain Assessment measure.

Display Measures

Social Need Screening and Intervention (Page 130)

SNP Alliance Response:

We appreciate the importance of screening and intervening on social risk factors. We do not support adding to the measure until more is known about performance in the first few reporting cycles. We reiterate comments previously shared and expand on these to share our thinking and field experience

that primarily focus on the timing, process, and reporting for/on the social risk screening. See SNP Alliance previous comments [AN 2024](#).

Multiplicity/Diffusion- Social risk screening (SRS) is occurring in many venues and is conducted by many staff within many diverse types of organizations. This can be positive or can be negative. Factors include: (1) how the person feels about the screening/answering these questions, and (2) whether the information is transmitted in a timely way to an entity that can do something with it.

For example, the screening may be conducted by community health workers, county case managers, hospital social workers, primary care providers, care coordinators, etc. as part of their outreach or service provision within community service, housing, treatment, or medical settings. Special needs health plans already conduct SRS as part of their required health risk assessment, upon enrollment and annually thereafter. This means that multiple people are asking related questions about these difficult issues. The challenges that result include:

- The individual resents or resists answering these personal questions repeatedly and may therefore refuse to answer,
- The information from the screening is written down and/or entered into some kind of database, but that data set is not transmitted to the health plan. The health plan may not even be aware of the screening that has occurred by an entity other than those over which the plan has control.
- The individual may receive the same counseling, education, or evaluation of eligibility over and over again, and even referral to the same services, but that does not resolve the issue—perhaps due to capacity or other parameters that the service organization has established.

Building Knowledge Base – These challenges are not reasons to avoid social risk screening, but to encourage capturing of contextual information to guide improvement. We hope that over time, there will be some way to build a repository of information about what methods and processes are most effective in screening, when it is best done, by whom, and what interventions are most acceptable to people with different characteristics. We encourage NCQA to build some way of capturing this important contextual information and some kind of information repository to help guide practices. Over time, who is not just screening and referring, but bringing about relief and how is this being done well for diverse groups of people?

Adult Immunization Status (Page 130)

SNP Alliance Response:

Please see our comments earlier in this letter about the challenges with securing accurate and complete data on immunizations.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Health Outcomes Survey (Part C)

HOS Field Testing & Social Risk (Page 134)

SNP Alliance Response:

We strongly support the use of outcomes-based measures in quality programs. We applaud CMS' efforts to address the need for changes to the Health Outcomes Survey. We agree that all instruments and

quality measures used in the Medicare program should be valid, reliable, accurate, fair, and have utility to promote improvement at the contract (plan) level. We are encouraged by the willingness of CMS to re-examine the Health Outcomes Survey. We agree with the interest in revising and field-testing new questions and methods. We appreciate the proposed use of items from PROMIS and the GAD-2 screen which could be used to replace current questions around functional status assessment and could add to the understanding of anxiety within the Medicare population. We strongly support the addition of a web-based mode for collection.

However, we remain concerned that HOS is not adequate as an instrument to be used for longitudinal measure response analysis to assess a plan's performance and to compare one plan contract to another because:

- (1) The sample size is too small
- (2) The samples T1 and T2 are not representative of the enrolment in the plan and there is too much loss in sample volume between the two time periods. Therefore, the resulting data is likely to be biased/skewed in some way
- (3) The sample does not adequately represent people of color and non-English speaking individuals
- (4) There is no contextual information provided to understand the person's responses
- (5) We do not know how/when/if the health plan or provider contributed to the current status of the person or did not contribute.

Additional comments are around context and attribution of the responses. First, regarding context, currently there is no contextual information gathered to understand the person's response. For example, if the person reports emotional distress – is this because of, for example, a recent loss? Has the loss been discussed with the person's provider or health plan? Does the person want to discuss the loss?

Regarding attribution, if the person reports they have a limitation in function – is this due to a medical condition or recent injury or a progressive neurological or musculoskeletal condition? Has it been reported to their doctor and has there been treatment or advice? We do not know. If their limitation is worse in Time 2, is this decline because of action or inaction of the provider or plan to respond to them? We do not know as we do not have context to understand the response in either time period.

We believe that responses to HOS provide a profile of the person at a point in time, and they reflect the person's self-report of health status and function. But the responses do not necessarily connect to the action or inaction of the health plan. Please see our previous comments and analysis found here: [AN 2024](#), [SNPA 2020](#), [HOS White Paper 2018](#)

We therefore recommend that CMS consider other ways to generate valid, reliable, and accurate self-report measures. We know that the goal is to obtain person-reported information related to their own perception of health status and about how their health plan and providers contributed to health outcomes they self-identify as important to them.

In the short term, it may be possible to use the identified PROMIS and GAD items being tested as standalone measures. It might be possible to also put these together with a few other items such as self-report of health status, functional status, and provider team activities—all validated items, to add to the CAHPS or incorporate into a shorter tool which is administered annually. Some have suggested that

there could be a few single-item stand-alone measures collected through CAHPS and calculated without the need for another survey. These are avenues to explore.

Other Part C Measure Concepts Proposed (Pages 136-137):

- Social Connection Screening and Intervention
- Functional Status Assessment Follow-up

SNP Alliance Response:

We have concerns about these two proposed measures that pertain to non-medical interventions as a follow up to screening/assessment, on social connections and functional status.

The measures proposed indicate reliance on electronic clinical data systems and data transfer to health plans through these systems. However, the entities that are most likely to be involved in helping to address social isolation and even functional status are not medical clinics or hospitals, but community service organizations. These entities are unlikely to have Electronic Clinical Data Systems, as they are not Medicare-certified organizations that can bill Medicare for their services. Therefore, there will be a large gap in data collection/tracking/reporting/transmitting. For example, there are many evidence-based programs that improve function (see NCOA/ACL list here: <https://www.ncoa.org/evidence-based-programs>). Some of these programs are funded through Title III-D of the Older Americans Act, but they are not funded by the Title 18 of the Social Security Act. We recommend an analysis of the capability of these types of community service providers in terms of electronic clinical data systems that meet required data exchange, privacy, and other standards. See: <https://www.cms.gov/priorities/key-initiatives/burden-reduction/implementation-guides-standards/standards-and-igs-index-and-resources>.