Special Needs Plan Alliance

Acting Administrator Stephanie Carlton
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-2024-0360-0001 (Advance Notice 2026)

Dear Acting Administrator Carlton,

The Special Needs Plan Alliance (SNP Alliance) is pleased to offer our comments on the Advance Notice (AN). The SNP Alliance is a national, non-profit thought leadership organization addressing the needs of high-risk and high-cost complex care populations with chronic conditions through specialized managed care. The Alliance is the only organization exclusively representing Medicare Advantage Special Needs Plans – Dual SNPs, Institutional SNPs (I-SNPs) and Chronic Condition SNPs (C-SNPs).

We represent approximately 65% of all SNPs. These plans have over 4 million beneficiaries enrolled across the country—totaling more than 55% of the national SNP and Medicare-Medicaid Program demonstration enrollment. Our primary goals are to improve the quality of service and care outcomes for complex care populations with chronic conditions and to advance integration for those dually eligible for Medicare and Medicaid. Of note, while Dual SNPs are targeted to persons who are dually eligible, the vast majority of all SNP enrollees, C-SNP and I-SNP, are dually eligible.

The SNP Alliance applauds the Administration's focus on Medicare Advantage Plans and complex care populations with chronic conditions which comprise all of SNP enrollees. We look forward to a positive, solutions-oriented relationship with President Trump's incoming leadership on these vulnerable high populations.

And, as part of our dialogue, we will provide thoughtful input on how to best balance the need for government efficiency via payment policy while ensuring access to high quality care for America's citizens with complex care needs through quality measurement. To date, we have had a positive working relationship with senior CMS officials in the Center for Medicare and the Medicare-Medicare Coordination Office (MMCO) and, also, look forward to continuing these relationships.

Special Needs
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While the SNP Alliance is mission-driven and thought-leadership organization in its entirety, we also are pragmatic. Margin drives mission. Adequate, accurate payment is needed to ensure access and quality. Our comments are aimed at striking an appropriate balance with the Alliance's mission and core values while aligning with efficiency and quality as articulated by the Administration.

Below is an executive summary of our comments, including a summary of our comments, with detailed comments following the summary. We greatly appreciate the opportunity to comment and look forward to working with the Administration on the array of opportunities to improve specialty managed care for persons with life-long complex, chronic conditions and other special care needs. To discuss our comments, please feel free to contact me at mcheek@snpalliance.org.

Respectfully,

Michael W. Cheek

Michael W. Cheek
President & CEO

CC: Kimberly Brandt, Deputy Administrator & Chief Operating Officer
Ing-Jye Cheng, Acting Deputy Administrator, Center for Medicare

Special Needs Plan Alliance

Executive Summary

The SNP Alliance recognizes the Administration's focus on efficiency and accuracy of payment and, also, embraces those priorities while balancing with the need for payment sufficient to meet the needs of persons with life-long complex, chronic conditions which comprise all of SNP enrollment. At the highest level, due to the nature of the population served, we urge the Administration to consider unique aspects of payment approaches and quality measurement needed by SNPs. Such considerations, articulated below, will provide the Administration with improved value for dollar and a clearer picture of quality outcomes for beneficiaries.

Of note, some of our payment recommendations are for all Medicare Advantage Plans, not SNP-only. We have noted SNP-specific payment policy comments in section headers. All quality-related comments are SNP-specific. Please note we have summarized CMS proposals where needed to frame our recommendations. Additionally, in the Executive Summary we also have summarized our recommendations. Detailed discussions of CMS' proposals as well as our detailed recommendations are included in the body of our comment letter below. We have provided related page numbers in the detailed sections.

Payment Policy

A. Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare FFS Growth Rate Percentage for Calendar Year 2026

1. *CMS Methodology for Estimating USPCC – Insufficient Data.* **Recommendation(s):** More transparency greatly would aid with a constructive dialogue. ***Page 9***

2. *Historical Years of Data – Lack of Clarity.* **Recommendation(s):** a) CMS should use the most current data, 2024 in this instance, to year-end; and b) CMS should address clarity challenges with data used as well as consolidating all key AN language in the AN, itself, rather than multiple outlets which impedes meaningful public input. ***Page 10***

3. *Full Medical Education Phase – Harm to SNP Enrollees.* **Recommendation(s):** OACT should greatly slow down phase-out of the medical education removal in order to limit the year over year impact of this change and prevent benefit reductions. ***Page 11***

B. Attachment II Changes in the Payment Methodology for Medicare Advantage and PACE for CY26

1. *B5. Additional Adjustments to FFS Per Capita Costs in Puerto – Adjust to Better Meet Unique Needs* **Recommendation(s):** a) CMS should make additional, and continuous 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; and b) 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. ***Page 11***

2. *Section 1. Frailty Adjustment for FIDE SNPs and PACE – Revisit Method with Stakeholders.* **Recommendation(s):** a) CMS should collaborate with stakeholders on approaches that could be used to measure frailty among FIDE-SNPs and PACE plans to update and improve the frailty adjustment to improve adequacy, accuracy, and therefore efficiency; b) the SNP Alliance would welcome the opportunity work with CMS on alternative frailty indexes or approaches; and c). We also recommend that CMS consider allowing FIDE-SNPs to survey only those members who are at a nursing home level of care so that such enrollees would have equal access through their SNP to the resources that are available to PACE enrollees. ***Pages 11-12***

3. *Section G. CMS-HCC Risk Adjustment Model for 2026 -- V28 Model Harms Most Vulnerable Populations and its Implementation Should Be Paused.* **Recommendation(s):** pause implementing the model for all Medicare Advantage plans not just SNPs and convene a technical expert panel regarding how to achieve efficiency goals while ensuring quality and access and; b) add immediately add critical behavioral health diagnoses codes back into the model which were removed by the previous Administration. ***Pages 12-13***

4. *Risk Adjustment Model Development Using Encounter Data – Highly Probability Will Cause Significant Issues for SNPs*. **Recommendation(s):** a) Build an extended timeline and engage in a more robust engagement effort, which could include a dedicated request for information (RFI) with CMS' detailed methodology for estimating the model on encounter data, use of user group calls with actuaries, and a technical advisory committee; b) release a white paper following the RFI and at least 60, if not 90, days to comment on each; and c) secure an independent, third party contractor to validate RTI's work. ***Page 14***

5. *Section K. Normalization Factors – CMS Should Revise the CMS-HCC Normalization Calculation.* **Recommendation(s):** The SNP Alliance recommends that CMS use a linear regression to estimate the normalization factor which excludes 2020 and 2021 from that trend**.** ***Pages 14-15***

C. Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2026

1. *Section D. Part D Risk Sharing – CMS Should Extend the Expanded Risk Corridors Under the Demonstration to MA-PDs Including SNPs***. Recommendation(s):** Due to inequities among PDPs, MA-PDs, and SNPs, the SNP Alliance recommends CMS expend the demonstration to MA-PDs and SNPs. ***Page 15***

2. *Section F. RxHCC Risk Adjustment Model*
    a. *Change Processes for Changing Model - No Ability for SNPs to Understand Potential Impacts.* **Recommendation(s):** The SNP Alliance recommends that CMS publish model software with any new model, and that they work collaboratively with stakeholders to develop new models prior to their introduction in the Advance Notice to allow SNPs and other stakeholders to understand the potential impacts of the new model. ***Page 16***

    b. *C26 Coverage of Anti-Obesity Medications Should Not be Required.* **Recommendation(s):** Because neither RxHCC model presented in the Advance Notice for 2026 incorporates any adjustments for AOM coverage, the SNP Alliance believes that CMS cannot move forward with coverage of AOMs in 2026 because plans would be undercompensated for beneficiaries who receive these medications. ***Page 16-17***

3. *Section G. Normalization Factors for the RxHCC Models – CMS Should Not Use Separate Part D Normalization Factors for 2026 – SNP Enrollees Disproportionately Impacted.* **Recommendation(s):** CMS should cease use of separate factors and work with stakeholders to address CMS policy goals or concerns which do not disproportionately impact people with complex care needs enrolled in SNPs. ***Pages 17-19***

D. Attachment IV. Updates for Part C and D Star Ratings 109

1. *Section A. Part C and D Star Ratings and Future Measure Concepts – More Stakeholder Input Needed and Attention to Burden.* **Recommendation(s):** a) utilize the PQM process for all Star measures and be transparent about findings maintaining adherence to scientific standards for measures and methods; b) retain guardrails to curtail wide swings in measure cut points from year to year which causes problematic volatility; c) consider the beneficiary, provider, and plan burden of measures against the anticipated value or benefit of additional data collection, with the measurement set taken as a whole; d) restrict additional measures being added to the Star Ratings (including the Display page) to only those measures that have been adequately tested, including among special population groups served by SNPs, all of whom have chronic conditions; d) reconsider the positive utility of process measures that are focused on key actions by the health plan in addition to clinical and outcome measures; e) for outcome measures derived from surveys of beneficiaries, continue to work with stakeholders on ways to obtain data from sources other than mail or telephone surveys, as the low response rates call into question the validity of findings; and f) attend to operational and capacity challenges in the transition to ECDS. Ensure testing is done through multiple EMR vendors. ***Pages 19-21***

