

The SNP Alliance



A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

SNP Alliance Comments 2017 CMS Advance Payment Notice and Draft Call Letter March 4, 2016

INTRODUCTION

The SNP Alliance appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed "Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter," released on February 19, 2016.

The SNP Alliance is a national organization exclusively focused on improving SNP and MMP policy and plan performance. Our 28 organizational members include the full spectrum of large and small organizations that sponsor over 300 public, for-profit and non-profit plans, and serve nearly 1.4 million beneficiaries. Our membership includes representation from every type of SNP and from every region of the US. We also work closely with leading State Medicaid agencies involved in dual integration efforts, inside and outside of demonstration authority, and with MMP sponsors from every state involved in the Financial Alignment Demonstration. We represent SNPs with the longest history of dual integration innovation and the largest proportion of beneficiaries with complex medical needs.

SUMMARY

With reference to the Advance Notice, (See pages 2-4) the SNP Alliance:

- Fully supports CMS' proposal to implement an updated CMS-HCC risk adjustment model, including revisions to the community model and inclusion of inclusion of the Psychiatric HCC x Substance Abuse HCC disease interaction for the disabled segments of the community model.
- Is concerned the recalibration of coefficients for the institutional beneficiaries will result in a substantial reduction in review for I-SNPs, which could significantly affect care for one of Medicare's most vulnerable subgroups and pose serious implications for the viability of I-SNPs, one of Medicare's most successful specialty care programs. We recommend that CMS postpone implementation of the 2017 calibration of the HCC risk adjustment model coefficients and related factors for long-term care beneficiaries until further impact analysis and data is collected on this vulnerable population and ensures that health plans have adequate resources to provide them with needed care.
- Is concerned that some elements of the CMS-HCC risk adjustment model contain disincentives for C-SNPs specializing in care of certain high-risk/high-need population segments.

With reference to the Draft Call Letter, the SNP Alliance wishes to highlight its comments related to the Star Ratings system and Medicare-Medicaid Integration:

- With reference to the Star Rating system (see pages 4-12), the SNP Alliance:
 - Strongly requests that CMS significantly increase its leadership role in addressing social determinants of health in performance measurement. While we support short-term implementation of the CAI methodology, we strongly encourage CMS to expand the factors and measures used in the methodology.
 - Requests that CMS establish a process and timeline to begin a more robust, meaningful accounting of SDOH/SES no later than Payment Year 2018.
 - Supports CMS' proposal to add care coordination measures to the Star Rating system, offers suggestions for measurement development, and provides other recommendations to improve the Star Rating system for high-risk/high-need persons.

- With reference to Medicare-Medicaid integration, (See pages 13-17) the SNP Alliance:
 - Thanks CMS for a variety of proposals to advance dual integration and offers specific recommendations for enhancing and expediting the process.

Following are details about these recommendations.

2017 ADVANCE PAYMENT NOTICE

1. Implementation of an updated CMS-HCC risk adjustment model (pages 27-42).

Discussion. The SNP Alliance agrees with CMS' assessment that the current CMS-HCC risk adjustment model under-predicts the cost of providing medical care to dual eligibles enrolled in MA plans, including SNPs. The results of CMS' analysis are noteworthy: the current HCC model under-predicts the cost of care for more than 3 million community-based dual-eligible enrollees in the MA program by a wide margin (-4.3%) regardless of plan sponsor. The model's under-prediction is even greater for over 2 million community-based full-benefit dual eligible enrollees (-8.6%). Even though the CMS-HCC model can reasonably predict costs for fee-for-service (FFS) beneficiaries overall and at the more granular condition (HCC) level, the study results from CMS are actually being experienced by dual eligible subsets within those cohorts today. CMS' proposal to correct the disparity for dual eligible and disabled population groups is vital to the MA program because under-prediction of costs for a defined population of beneficiaries in a prospective risk adjustment model leads to systemic under-payment for that set of beneficiaries across all plans. Moreover, such broad MA under-payments create perverse incentives in a capitated payment system for any health plan to avoid enrolling these most vulnerable beneficiaries.

The potential for Medicare to under-pay for dual eligibles enrolled in the MA program has long been of concern to the SNP Alliance. We firmly believe specialized managed care is the most efficient and effective system for serving this population as their health and socio-demographic profile warrant a focused benefit design and coordinated care approach.

Recommendation. The SNP Alliance fully supports CMS' proposal to implement updates to the CMS-HCC risk adjustment model and is committed to working with CMS to assure that the CMS-HCC risk adjustment model continues to improve its accuracy both in the aggregate and for important subsets.