2. *Section B. Reminders -- Longitudinal Health Outcome Survey Derived Measures Should be Removed from the MA Star Rating Measure Set.* **Recommendation(s):** Remove the Improving or Maintaining Physical Health and Improving or Maintaining Mental Health, from the MA Star Ratings measure. If retained, the measure weights should remain a “1.” ***Pages 21-22***

3. *Section H. Efforts to Simplify and Refocus on the Measure Set to Improve the Impact of the Star Ratings Program*

   a. *Measure Alignment and Streamlining is Important but Retain Valid Measures that are Directly Tied to Health Plan Action and Are Important to Consumers*. **Recommendation(s):** Develop and implement mitigation solutions to ensure plans are not negatively impacted by removal (see below for more detail) or do not remove the eight measures. Two mitigation solutions are discussed below. ***Pages 22-24***

   b. *Assessment of Function, Pain, and Current Medication is Important for All Medicare Beneficiaries, not Only Those Enrolled in SNPs.* CMS indicates its interest in retiring SNP-specific measures: 1) Special Needs Plan (SNP) Care Management (Part C); 2) Care for Older Adults – Medication Review (Part C) and 3) Care for Older Adults – Functional Status Assessment (Part C). **Recommendations:** a) Care Management - remove the SNP-specific measures if two conditions are met and implement a hold harmless adjustment should a SNP experience a drop due to the measure removal; b) Care for Older Adults - Measures on function, pain, and medication review should be re-examined, re-calibrated, and re-tested in all populations of Medicare beneficiaries by NCQA using ECDS reporting methods. Testing results must be fully reported; and b) based on findings, any new or revised measures should be applied to all MA plans. Otherwise, these three measures impose an unequal burden on SNPs compared to other MA plans. ***Pages 24-25***

   c. *Consider the Importance of Functional Status in Case Mix Adjustment.* **Recommendation(s):** Develop a functional status case mix adjuster to test and add/integrate into the quality measurement system when sufficiently modeled/tested. ***Pages 25-26***

   d. *Move Away from HOS as a Data Source to Generate Measures.* **Recommendations:** a) conduct additional testing of the HOS instrument, methods, and measures to address the relevance, reliability and applicability to specific sub-population groups, given ethnicity, language, literacy, and other key characteristics, such as physical disability; b) gather contextual information from the respondent in the HOS to understand when they report a health improvement or decline in physical or mental health; c) increase the representativeness of the HOS sample; d) exclude HOS measures in the Health Equity Index. ***Pages 26***

E. Specific Measures: Transitions of Care Part (Part C)

1. *Transitions of Care Measure – Move to Display Page While Undergoing Re-evaluation.* **Recommendation(s):** a) remove the Transition of Care measure from Stars for the next two years while the measure undergoes revision, including removing the first two sub-

measures from the TRC, and then re-test the measure; b) ensure testing within chronic care population groups and in rural/remote, low-income urban, and in a variety of regions in the county to capture and understand the realities of data transfer and interoperability; and c) fully report on findings of the testing and consider the utility, value, and attribution of the measure to the entity that is most in control of the outcomes. ***Pages 26-27***

2. *Specific Measure: Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control (Part C).* **Recommendation(s):** The SNP Alliance does not support extending the HOS-derived measure specifications for inclusion of younger people with disabilities into the Stars ratings until there is further testing of the instrument. Any additional measure expansion using HOS should be suspended at this time. ***Page 27-28***

F. Section I. Display Measures

Social Need Screening (SNS) and Intervention (Part C) -- SNS Measure Has Many Limitations and Was Not Endorsed. Focus on Examining and Understanding Current SNS Actions in Communities to Guide Next Steps. **Recommendations:** a) NCQA conduct a more thorough examination on the many ways that social risk screening is conducted; Suspend SNS measure development until a thorough environmental assessment of current practices in community, clinical, and other settings around social risk screening has been conducted, taking care to examine small/rural, large/urban and diverse regional areas; b) document the setting, timing, required instruments, data capture, database platforms and other important information to provide a clear picture of where social risk screening is conducted, and where and in what form the data is held, as well as how easily these data can be transmitted to a health plan for purposes of developing or augmenting a care plan; and c) publish the results for examination; and d) present the finalized measure to PQM it to the Partnership for Quality Measurement (PQM) to review the measure. ***Page 28-29***

G. Financial Reasons for Disenrollment (Part C & D).

CMS notes that this measure captures a variety of reasons related to the cost or affordability of services for leaving a plan. **Recommendation(s):** Alliance supports this proposal and agrees with CMS that having more detail and information around financial reasons for disenrollment would be helpful. ***Page 28-30***

H. Section K. Potential New Measure Concepts and Methodological Enhancements for Future Years

1. *Health Equity (Part C and D) – More Transparency and Data Needed on Current HEI and a Slower more Inclusive Approach on Proposed Updated Version.* **Recommendation(s):** a) transition from the existing reward factor to this HEI reward factor be slowed and that the effects of the implementation of the HEI be studied and more fully understood before proceeding with more changes; b) add SNP Alliance set of information for HEI before additional changes are made; c) consider what can be done to

reach more contracts with the HEI in order to provide additional resources, ensuring high need Medicare beneficiaries who have complex chronic conditions receive needed services in an efficient and effective manner; d) D-SNPs that are required to move to separate contracts that their states be held harmless in terms of being able to access the HEI reward factor; and e) urge CMS to take another look at the opportunity to address resource complexity characteristics and appropriate case mix adjustment in the measurement system by utilizing the Categorical Adjustment Index. ***Pages 30-32***

2. *Adult COVID-19 Immunization (Part C).* **Recommendation:** CMS work with CDC to promote national public health efforts around vaccinations but cannot support moving but not move ahead with a health plan measure around vaccination at this time. ***Page 32***

3. *Disability Equity (Part C).* **Recommendation:** We respectfully request that CMS pause on this measure concept. The SNP Alliance would welcome the opportunity to work with CMS and NCQA in the future around a potential measure. ***Page 32-33***

4. *Person-Centered Outcomes (Part C).* **Recommendation(s):** Continue the PCO measure testing by NCQA and await results to analyze before proceeding with further measure development. Specific CMS and NCQA work areas are provided below. ***Pages 33-34***

Detailed Comments

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2026

Below, we provide an overview of the SNP Alliance's key concerns *in italics*. After each concern, we provide an explanation of the issue and recommended solutions for CMS consideration.

CMS' Methodology for Estimating the USPCC Lacks Transparency

In the Advance Notice, with respect, CMS provides little detail on the model used to develop estimates, and why these estimates change notably year over year. CMS provides a series of tables, which differ between the Advance Notice and Final Notice. Also challenging, CMS does not provide detail on how to interpret or use the estimates in these tables, or how they interact to determine the USPCC. As an example of the limited explanation provided, in the Advance Notice, CMS states it is publishing two documents on their website to support USPCC calculations. Yet neither document indicates how these numbers are used to inform CMS estimates nor provide a clear explanation of how they should be interpreted. For example, one document contains a short narrative and lists the fee-for-service (FFS) unit costs, but not how these are used. The other document has no narrative and is a series of tables on costs and trends. We offer these as constructive observations so CMS may improve information display and, therefore, receive more meaningful stakeholder input.

As a result of this lack of detail, for its member plans, the SNP Alliance is unable to understand how the CMS estimated trends compare to the actual SNP trends for SNP populations. In reviewing the Final Rate Notices from the past decade, a consistent comment has been for the provision of more detail on CMS estimates and USPCC methodology. We share the following only to demonstrate the urgent need for additional information as well as to present an opportunity for CMS to provide helpful information to support meaningful public comment. For example, in the 2022 Final Rate Notice, CMS states that "one commenter requested that CMS provide a specific explanation of how each published forecast (Advance Notice, Rate Announcement) is developed, including the types/sources of data and methodologies used for each, and the differences between the forecasts." In another comment, CMS notes that "Many commenters recommended that CMS provide additional details regarding the sources of data and assumptions behind the agency's estimates, especially with regard to the COVID- 19 pandemic." In response, CMS stated the following:

> *We discussed in the CY 2022 Advance Notice Part II the methodology, sources of data, assumptions, and trends underlying the MA capitation rates at a level of detail consistent with past practice, which we believe to be sufficient for the public to understand and provide meaningful comments on*

the development of the MA capitation rates.

Recommendation(s): 1) CMS should ask health plan actuaries for a list of the questions to be addressed in the Advance Notice; b) conduct a dialogue with stakeholders about what types of information could be included in the Advance Notice; and c) provide a step-by-step description of its methodology in the Final Rate Notice.

Lack Of Clarity on Which Years CMS Uses in Their Historical Data

Below we note several challenges associated with how CMS communicates data used in the Advance Notice (AN). CMS states that they used CY 2023 data as the base year for expenditures for their projections on page 10. However, CMS noted in a stakeholder call conducted within one hour of the release of the Advance Notice that they used some Part B data from 2024, but not Part A. We are concerned that CMS used this stakeholder call to provide information that should be provided as part of the Advance Notice. Stakeholders also have observed a tendency to provide additional detail in the Office of the Actuary (OACT) user group calls that should instead be provided in the Final Notice. And finally, we respectfully question using data other than 2024.

In a detailed example of the challenges associated with clarity, CMS' Part A per-member/per month (PM/PM) FFS estimates are nominally different between last year's estimate and this year's estimate, but the Part B PM/PM estimates are more than 2 percent higher for each year after 2023 (see Table 1). Unfortunately, CMS did not explain what accounts for this difference. Presumably, part of the difference could be from CMS using some 2024 Part B data but not any Part A data in their projections. Again, it is not clear why Part B data would have been used, and why Part A data would not have been used. Additionally, related detail also is spread over other media, stakeholder calls and Fact Sheets, rather than being included in the AN in a consolidated manner which would ensure more meaningful, constructive stakeholder input.

Table 1. Current vs. Previous Estimates of FFS-USPCC - Non-ESRD

	Part A			Part B		
Calendar year	Current estimate	Last year's estimate	Percent Difference	Current estimate	Last year's estimate	Percent Difference
2023	$417.47	$419.82	-0.6%	$633.41	$628.51	0.8%
2024	$428.47	$431.23	-0.6%	$672.75	$654.25	2.8%
2025	$441.80	$441.68	0.0%	$707.01	$689.17	2.6%
2026	$446.21	$446.80	-0.1%	$748.78	$731.88	2.3%
2027	$466.80	$468.46	-0.4%	$793.35	$777.17	2.1%

Source: Adapted from Table I-5. Comparison of Current & Previous Estimates of the FFS USPCC – Non-ESRD

Full Medical Education Phase-Out Will Harm Enrollees in SNPs

On Table I-1 of the Advance Notice (page 14), CMS indicates the phase out of medical education costs would result in an additional 1.4% reduction to the FFS growth rate, which would otherwise be 7.09%, had the medical education phase-out remained at 52%. The SNP Alliance notes that OACT was directed to reduce the phase-out that was proposed in the 2025 Advance Notice – from 67% to 52% - and this change appears to have been done in order to have the same bottom line revenue impact for both the Advance and Final Notice (of -0.16%, before the application of risk score growth), since the FFS growth rate was lower in the 2025 Final Notice than in the Advance Notice.

Stated differently, this action step pushed off the impact to 2026 and the AN includes a proposal to move fully towards a large payment cut that would lower the growth rate for SNPs by 1.4%.

Recommendation(s): Slow down the phase-out of the medical education removal in order to limit the year over year impact of this change and prevent benefit reductions for enrollees.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2026

B5. Additional Adjustment to FFS per Capita Costs in Puerto Rico

CMS Should Adjust MA Payments in Puerto Rico

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. CMS should continue making the adjustments that it has made but should also make additional adjustments as needed. 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.

Recommendation(s): a) CMS should make additional, and continuous 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; and b) 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 I. Frailty Adjustment for FIDE SNPs and PACE Organizations

CMS Should Reconsider How It Measures Frailty

The frailty factor has been in effect for many years, but the approach that CMS has used to estimate the frailty factor has not been revisited in some time. Currently, CMS calculates the frailty factor based on the amount of costs that are 'residual costs' from the CMS-HCC model. In the Advance Notice, CMS points out that when it estimated the new frailty factors with the V28 model, it "noticed differences in the frailty factor patterns to relative to prior years". The agency also stated that it anticipates a "multi-year analysis will be necessary to isolate the underlying pattern differences."

Recommendation(s): a) CMS should collaborate with stakeholders on approaches that could be used to measure frailty among FIDE-SNPs and PACE plans to update and improve the frailty adjustment to improve adequacy, accuracy, and therefore efficiency; b) the SNP Alliance would welcome the opportunity to work with CMS on alternative frailty indexes or approaches; and c). We also recommend that CMS consider allowing FIDE-SNPs to survey only those members who are at a nursing home level of care so that such enrollees would have equal access through their SNP to the resources that are available to PACE enrollees.

Section G. CMS-HCC Risk Adjustment Model for 2026

V28 Model Harms Most Vulnerable Populations and its Implementation Should Be Paused

CMS proposes to complete implementation of the V28 model (2024 CMS-HCC model) to calculate MA risk scores for 2026. This model, first introduced in 2024 under the previous Administration, reduced risk scores dramatically for the enrollees with multiple comorbid conditions as compared to the model that had been in effect. While we appreciate CMS' solicitation of comment on V28 each year of the phase in, our concerns with the initial proposal remain. Research discussed below indicates the model changes disproportionately impact the most expensive and sickest enrollees who comprise the entirety of SNP enrollees.

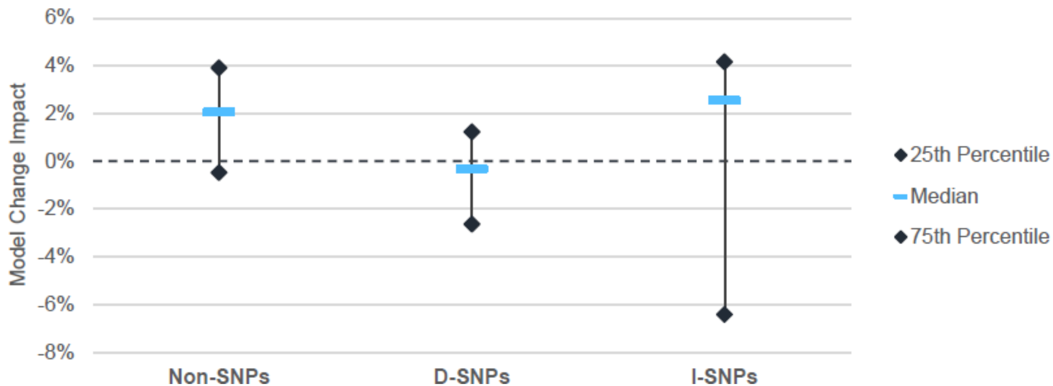
CMS noted previously that in developing the model, the agency carefully considered and analyzed impacts on dual eligibles. Yet our SNP plans have reported that the 2024 CMS-HCC model negatively affects their dually eligible enrollees and vulnerable populations (e.g., minority individuals, those under the federal poverty level, or those with complex, chronic health conditions) and is jeopardizing D-SNP stability. We also have seen negative impacts for our C- SNP and I-SNP populations from the model.

A 2024 Milliman report commissioned by the SNP Alliance found that SNPs were negatively impacted by the new model (Figure 1). For this study, Milliman surveyed 22 SNP Alliance member organizations, and noted the following:

> *for SNP Alliance member organization plans included in the analysis, the median change to average risk scores for D-SNPs (including Medicare Medicaid Plans, or MMPs) and I-SNPs is -0.3% and 2.6%, respectively, 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 while the impact for I-SNPs ranges from -6.4% at the 25th percentile to +4.2% 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.

FIGURE 1: 2024 RISK SCORE MODEL CHANGE IMPACT BY PLAN TYPE (NON-ESRD / NON-HOSPICE BENEFICIARIES)



A recent analysis, also from Milliman, highlights how the model may have resulted in reductions in benefits for D-SNPs.[1] Milliman states in this report that "from 2024 to 2025, the total value added of D-SNP MA plans shrunk by about $15 per member per month (PMPM), mainly due to benefit degradations in the Part C (medical) benefit."

SNP Alliance: **Considering the continued negative impacts of the V28 model for SNPs, we urge CMS to pause implementing the model for all Medicare Advantage plans including SNPs**. We believe that CMS should impute diagnoses back into the model that were removed which have had particularly problematic impacts – behavioral health codes.

These removed codes should be reassessed for inclusion based on clinical, provider, and beneficiary impact. We would specifically recommend that CMS add major depressive disorder, recurrent, mild (F33.0) and major depressive disorder, single episode, mild (F32.0) back into the risk model starting in CY 2026. To say that these codes do not require costs by removing them is clinically inaccurate and harms beneficiaries by compromising the accuracy of the risk model.

Recommendation(s): a) pause implementing the model for all Medicare Advantage plans not just SNPs and convene a technical expert panel regarding how to achieve efficiency goals while ensuring quality and access and; b) immediately add critical behavioral health diagnoses codes back into the model which were removed by the previous Administration.

Risk Adjustment Model Development Using Encounter Data

[1] Friedman, J., Cates, J., & Bentley, C. (2024, December 19). State of the 2025 Medicare Advantage industry: Dual-eligible plan valuation and selected benefit offerings. Milliman. Retrieved from https://www.milliman.com/en/insight/state-of-medicare-advantage-d-snp-2025.

CMS Should Collaborate with Stakeholders to Develop a New Encounter Data Model

In this section, CMS mentions that it "has been working on calibrating the risk adjustment model using MA encounter data (diagnosis, cost and use data submitted to CMS by MA plans), and CMS may be able to start phasing in an MA encounter data-based model as early as CY 2027." We believe such significant changes require substantially more information as well as time for plan adaptation. Specifically, inclusion in the 2027 Advance Notice, as is contemplated by CMS, would create massive uncertainty and upheaval for SNPs.