2. Recalibration of the institutional segment of the CMS-HCC Model (pages 34-35).

Discussion. CMS notes that the principal change to the institutional segment of the CMS-HCC model is a recalibration based on more current data and not a change in the model itself. The SNP Alliance has

learned that a number of Institutional Special Needs Plans (I-SNPs) have forecasted a very significant drop in revenue of approximately 10% (or more) as a result of this change. It is unclear why this has occurred. Since CMS did not propose to make any changes to the institutional segment of the model other than to measure dual status concurrently, we did not anticipate that recalibration would have a significant effect on payments made on behalf of enrollees residing in institutions. We are concerned that there may have been an error in the determination of the new coefficients for this segment of the model or in the calculations. The SNP Alliance requests that CMS review these data carefully to assure their accuracy.

To the extent that the new coefficients and calculations are correct, the SNP Alliance believes that the substantial drop in revenue for institutional enrollees could have a devastating effect on care for a very vulnerable population segment and undermine the viability of the Institutional SNP. Institutional Special Needs Plans make a significant contribution toward promoting quality and cost effectiveness in nursing home settings. In its 2013 *Report to Congress on Medicare Payment Policy*, MedPAC highlighted that I-SNPs demonstrably reduce hospital readmission rates, suggesting the importance of having available a more integrated and coordinated delivery system than Medicare fee-for-service. More specifically, MedPAC stated:

Institutional SNPs (I-SNPs) are plans for beneficiaries residing in nursing homes or in the community who are nursing home certifiable. They perform well on a number of quality measures. In particular, I-SNPs have much lower than expected hospital readmission rates, which suggest that I-SNPs are able to reduce hospital readmissions for beneficiaries who reside in nursing homes. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.

Recommendation. We recommend that CMS postpone implementation of the 2017 calibration of the HCC risk adjustment model coefficients and related factors for long-term care beneficiaries until further impact analysis and data is collected on this vulnerable population and ensures that health plans have adequate resources to provide them with needed care

3. **Disease Interactions (pages 33-35).**

Discussion. CMS identified disease interactions that will be used in the 6-segment community model with one exception (Psychiatric HCC group x Substance Abuse HCC group), which will only be included in the three community disability models. The SNP Alliance has expressed interest in exploring inclusion of the (Substance Abuse and Psychiatric) disease interaction in the past and appreciates CMS proposing its use in the 2017 HCC model.

Recommendation. The SNP Alliance fully supports inclusion of the Psychiatric HCC x Substance Abuse HCC disease interaction for the disabled segments of the community model.

4. **Encounter Data as a Diagnosis Source for 2017 (pages 46-47).**

Discussion. For PY 2016, CMS blended risk scores by weighting the risk score from Risk Adjustment Processing System (RAPS) and FFS by 90% and the risk scores from the Encounter Data System (EDS) and FFS by 10%. For 2017, CMS is proposing to blend the two risk scores, weighting the risk score from RAPS and FFS by 50% and the risk score from EDS and FFS by 50%. The SNP Alliance is concerned about the potential for unintended consequence of implementing a 5-fold increase in weights for EDS and FFS.

One big issue that is impacting all plans is the completeness and accuracy of the MAO-004 reports CMS is sending us. This impacts the plans ability to verify the risk adjustment calculations from the encounter

data.

The SNP Alliance opposing CMS making any changes to this ratio until CMS is capable of disseminating complete and accurate MAO-004 reports. Those reports have gaps in dates of service, some are missing header records, and there is a problem with the quality of the HICN data. As a result, MAOs, including SNPs, have been unable to verify the accuracy of the risk adjustment data. This verification mechanism is essential in order for MAOs to assure that the encounter data that they submit to CMS is accurate and complete.

Recommendation. The SNP Alliance recommends that CMS delay moving to a 50-50 allocation. Plans should be given an opportunity for further review and analysis after EDS-based risk scores that are accurate and complete and made available by CMS so completeness issues, filter and data screen issues and other implementation concerns can be resolved. Additionally, the recent ICD-10 implementation adds complexity to claims submission, which increases our concern with proper implementation of the EDPS-based risk scores resulting in what we believe to be inappropriate timing for this change.

5. **Updated on the RxHCC risk adjustment model; Chronic Viral Hepatitis C RxHCC (pages 48-49).**

Discussion. The SNP Alliance commends CMS' decision not to implement a downward adjustment to the Chronic Viral Hepatitis C RxHCC. We agree that there is continued uncertainty regarding the pattern of chronic Hepatitis C among Medicare beneficiaries and current expenditures to justify such a change at this time.

Recommendation. The SNP Alliance supports this updating of the RxHCC risk adjustment model.