The risk adjustment model is critical for ensuring that the payments made to the sickest enrollees best represent their expected costs, so that adverse selection does not occur – a critical aspect of MA payment policy. Our understanding of this process is that CMS works directly with its contractor, Research Triangle Institute (RTI), to develop this model but with little transparency. Typically, once the model is developed, CMS publishes a proposed model with the Advance Notice, but by then, it is much too late for plans to provide meaningful due to the statutory implementation requirement. Specifically, CMS releases the Advance Notice in late January or early February, a 30-day comment period ensues, and the Final must be promulgated by the first Monday in April. As an example of how challenging the timeline above can be for major changes, this process most recently was followed with the introduction of the V28 model for 2024. We also note that the same contractor who develops the model – RTI – is also conducts the Congressionally mandated evaluations of the model raising questions about objectivity.

SNP Alliance: We believe that a different approach could be undertaken by CMS that would result in a better outcome for all parties involved. **Recommendation(s):** a) Build an extended timeline and engage in a more robust engagement effort, which could include a dedicated request for information (RFI) with CMS' detailed methodology for estimating the model on encounter data, use of user group calls with actuaries, and a technical advisory committee; b) release a white paper following the RFI and at least 60, if not 90, days to comment on each; and c) secure an independent, third party contractor to validate RTI's work.

Section K. Normalization Factors

CMS Should Revise the CMS-HCC Normalization Calculation

CMS proposes using the multilinear regression model to account for the decrease in MA risk scores due to COVID-19. However, the SNP Alliance believes this particular adjustment is no longer needed, given that the agency has three years of data after COVID-19 with which to estimate a trend. Moreover, estimating a linear trend using these three years would not be notably different from what CMS finds in their model, and it would return CMS closer to the methodology it had used for many years previously. Were CMS to use a linear regression based on the 2022 to 2024 data points, the normalization factor would be 1.062, as compared to 1.067 estimated by CMS, for the V28 model.

Recommendation(s): The SNP Alliance recommends that CMS use a linear regression to estimate the normalization factor which excludes 2020 and 2021 from that trend**.**

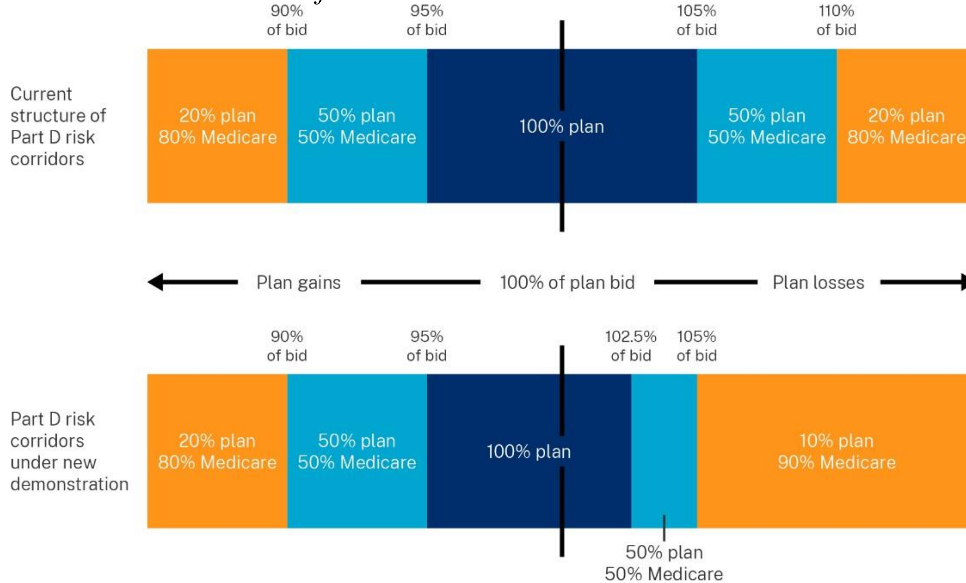
Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2026

Section D. Part D Risk Sharing

CMS Should Extend the Expanded Risk Corridors Under the Demonstration To MA-PDs (Including SNPs)

For the 2025 plan year, CMS introduced a demonstration which provided narrowed risk corridors, but only for standalone Prescription Drug Plans (PDPs).[2] Figure 2 shows how the corridors differ between Medicare Advantage Prescription Drug plans (MA-PDs) (including SNPs) and PDPs. CMS notes in the Advance Notice that it intends to continue to narrow risk corridors for PDPs but will provide specific parameters following the submission of the National Average Medicare Bid (NAMBA) from MA-PDs and PDPs.

Figure 2. Risk Corridors in 2025 for MA-PDs vs. PDPs[3]



SNP Alliance: The SNP Alliance is concerned that the demonstration as structured provides PDPs with an unfair advantage compared to SNPs. Over time, more and more enrollees have moved from PDPs to MA plans, and the number of enrollees in SNPs has grown substantially. In fact, in 2014, 15% of enrollees in MA-PDs were in SNPs and by 2024, this

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[2] Under this same demonstration, CMS provided additional direct subsidy payments to these PDPs to prevent premium increases.

[3] Jackson Hammond, Paragon Institute, “Bailing Out Bad Policy”, https://paragoninstitute.org/paragon-prognosis/bailing-out-bad- policy/, August 5, 2004.

percentage had increased to 22%. The number of SNP enrollees during this time period more than tripled, from 2.1 million in 2014 to 7 million in 2024. [4]

PDPs and SNPs offer different value propositions to prospective enrollees. Given that the MA market is a private market, we do not believe that the government should be in the position to pick winners and losers among different plan types. Yet this demonstration does so. Moreover, as we discuss later in our discussion of the Part D normalization factor, CMS is tilting the field towards PDPs.

Recommendation(s): Due to inequities among PDPs, MA-PDs, and SNPs, the SNP Alliance recommends CMS expend the demonstration to MA-PDs and SNPs.

Section F. RxHCC Risk Adjustment Model

CMS Should Change Its Processes for Changing Risk Adjustment Models

As we noted earlier in our comments on the encounter data-based model, we are concerned that CMS' process lacks sufficient transparency to provide meaningful input on risk adjustment models. For 2026, CMS has estimated two different types of models, one with an adjustment for drugs that will have maximum fair prices (MFPs), and one that does not include an adjustment. Both models use 2022 diagnoses to predict 2023 expenditures.

CMS provides predictive ratios that measure the accuracy of the model – where accuracy is determined based on the comparison of predicted to actual costs – but this analysis does not allow SNPs – or Part D sponsors in general – to understand the potential impacts of the new model. Therefore, we are unable to comment.

Recommendation(s): The SNP Alliance recommends that CMS publish model software with any new model, and that they work collaboratively with stakeholders to develop new models prior to their introduction in the Advance Notice to allow SNPs and other stakeholders to understand the potential impacts of the new *model.*

Coverage of Anti-Obesity Medications Should Not Be Required for 2026

CMS did not propose a policy which would require Part D sponsors to cover AOMs for obesity. The implications for the RxHCC model from this change are profound, as risk adjustment is about setting relative factors properly. Increased AOM utilization will dramatically shift predicted dollars for certain diseases as compared to others. However, because CMS is not making any adjustments to the RxHCC model to account for AOM coverage, the risk scores for the individuals with these particular diseases could be

[4] Analysis of December 2014 and 2024 enrollment data from Centers for Medicare & Medicaid Services: *Medicare Monthly Enrollment* (Accessed January 30, 2025): https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid- reports/medicare-monthly-enrollment

dramatically lower than their actual risk (i.e., their actual drug expenditures), should CMS choose to move forward with this coverage decision. In short, including AOM coverage in 2026 would mean the RxHCC coefficients would likely be biased.

Recommendation(s): Because neither RxHCC model presented in the Advance Notice for 2026 incorporates any adjustments for AOM coverage, CMS should cease movement forward with coverage of AOMs because plans would be undercompensated for beneficiaries who receive these medications

Section G. Normalization Factors for the RxHCC Models

CMS Should Not Use Separate Part D Normalization Factors for 2026

In 2025, CMS noted that the trend in risk scores differed between the MA-PDs and PDPs. CMS then developed a separate normalization factor, which had the effect of increasing the standardized MA-PD bids and decreasing the PDP bids. Compared to a combined normalization factor, the higher MA-PD bid means a higher Part D premium, which in turn reduces the amount of rebate dollars available to devote to supplemental benefits. CMS' decision to split the normalization factors, combined with the demonstration program, benefit PDPs at the expense of MA-PDs. SNPs – who have higher bids than non-SNPs – are particularly impacted by this policy. As noted earlier, SNPs had reduced value in benefits for 2025, which may have been due, in part, to this increase in the Part D premium and, as noted earlier, from the negative impacts of the V28 model.

What makes CMS' policy particularly problematic for 2026 is the extent to which the normalization factors diverge between MA-PDs and PDPs (Table 2). The difference in these factors was 12.4% in 2025 but would nearly triple to a difference of 34.6% for 2026. Furthermore, the MA-PD normalization factor would be 11% higher in 2026 than 2025 (1.194 vs. 1.073). In other words, CMS expects that MA-PD Part D risk scores will grow by 11%, which does not seem reasonable given that their expectation of the annual growth in MA-PD scores, from their multi-regression model, is about 3%.