6. **Updates to the CMS-HCC risk adjustment model with implications for C-SNPs.**

Discussion. The SNP Alliance is concerned that some of the revisions CMS has proposed making to the Medicare Advantage risk adjustment model continue to exhibit a number of underlying problems that create disincentives for plans to specialize in care of certain high-risk/high-need populations. Some of the conditions that appear to be negatively impacted are: diabetes without complications; diabetes with chronic complications; major depressive, bipolar and paranoid disorders; congestive heart failure; ESRD; and COPD. These are among Medicare's highest-cost and fastest-growing subgroups and require intense focus on resources on diagnosis and management to improve quality and cost outcomes. They require plans to provide more high-touch care to their members with more sophisticated diagnostic and clinical interventions involving changes and collaborative arrangements encompassing a plan's entire network of providers. While these and other high-risk/high-need conditions are the primary focus of chronic condition Special Needs Plans (C-SNPs), C-SNPs are not provided the payment and regulatory structure they need to optimize quality and cost performance.

Recommendation: The SNP Alliance request that CMS establish a demonstration during which C-SNPs demonstrating high-quality and innovative care arrangements in serving high-risk/high-need persons would be provided variances to existing payment methods (including an elimination of or reduction in coding intensity requirements) and regulatory policy (including additional flexibilities around co-payment requirements, benefits design, model of care, network adequacy, and use of supplemental benefits) to advance and demonstrate the effectiveness of specialty care interventions in comparison with a comparable group of persons served in traditional Medicare and by standard Medicare Advantage Plans.

In addition, we recommend that CMS commission an independent evaluation to analyze the accuracy of the HCC risk model in predicting costs for subpopulations identified for C-SNP specialization and to

propose changes in payment for plans specializing in care of high-risk/high-need beneficiaries to:

- Promote early detection of chronic diseases, prevention of complications and disease progression, and disease management;
- Include all conditions identified for specialization by SNPs, including CKD stages 1-5, Diabetic Neuropathy, and Alzheimer’s disease and related dementias (ADRD), Severe and Persistent Mental Illness, HIV-AIDS, ESRD, frailty, and end of life care.
- Ensure care management and disease related costs associated with caring for these high-risk/high-need persons are accurately represented.
- Improve total quality and cost performance.

Demonstration criteria would include C-SNPs that have a demonstrated ability of offering high quality care (e.g., plans with a 3-year approval of their MOCs, or plans with an average of 4 stars or higher on the four SNP specific measures include in the CMS’ Star Ratings program (Care management, Care for older adults-Medication review, Care for older adults-functional status assessment, and care for older adults-pain assessment)).

2017 DRAFT CALL LETTER

1. Enhancements to the 2017 Star Ratings and Beyond (page 101-151)

a. Introduction

Discussion. The SNP Alliance has previously commented to CMS on quality and performance measurement and Star Ratings (December 10, 2015). We refer CMS to review those previous comments for more detail.

First, we want CMS to know the SNP Alliance appreciates CMS’ movement toward addressing the inequities in the Star Rating measures and methods to consider the high-risk/high need populations. This is particularly important to Special Needs Plans, given that they were created by Congress to provide specialty care arrangements for these beneficiary groups. We reiterate our previous comments that call for an enhanced approach—to focus on quality measures and performance improvement that recognizes the complex nature of conditions experience by poor, frail, disabled Medicare beneficiaries and those with multiple, complex, and ongoing care requirements—as different from those who have greater financial means, are relatively healthy, and have fewer chronic conditions. We are concerned that the needs of these high-risk/high-need beneficiaries (the highest cost and fastest growing Medicare subgroup) — and the care management activities of SNPs to address them — are not adequately represented in the Star Rating system.

Overall recommendation. We encourage CMS to take a stronger leadership role in addressing quality measurement and risk adjustment deficiencies of the current program, in order to recognize issues of unique importance to frail and disabled Medicare beneficiaries as well as those with late-stage and/or complex medical conditions—Medicare’s most costly and complex care subgroups. Stakeholders are looking to CMS to **drive the process** to pay more attention to measuring the *total quality and cost performance* as a beneficiary’s needs evolve over time and across settings. We urge CMS and the measure stewards to recognize that the focus of performance measurement must move beyond the medical measures for single illnesses and attention to the tasks, interventions or experiences with a single provider, setting, or recent interaction. As innovations in the field connect medical services with long-term services and supports in order to integrate care, the development of measures that help capture and reflect

effective cross-continuum, cumulative care practices will be central to improving quality and cost performance over time. CMS must take an active leadership role.