Table 2. Part D Normalization Factors, 2025 vs 2026

	2025	2026
MA-PD Factor	1.073	1.194*
PDP Factor	0.955	0.887
Percent Difference, MA_PD vs PDP	12.4%	34.6%
Combined Factor	1.018	1.067

*Based on model that incorporates MFPs

SNP Alliance: We are confused by what appear to be inconsistencies with the calculations for 2026 and 2025 (Table 3). As shown, the risk scores used for the 2026 calculation for every year are lower by nearly 2% for the new model than those used for the 2025. Yet at the same time, CMS states that the normalization factor – which by itself is their expectation of the growth in MA-PD Part D risk scores from 2025 to 2026 – is 11% higher for 2026 than 2025. These wide differences raise serious methodological questions about its validity. These types of differences should be explained by CMS in the Final Rate Notice, particularly if it chooses to move forward with a split normalization factor.

Table 3. Risk Scores Used to Calculate MA-PD Part D Normalization Factors, 2025 vs 2026

Year	2025 Estimates (page 108 of 2025 Advance Notice)	2026 Estimates (page 105 of 2026 Advance Notice)	Difference
2019	1.020	1.002	-1.8%
2020	1.047	1.030	-1.6%
2021	1.029	1.011	-1.7%
2022	1.078	1.062	-1.5%

Finally, CMS' split normalization factor creates large increases in MA-PD premiums (Table 4). Because the normalization factor is 11% higher, that in turn means the standardized bid would be more than $20 higher, and the Part D premium bought down with rebate dollars would also appear to be more than $20 higher. CMS' policy would result in reduced benefits for beneficiaries in SNPs, and this reduction would be at a time when the average total added value under D-SNPs declined by $15 per member per month from 2025 to 2026, as cited earlier from a study from actuaries at Milliman.[5]

[5] Friedman, J., Cates, J., & Bentley, C. (2024, December 19). *State of the 2025 Medicare Advantage industry: Dual-eligible plan valuation and selected benefit offerings*. Milliman. Retrieved from https://www.milliman.com/en/insight/state-of-medicare-advantage-d-snp-2025.

Table 4. Premium Comparison for MA-PDs from Higher Normalization Factor, 2025 vs. 2026

	2025	2026
Part D Plan Bid	$215.00	$215.00
Risk Score	1.200	1.200
Normalization Factor	1.073	1.194
Normalized Risk Score	1.118	1.005
Standardized Bid	$192.25	$213.93
NAMBA	$179.45	$179.45
Base Beneficiary Premium	$36.78	$36.78
Direct Subsidy	$142.67	$142.67
Premium	$49.58	$71.26
Net Change	$21.68	

Recommendation(s): CMS should cease use of separate factors and work with stakeholders to address CMS policy goals or concerns which do not disproportionately impact persons with complex care needs enrolled in SNPs.

Attachment IV. Updates for Part C and D Star Ratings 109 Section A. Part C and D Star Ratings and Future Measurement Concepts

Stability, Reliability, Accuracy, Fairness, Utility, and Feasibility Should be Hallmarks of the MA Quality Measurement System

All Special Needs Plan (SNP) enrollees have complex care needs and typically multiple chronic conditions. Accurate, targeted measurement of SNP care is critical to ensuring quality and efficiency of care. The SNP Alliance recommends CMS consider the importance of stability, reliability, accuracy, utility, and feasibility when proposing changes to the MA Part C and D Star Ratings. The last several years have been marked by volatility and multiple changes in the quality measurement and performance evaluation system applied to Medicare Advantage plans. Some of these changes have had disproportionate effects on SNPs and their beneficiaries. There has been a downward trend in plans' Stars ratings due to measure or methodological changes, not to plan performance. Additionally, some of the measures have not been adequately tested within the special needs populations who have chronic conditions nor vetted by measurement experts.

SNP Alliance: First, we urge CMS to utilize the Partnership for Quality Measurement (PQM) for measure review, endorsement, and maintenance, so Star Rating measures are relevant for the population being measured. The SNP Alliance recommends PQM because it utilizes a structured process for obtaining expert, stakeholder, and beneficiary input that is part of a consensus and scientific approach. Issues such as attribution and timeliness are also part of what is considered, in addition to the measure specifications and testing results. PQM endorsement should occur prior to moving a measure to the Measures Under Consideration (MUC) list.

Second, the measure list, methods, and weighting of Star measures should be supportable, with evidence, science, and stakeholder input. CMS needs to carefully consider the populations and settings in which the measure has been tested. The measures and methods should provide all stakeholders with confidence that the measure is sound, relevant, and is evaluating action or inaction by the responsible party in an accurate way. CMS and other relevant parts of the federal government, such as the Department of Government Efficiency (DOGE), and stakeholders need the information that upholds the assertion that the measure results reflect performance by the entity being measured. Such an approach will provide a guide quality improvement and ensure the methodology to aggregate results and compare across plans is also accurate.

Third, we support measure alignment and streamlining but reiterate the utility of having some process measures that focus on key actions that lead to quality of care and achieving health outcomes. Process measures can be particularly valuable moving toward standardization and concretizing best practices. Regarding survey-based measures, the SNP Alliance urges attention to the survey response rate which continues to decline. Lower response raise questions regarding how representative the remaining sample is of the actual full population enrolled.

Finally, we note the continued challenges with transitioning to electronic clinical data set (ECDS) reporting. Such reporting relies on provider action and technology capacity as well as health plan action. With the number of measures transitioning to ECDS, we are concerned about the use of only one electronic medical record vendor. The SNP Alliance urges CMS to require use of several EMR vendors and to consider allowing more time to fully transition to ECDS to ensure ECDS capability and readiness to report on required measures.

Also, with the transition to ECDS there likely will be a drop in performance related to access to data and not necessarily a true decrease in care delivered. For example, the colon cancer screening rate will drop for a couple of years as plans transition to getting data via ECDS, but that does not necessarily mean the testing rate actually dropped. This is another reason (measure and method changes) to retain the guardrails.

Recommendation(s):

- Utilize the PQM process for all Star measures – ensuring they have been adequately tested and validated in special needs populations. Be transparent about findings and maintain adherence to scientific standards for measures and methods in the MA quality measurement system.

- Retain guardrails to curtail wide swings in measure cut points from year to year. The unpredictability and volatility are causing difficulty in setting and pursuing quality improvement targets and reduced available resources to meet the needs of special populations. The SNP Alliance also recommends exploring additional approaches to reduce volatility.

- Consider the beneficiary, provider, and plan administrative burden of measures against the anticipated value or benefit of additional data collection, with the measurement set taken as a whole. Unneeded administrative and federal bureaucratic

burden detracts from resources which could be used for efficient management of care. CMS should take a careful, stepwise, and methodological approach when considering expansion or other substantial adjustments. Moreover, swings from expansion of the measure to proposed removal of the measure (such as with the Medication Therapy Management (MTM)) creates unnecessary burden, as the time to plan and make investments anticipating measure changes can be substantial, only to have it removed thereafter.

- Restrict additional measures being added to the Star Ratings (including the Display page) to only those measures that have been adequately tested, including among special population groups served by SNPs, all of whom have chronic conditions.

- Reconsider the positive utility of process measures that are focused on key actions by the health plans in addition to clinical and outcome measures. They have value.

- For outcome measures derived from surveys of beneficiaries, continue to work with stakeholders on ways to obtain data from sources other than mail or telephone surveys, as the low response raise questions about the validity of findings.

- Attend to operational and capacity challenges in the transition to ECDS. Ensure testing is done through multiple EMR vendors. Use of only one vendor does not provide an adequate picture of the feasibility of implementing the measure and does not offer a clear line of sight into feasibility. Recognize the potential measure rate drop due to data access with the ECDS transition and provide guardrails to slow the impact on plans.

Section B. Reminders

The Longitudinal Health Outcome Survey Derived Measures Should be Removed from the MA Star Rating Measure Set

CMS indicates they will move two measures, Improving or Maintaining Physical Health and Improving or Maintaining Mental Health, to the 2026 Star Ratings after substantive specification changes. They indicate that these two measures are generated from the Health Outcome Survey (HOS) and have a weight of one (1) for the 2026 Star Ratings, moving to a weight of three (3) beginning with the 2027 Star Ratings.

The SNP Alliance does not support this change. We believe the current HOS presents significant challenges. And, in keeping with our solution-oriented focus, we offer a detailed analysis and related information regarding HOS instrument and methods challenges and the longitudinal HOS derived measures. Specifically concerns include:

- Small and unrepresentative sample;
- Lack of access to HOS among people who speak a language other than the four;
- The lack of testing in ethnic populations;

- Inability to determine source (positive or negative) of self-reported changes in health status;
- Lack of attention to/data collection about several key medical and behavioral health conditions (e.g., self-reported neuromuscular diseases such as Parkinson's or ALS, Alzheimer's disease, or other immunological diseases, such as HIV/AIDs, or behavioral health conditions such as Substance Use Disorder); and
- Lack of information about contextual issues when a respondent indicates a change in health status.

These issues call into question the utility, and accuracy of measures generated from these data, particularly for longitudinal measures. They raise questions about the ability to attribute responses to health plan actions and to compare one health plan to another when no concomitant information about enrollee characteristics is available for comparisons. Determining sample characteristics and comparing those samples prior to applying statistical analysis to compare results in two (or more) samples is a key step in statistical methods and scientific research. These limitations do not support performance evaluation of a health plan, nor comparisons between plans. The measures do not support quality improvement. This is an area where administrative burden can be reduced and efficiencies achieved—by removing these two measures from the MA Star program. The SNP Alliance has a detailed set of recommendations which we would be pleased to discuss.

Recommendation(s): Remove the *Improving or Maintaining Physical Health* and *Improving or Maintaining Mental Health*, from the MA Star Ratings measure. If retained, the measure weights should remain a "1".

Section H. Efforts to Simplify and Refocus the Measure Set to Improve the Impact of the Star Ratings Program

Measure Alignment and Streamlining is Important, but Retain Valid Measures that are Directly Tied to Health Plan Action and Are Important to Consumers

CMS is considering ways to simplify and refocus the measure set. Additionally, the Agency is exploring removal of several measures, including Medicare Plan Finder Price Accuracy (Part D), Complaints about the Health and Drug Plan (Part C and D), and Call Center – Foreign Language Interpreter and TTY Availability (Part C and D). CMS has indicated that the agency can continue to monitor plan performance and compliance, even after these measures are removed, from the Star Ratings program. CMS also proposes to remove:

- Plan Makes Timely Decisions about Appeals (Part C); and
- Reviewing Appeals Decisions (Part C) measures.

In addition, two measures that use plan-reported data from the Part C and D Reporting Requirements: MTM Program Completion Rate for Comprehensive Medication Review (CMR) (Part D) could be removed. The measures are process measures that indicate how often a contract completed a CMR for MTM program enrollees. CMS is interested in feedback about retiring these measures from the Star Ratings program.

SNP Alliance: The SNP Alliance agrees it is a worthy goal is to simplify and align measures across programs toward a universal measure set when appropriate across Medicare and Medicaid. This is a goal articulated by the incoming Administration. This will reduce burden and help coalesce efforts to improve health outcomes.

That said, measures slated for the Universal Foundation measure set should be sufficiently tested and validated in all beneficiary populations and settings if they will be so applied. As CMS deliberates what should be in a universal measure set, there are additional considerations. Specifically, the agency should consider case mix adjustment, inclusion/exclusion criteria, attribution, and other methodological issues.

Also, CMS is proposing to remove the following operational measures:

- Medicare Plan Finder Price Accuracy (Part D);
- Complaints about the Health and Drug Plan (Part C and D);
- Call Center – Foreign Language Interpreter and TTY Availability (Part C and D);
- Plan Makes Timely Decisions about Appeals (Part C);
- Reviewing Appeals Decisions (Part C); and
- MTM Program Completion Rate for Comprehensive Medication Review (CMR) (Part D);

If the measure is administrative and can be monitored by CMS without being part of the Star measure set, the SNP Alliance agrees this should be examined. However, some measures which directly emanate from plan performance, such as captured in the *Complaints* and the *Appeals* measures, are still important to consumers. We urge CMS to consider how these could be retained and reported even if outside of the Star rating system. We are encouraged by CMS' proposal to continue to monitor such actions.

We support removing measures where a few case outliers can have a disproportionate impact on the score and where the measure is dependent on actions outside of the health plan control, such as with the *Call Center – Foreign Language Interpreter and TTY Availability*. When just a few cases cause wide shifts in performance, this suggests methodological and measure specification limitations. Such measures should be removed from Stars and monitored in another way. CMS has indicated these issues will be monitored and reported in other ways and we look forward to working with CMS on these approaches.

Recommendation(s): CMS should consider the impact of the proposed measures being removed on overall Star Ratings. While streamlining and aligning the measure set are important goals, there is an impact on overall Star Ratings due to this measure set change. Such an impact will be independent of a change in plan performance. We are concerned that this will result in a substantial drop in overall ratings, due to measure system changes, not actual plan performance. Therefore, **we recommend that solutions for mitigating this impact be put in place simultaneously to ensure health plans are not harmed. Only if there are mitigation solutions to prevent unintended harm on overall Star ratings, do we support the proposal to remove the eight (8) listed measures from the MA Star Rating system.** In keeping with our

solutions-oriented approach, we offer the following mitigation remedies including:

1. The overall Star Rating is recalibrated so that the removal of these eight measures does not cause a shift in overall performance of Star ratings. This is done for MA plans as a whole and for SNPs as a separate sub-group of plans. The methodology and results of this recalibration is published to adhere to tenets of transparency and ensure stakeholders are informed.
2. Put in place a hold harmless provision for two years so that health plans would have an opportunity to adjust their focus. This means that if the plan experienced a drop in overall Star rating performance due to removal of these eight measures, that plan would be held harmless with an adjustment factor applied to bring the plan back to the most recently calculated Star rating when the eight measures were in place.

Assessment of Function, Pain, and Current Medication is Important for All Medicare Beneficiaries, not Only Those Enrolled in SNPs

SNP-Specific Measures and Care for Older Adults (COA): Functional Status Assessment and Medication Review (Part C)

CMS indicates its interest in retiring SNP-specific measures:

- Special Needs Plan (SNP) Care Management (Part C);
- Care for Older Adults – Medication Review (Part C); and
- Care for Older Adults – Functional Status Assessment (Part C).

  a. *Care Management (Part C)*

CMS notes these measures focus on processes of care and are only applicable to a subset of contracts and enrollees. CMS states it is interested in the outcomes of conducting assessments, and not only their completion rates.

SNP Alliance: The SNP Alliance's analysis shows that while SNPs report that SNP-specific measures require a substantial effort to collect these data and report in the MA quality measurement system, they do have value. The main reason for removal should not be that they are process measures. As indicated earlier, process measures have utility, particularly when fostering standardization and concretizing best practices.

Since functional status, pain, and medication review are already part of the annual health risk assessments (HRA) conducted as part of the SNP Model of Care. SNPs are the only type of MA plan that routinely seek information about these issues from the beneficiary. The HRA is one source of information to generate an Individualized Care Plan for every SNP enrollee. Therefore, SNPs are aware of these issues, even if the measures are moved to a Display page or retired in their current form.
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Recommendation(s): Remove the SNP-specific measures, if two conditions are met:

(1) Issues of functional status, pain assessment and medication review are focus areas for future measure development for all Medicare beneficiaries, not only those enrolled in SNPs; and

(2) Hold harmless adjustment should be made to bring that SNP back to previous Star rating performance if the drop in performance is due to the removal of these three measures.

b. Care for Older Adults (COA) (Part C)

We urge NCQA and CMS to consider developing, testing, validating, and applying any functional status assessment, pain assessment, and medication review measure to all Medicare beneficiaries, and to support such assessment and review by both providers and health plans.

Recommendation(s):

- Measures on function, pain, and medication review should be re-examined, re-calibrated, and re-tested in all populations of Medicare beneficiaries by NCQA using ECDS reporting methods. Testing results must be fully reported; and

- Based on findings, any new or revised measures should be applied to all MA plans. Otherwise, these three measures impose an unequal burden on special needs plans compared to other MA plans.

Consider the Importance of Functional Status in Case Mix Adjustment

The SNP Alliance urges attention to functional status as an indicator to be used in case-mix adjustment for assessing and comparing outcomes. Functional status is a critical factor in considering health and comparing health outcomes. For at least the last 20 years, clinician-researchers and subject matter experts have called for attention to functional status as a case-mix adjustment factor that should be considered.[6] [7] [8]

Furthermore, CMS should consider a case mix adjustment factor recognizing functional status. We have been working over the past two years to better understand and document how vastly different the functional status profile is for SNP enrollees compared to Traditional Medicare and general MA enrollees. We would be pleased to share this information with CMS. Additionally, the level of difficulty or ease for a person to perform their activities of daily living affects everything else. Unfortunately, functional status is often overlooked in medical exams, treatment reviews, and progress reports. Having a consistent functional status assessment across the Medicare population would greatly enhance understanding and attention to beneficiaries' level of care needs and risk factors to intervene earlier to avoid decline.

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[6] Clauser SB, Bierman AS. Significance of functional status data for payment and quality. Health Care Financ Rev. 2003 Spring;24(3):1-12. PMID: 12894631; PMCID: PMC4194831.

[7] Greysen SR, Stijacic Cenzer I, Auerbach AD, Covinsky KE. Functional impairment and hospital readmission in Medicare seniors. JAMA Intern Med. 2015 Apr;175(4):559-65. doi: 10.1001/jamainternmed.2014.7756. PMID: 25642907; PMCID: PMC4388787.

[8] Mayo NE, Nadeau L, Levesque L, Miller S, Poissant L, Tamblyn R. Does the addition of functional status indicators to case-mix adjustment indices improve prediction of hospitalization, institutionalization, and death in the elderly? Med Care. 2005 Dec;43(12):1194-202. doi: 10.1097/01.mlr.0000185749.04875.cb. PMID: 16299430.

Recommendation(s): That CMS develop a functional status case mix adjuster to test and add/integrate into the quality measurement system when sufficiently modeled/tested.

Move Away from HOS as a Data Source to Generate Measures

The SNP Alliance supports the current HEDIS and CAHPS measures but not the HOS. The longitudinal measures are particularly problematic. As mentioned, the SNP Alliance has provided detailed analysis and information in past years regarding HOS challenges. The Alliance's work raises questions about attribution to health plan action and accuracy in making comparisons across health plans. Working with the Alliance on such changes presents an opportunity for CMS to implement programmatic improvements.

Recommendation(s):

- Additional testing of the HOS instrument, methods, and measures to address the relevance, reliability and applicability to specific sub-population groups, given ethnicity, language, literacy, and other key characteristics, such as physical disability;

- Gathering contextual information from the respondent in the HOS to understand when they report a health improvement of decline in physical or mental health to better understand self-reported reasons to the change and query the respondent as to how the health plan did/did not contribute to the decline or improvement;

- Increasing the representativeness of the HOS sample. If a proper, sufficient, representative sample cannot be generated, then the measure should not be reported for that health plan nor included in the Star measure calculation; and

- Do not include HOS measures in the Health Equity Index (HEI). Given the limitations described, the instrument and methods need to be modified first. Using these HOS-derived measures in the HEI brings the challenges with these measures into the index, multiplying the problem for plans that serve a high proportion of dually eligible/disabled/low-income individuals.

Specific Measures: Transitions of Care (Part C)

Transitions of Care Measure – Move to Display Page While Undergoing Re-evaluation

CMS notes NCQA is re-evaluating the 4-part composite Transitions of Care (TRC) measure that focuses on notification and receipt of information by providers and then patient engagement. NCQA intends to conduct measure testing in 2025 to implement a new ECDS-reported measure for the 2027 measurement year. NCQA plans to maintain the current TRC measure alongside the new measure for a period of time to allow for transition to the new measure.

SNP Alliance: The SNP Alliance notes the TRC is a 4-part measure and is problematic because it

relies on providers' timely exchange of information among one another which is out of the plans' control. The timeliness of information transfer depends on the data infrastructure and interoperability. Often, health plans are not notified in time to affect the information transfer nor meet the measure specification deadlines.

The burden related to the first two TRC sub-measures is that compliance can only be proven using outpatient medical record information in the form of a hybrid review or supplemental data. Hybrid reviews are labor-intensive. Further, proving compliance by supplemental data for this measure requires a manual process to incorporate the information into the HEDIS software and it must be auditor approved. There are no standard code sets that can relay the information. We recommend these first two TRC sub-measures be retired because they do not align with CMS' goal of simplifying and targeting meaningful measures. The third and fourth TRC sub-measures pertain to patient engagement/follow-up within 7 days and medication reconciliation.

We think this is a measure that should be applied to providers—hospitals and clinics—not health plans. That said, we are encouraged by NCQA effort to re-evaluate this measure, re-test it in 2025, report on findings, and consider it for the future. We strongly advise testing in beneficiary groups with chronic conditions and care complexity and in various regions to examine interoperability and data transfer capacity within different settings and marketplaces.
Until the testing is done and reported, the TRC measure should be moved to the Display page. If the measure is unsound, it should not continue to be used in the MA Star Rating system. Moreover, having two TRC measures—one "old" and one "new" represents an unnecessary administrative burden on providers and plans. It would be more efficient to remove the TRC measure while the new measure is being developed.

Recommendation(s):

- Remove the TRC measure from Stars for the next two years while the measure undergoes revision, including removing the first two sub-measures from the TRC, and then re-test the measure;

- Ensure testing within chronic care population groups and in rural/remote, low-income urban, and in a variety of regions in the county to capture and understand the realities of data transfer and interoperability; and

- Fully report on findings of the testing and consider the utility, value, and attribution of the measure to the entity that is most in control of the outcomes.

Specific Measure: Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control (Part C)

CMS practice based these three HEDIS measures on HOS. CMS and NCQA are considering applying this to people under the age of 65.

SNP Alliance: The SNP Alliance previously has provided extensive comments about the limitations of the HOS instrument, sampling, administration, accuracy, reliability, validity, and

utility. We offer to share our work and to partner with CMS in a solutions-oriented manner. These issues must be addressed before expanding the population to which this will be applied.

Recommendation(s): The SNP Alliance does not support extending the HOS-derived measure specifications for inclusion of younger people with disabilities into the Stars ratings until there is further testing of the instrument. Any additional measure expansion using HOS should be suspended at this time.

Section I. Display Measures

Social Need Screening (SNS) and Intervention (Part C)

SNS Measure Has Many Limitations and Was Not Endorsed. Focus on Examining and Understanding Current SNS Actions in Communities to Guide Next Steps

CMS notes this measure captures the percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positively. NCQA's analysis of data from the first year demonstrated that performance was low and there were challenges for contracts reporting the measure. To increase performance, NCQA is considering potential measure updates across all product lines to include G and Z codes for the screening indicators. Currently, the screening indicators only allow for the capture of LOINC codes mainly used in electronic medical records. NCQA is hopeful that the inclusion of G and Z codes would help overall performance for screening as health plans could also pull administrative data.

SNP Alliance: The SNP Alliance appreciates the proposal to add G and Z codes to potentially capture more documentation of social risk screening in a clinical setting. Respectfully, this is unlikely to make a substantial difference. There are several challenges with this measure, which we previously identified when the measure was first proposed. And, from the first year, NCQA confirmed the finding that contracts had substantial challenges in reporting and therefore performance was low, as anticipated.

The inclusion of G and Z codes may not improve performance in this measure result for three reasons: (1) these codes are infrequently used by providers; (2) where screening is done outside of a clinical/medical setting there is no ECDS data capture; and (3) even within a clinical/medical setting the social risks may not be assessed, given medical appointment time limits and when the patient and/or provider need the time to attend to other priority medical issues.

Regarding the discussion, above, the frequency and settings where this screening is performed has grown over the last five years and the SNP Alliance recognizes the great interest in social risk screening. Social risk screening is frequently required and conducted outside of a clinical/medical environment. In many states, State Medicaid Agencies require social risk screening and require that specific instruments be used in/by communities, counties, providers, and plans where the instruments are not LOINC coded. Social risk screening results conducted

outside the clinical/medical environment will not be found in a medical record. Therefore, some beneficiaries have expressed frustration with multiple social risk screenings and are becoming less willing to answer these questions which negatively impacts gathering such data. Complicating matters, health plans are unable to access the screening results.

Recommendation(s):

- NCQA conduct a more thorough examination on the many ways that social risk screening is conducted – the timing, by who, in what setting, and where the information is captured. Such an examination will reveal the many avenues and processes that currently exist around social determinants of health risk screening highlighting duplication. Such duplications or barriers cause harm and beneficiary abrasion, are counter to the intent and create administrative burden. Such an examination also will offer insight regarding how these practices do or do not connect to the actions of the health plan and when the information is or is not available to the health plan.

- Suspend SNS measure development until a thorough environmental assessment of current practices in community, clinical, and other settings around social risk screening has been conducted, taking care to examine small/rural, large/urban and diverse regional areas.

- Document the setting, timing, required instruments, data capture, database platforms and other important information to provide a clear picture of where social risk screening is conducted, and where and in what form the data is held, as well as how easily these data can be transmitted to a health plan for purposes of developing or augmenting a care plan.

- Publish the results. The examination will inform next steps and help all stakeholders participate in the consideration of feasibility, accuracy, utility, and burden with regard to contemplating a measure around social risk screening.

- When a measure is ready, present it to PQM to review the measure. During the first round of review, the PQM did not recommend this social risk screening measure be advanced, with 65% of the committee concerned about the lack of any plan-level analysis and members expressing concern about the difficulty in defining interventions expected as a response if needs were identified. The PQM analysis should be followed wherever possible to build confidence in the measurement system.

Financial Reasons for Disenrollment (Part C & D)

CMS notes that this measure captures a variety of reasons related to the cost or affordability of services which impact beneficiary decisions to leave a plan. CMS is considering replacing one general cost-related leave reason (found a plan that costs less) with three more specific cost-related reasons to leave health or drug plans: 1) plan with a lower copayment for prescription drugs (MA & PDP); 2) lower copayment for doctors' visits (MA); and 3) lower monthly

premium (MA & PDP). The updated measure is currently being tested and will be available for the 2026 Display Page that covers the 2024 measurement year.

Recommendation(s): The SNPA Alliance supports this proposal and agrees with CMS that having more detail and information around financial reasons for disenrollment would be helpful.

Section K. Potential New Measure Concepts and Methodological Enhancements for Future Years

Recognize a Longer Phase-in of the Health Equity Index is Needed, with Data on the Effects, Prior to Expanding the Index

Health Equity (Part C and D)

CMS is considering adding social risk factors (SRFs) to the Health Equity Index (HEI) reward. One SRF being considered is geography (e.g., rural or urban). The Agency would like preliminary feedback on the addition of geography to the HEI reward and how to define this. Any changes to the HEI would be proposed through future rulemaking.

SNP Alliance: The SNP Alliance understands proposed, updated HEI still is in the modeling/simulation stage and substantial changes are already underway. It is yet unknown what kind of effect these changes will have on the resources available to health plans that specialize in serving the dually eligible/disabled/low-income population who have multiple chronic conditions. Additionally, SNPs have shared with us their difficulty in trying to replicate and forecast the current HEI. Below we break out HEI challenges and proposals and offer recommendations for each area:

1. Plans and all other key stakeholders, including states and beneficiaries, are still without any information about the HEI simulations that have been conducted now for two years. CMS has these data and could share summarizes the results. **Recommendation(s):**

    - Pause work with stakeholders on the updated HEI before promulgating a largely finalized approach. Such collaboration would include reporting data to allow stakeholder simulation as soon as possible prior to implementation for Stars 2027;
    - We offer recommendations for a set of information which needs to be added for HEI reporting by CMS before additional changes are made:
        - Final measure set and weights for the 2027 HEI, based on MY 2024- and 2025-Star ratings selected measures. Data collection for 2025 is already underway and Measurement Year 2024 has concluded. It should be straightforward to provide the list of measures and the weights that will be used to create the composite index used in the HEI for Star Ratings 2027.
        - Details on the methodology and regression analysis, so that health plans could replicate each step and confirm the results.
        - Details on the tertile cut point thresholds for each measure and overall across the two years.

- Basic summary tables and graphs, with brief descriptions, from the first two years of simulation (which have already been performed by CMS but have not been released to the public). CMS has the data as the Agency already created and distributed MAO-specific reports in 2023 and 2024. CMS knows the number of contracts and the distribution of contracts, by measure and overall. In the interest of transparency and to provide information to assist plans in estimating potential HEI reward, we request these summary tables and summary graphs in a report to show:

    a. The number of H# contracts that ***did not*** *make the enrollment threshold* each year for being considered eligible for the HEI based on ½ the median of enrollment that is dually eligible/disabled/low-income; and the total enrollment of these contracts.

    b. The number of H# contracts that ***did*** *make the enrollment threshold* each year for being considered eligible for the HEI based on ½ the median of enrollment that is dually eligible/disabled/low-income; and the total enrollment of these contracts.

    c. Of these, how many contracts are eligible only for half of the HEI reward?

    d. Of the contracts included in the HEI eligibility cohort, the graphs, by measure and overall. Tables and graphs should show the Part C HEI included measures and Part D HEI included measures and then for overall. Such graphs showing the measure score distribution are important. This allows the reader to understand the shape of the distribution, such as if the measure score (of contracts included in the HEI eligibility "pool") is unimodal, bimodal, or has another shape and where the tertile cut-offs are.

    e. How many contracts did not meet the enrollment eligibility threshold despite having D-SNP, I-SNP, or C-SNP plan benefit packages contained within them and therefore how many dually eligible/disabled/low-income individuals will not be in contracts that are eligible to receive a Health Equity Index reward.

2. Regarding the impact of the HEI reward, the methodology is set up to reward only the top third of contracts. We understand that there may be adjustments in the methodology over time. **Recommendation(s):** CMS consider what can be done to reach more contracts with the HEI in order to provide additional resources, ensuring high need Medicare beneficiaries who have complex chronic conditions receive needed services in an efficient and effective manner.

3. In addition to needing more information and requesting transparency about the results of the two simulations to date, some states are requiring D-SNPs to move to separate contracts. One issue is the size of the resulting D-SNP-only contract. The resulting D-SNP only contract usually has a much smaller number of enrollees. This affects measure score distribution; even a few outliers will impact the result. A few outliers will not be

evened out from a larger volume of scores. This leaves the smaller contracts in a more precarious position in terms of predictability of meeting measure score thresholds to achieve the HEI reward factor. **Recommendation(s): That** D-SNPs that are required to move to separate contracts that their states be held harmless in terms of being able to access the HEI reward factor. That is, if they would have been able to access the reward factor as part of a larger contract, this reward be available to them for at least two years following the contract separation.

4. When a more complete understanding of the effects of the HEI is known, and when/if CMS considers geography as a potential social risk factor, we believe that the index used would have to be at the nine-digit zip code level. This level of granularity (e.g., this might relate to a few dozen residences) could be unwieldy. **Recommendation(s):** Identity opportunities to address resource complexity characteristics and appropriate case mix adjustment in the measurement system by utilizing the Categorical Adjustment Index. As suggested in previous comments, CMS should improve the coefficients for Level 9 of the index. The SNP Alliance believes this to be a simple adjustment which would recalibrate the index to provide more resources to plans that serve a high number of individuals with complex needs. This might provide a more streamlined, effective way to disseminate resources to plans serving these individuals.

Adult COVID-19 Immunization (Part C)

The current environment does not support adding to required measures around vaccination rates. There are vastly different immunization rates (of COVID-19, flu, pneumonia, and other vaccines) across the country. The issue, unfortunately, has become polarizing. There are personal, religious, and cultural beliefs which affect the choice individuals regarding vaccination and therefore the rate of vaccination. None of these factors are easily overcome when trying to promote vaccination. National data shows widely different geographical variation in vaccination rates.[9] To set cut points, they would have to be vastly different from one area of the country to the other. Any vaccination measure would have to recognize and allow reasonable exclusions from the measure based on these factors.

Recommendation(s): That CMS work with CDC to promote national public health efforts around vaccinations but not move ahead with a health plan measure around vaccination at this time.

Focus Should Be on Conducting a Thorough Review of Disability Data Sets and Reporting on Findings Before Proceeding

Disability Equity (Part C)

CMS indicates that NCQA is developing a measure of completeness and quality of disability

[9] U.S. Centers for Disease Control and Prevention: COVID-19 Vaccine Uptake and CDC's Commitment to Vaccine Equity (November 2023): https://www.cdc.gov/ncird/whats-new/vaccine-equity.html#:~:text=Adults%20in%20rural%20areas%20(10,and%20suburban%20areas%20(14%25)

status data to inform potential future measures of access to primary and preventative care for individuals with disabilities and a targeted measure for individuals with intellectual and developmental disabilities. NCQA is seeking input on this measure concept from advisory panels, a focus group, and public listening sessions. This measure is planned for measurement year 2026 at the earliest.

SNP Alliance: Due to the nascent nature of a disability equity measure, we recommend that NCQA work with the disability community, and advocates, researchers, demographers, and others—such as subject matter experts in surveys and databases as they explore this concept. Surveys such as the National Core Indicators Survey, the American Community Survey, the Census, the County Health Rankings, and other surveys already administered with well-respected definitions and datasets will help inform NCQA about what data exists already, the data definitions, the data sources, etc., and how these might be enhanced to capture more information on people with disabilities. We are happy to be part of a stakeholder group to help inform the discovery process.

Recommendation(s): We respectfully request that CMS pause on this measure concept. The SNP Alliance welcomes the opportunity to work with CMS and NCQA in the future around a potential measure.

More Development and Review of Testing Results Needed; Align with Other PCO Work; When Ready, Submit to PQM Review Process

Person-Centered Outcomes (Part C)

CMS reports NCQA is developing three measures focused on identifying, measuring, and tracking goals over time. The first measure, Goal Identification, assesses whether a person-centered outcome goal was identified, documented using either a patient-reported outcome measure (PROM) or goal attainment scaling (GAS), and an action plan developed. The second measure, Goal Follow-up, assesses if the person-centered outcome goal was followed up upon within two weeks to six months of when the goal and PROM/GAS were identified. The third measure, Goal Achievement, assesses whether the person-centered outcome goal was achieved. CMS asks for comments on this measurement concept and whether SNP-specific measures should be considered given our goal of trying to simplify and refocus the Star Ratings measure set.

SNP Alliance: The SNP Alliance appreciates the work on person-centered measures and the intent to focus on an individual's goals. And, the SNP Alliance is participating on the advisory group at the request of NCQA on this effort and appreciate such engagement. However, much work is needed before contemplating a measure for health plans in the Stars program. We understand the testing will be ongoing through 2027 with additional analysis to absorb what was learned and appreciate these efforts.

The testing, so far, is only with SNPs. We do not believe this measure, if deemed valid, reliable, feasible and useful, should only be applied to SNPs. It should be expanded to all MA plans. The testing will reveal how/when person-centered goal setting and attainment is captured in data. The

testing also must demonstrate it is within the health plan's locus of control and influence to be able to increase goal setting and attainment. Given the very wide scope of goals—such as attending church services, or participating in family events, it is unclear how/if/when the health plan could provide the necessary resources to advance attainment. Many of the goals may be outside the sphere of influence of the health plan. If there are PCO measures being similarly developed and tested in provider settings, the findings need to be integrated with those of the testing in health plan settings to guide the next steps.

Measures need to be valid, reliable, feasible and the results accurate and useful. The responsible party which influences performance needs to be clear in this measure; results in performance need to be attributed to that responsible party. None of this is yet clear. When the testing is completed and analyzed, if goal setting and attainment has been documented and tracked in a consistent way, and if it the measure is deemed something that can be influenced by the health plan in a way that is feasible, this would be the point in time to vet a measure concept.

Recommendation(s):

- Continue the PCO measure testing by NCQA and await results to analyze before proceeding with further measure development; and
- To truly embrace person-centered outcomes, CMS in partnership with NCQA should:
    - Continue to conduct the PCO measure testing in health plans—moving beyond SNPs;
    - Connect that to PCO measure testing in provider settings;
    - Complete the testing (by 2028) and report results;
    - Then this will guide the next steps to determine how to craft or modify a PCO measure;
    - Present the findings to the PQM. Accept their review and determination as to whether the measure can be endorsed; and
    - Based on their determination, proceed or set aside this as a viable measure for health plans.