We recommend that CMS develop and convene a technical review panel of stakeholders to participate with a CMS-commissioned research organization to undertake an independent evaluation of the Star measures/ specifications. While many of the Star measures are important in serving these high-risk/high-need groups, in many cases the metrics do not adequately account for their interdependence with other co-morbid illnesses, the presence of frailty and/or disabilities, and issues of unique concern to people with complex and/or late-stage medical conditions, such as those with HIV-AIDS or severe and persistent mental illness (SPMI). A primary focus of this CMS-led effort would be to consider the implications of addressing (or not addressing) the social determinants of health (SDOH) and socio-economic status (SES) characteristics of the Medicare population. A key part of this work would be to evaluate the adequacy of data. The SNP Alliance believes limitations in the free Census data and other existing data sources on which most measures improvements are addressed have obscured key findings that would support more aggressive adjustments.

b. Impact of Socio-economic and Disability Status on Star Ratings (begins on page 107)

i. Adoption of Categorical Adjustment Index (CAI) with six Part C measures.

Discussion. CMS offers a lengthy discussion of the “Impact of Socio-economic and Disability Status on Star Ratings.” CMS acknowledges that its research has provided evidence that there “exists a within-contract LIS/DE and disability effect for a subset of the Star Ratings measures.” CMS suggested two options and has selected an interim, short-term approach for 2017 as an adjustment. This “Categorical Adjustment Index” (CAI) is a factor that would be added to or subtracted from a contract’s overall Star rating. This adjustment is isolated to just six of the forty-seven Part C measures.

We appreciate and support CMS’s effort to advance the CAI as a short-term approach. However, the proposed adjustment does not goes far enough. As CMS’ own analysis shows, the effect is minimal—representing a change in only 11 contracts with just half a star increase (page 117). As others have commented, the CAI method only minimally performs. It does not adequately address the disparities in Stars ratings for plans specializing in care of poor Medicare beneficiaries. The method is hampered by the limitations of the measures selected and the number of measures upon which it is based. It is not clear why the decision was made to focus on just these six measures. Some plan-specific examinations have indicated that some measures can be especially problematic for an older population, such as Breast Cancer Screening. As the number of measures for adjustment decreases, the net effect naturally will be smaller. Thus this minimal adjustment results in minimal impact.

As commented previously, there are other measures within Part C & D where CMS’ internal analyses identified disparities between low income and non-low income beneficiaries. Dual eligibility status had an independent effect on at least 7 measures, according to research by Inovalon. We also note that some of the measures, such as Osteoporosis Management in Women Who had a Fracture, provide no impact for a number of the smaller plans because they do not have large enough enrollment to count this measure. We note that the National Quality Forum (NQF) has indicated that adjustment is appropriate for any measure where there is evidence of population differences that drive results. They assert that adjustment is called for if the intent of

the quality ratings is to answer the question: “how would the performance compare to others if hypothetically the two plans had the same mix of patients?”

Recommendations.

- 1. We endorse the use of the CAI as a short-term approach.**
- 2. We ask CMS to include additional Star measures in the CAI methodology to more fully account for impacts of SDOH and SES on the Star Ratings system.** There also may be a set of measures that, in combination, will move further toward recognizing the true population differences in beneficiary groups enrolled in MA plans.
- 3. We also ask CMS to use additional available data on SDOH and SES factors in the CAI methodology that are important and characterize the beneficiary population.** We strongly recommend that this include demographic and geographic data on poverty/income at the neighborhood level (zip code + 4 data), as well as other data, such as beneficiary education level, and beneficiary household size (indicating social supports present).

We believe a more robust approach is needed, as this CAI method will not go far enough to provide relief or address quality-rating differences arising from disparities in enrollee groups. Many health plans will continue to be barred from receiving quality bonus payments (QBPs), which creates a financial hardship. Given the high risk/high need/high cost characteristics of selected beneficiaries, we suggest that any additional short-term steps be applied to those health plans that have the highest proportion of dually eligible and low-income beneficiary enrolled populations. CMS has the authority to make this adjustment.

- 4. We request that CMS provide health plans an opportunity to review and comment on any changes to the CAI methodology, as well as to future adjustments in Stars Ratings intended to account for population differences such as SES/SDOH. Plans need sufficient data and time to review prior to methods being put into effect. We also request that CMS hold plans harmless from adverse effects of these planned CAI changes in the Star Rating methodology, given that the method is an interim approach that has not yet been tested in the field.**
- 5. We recommend that CMS establish a process and timetable to begin a more robust, meaningful accounting of SDOH/SES no later than Payment Year 2018, beginning with adjustment of SDOH/SES factors for the plan all-cause hospital readmission measure.**

We are particularly concerned that CMS does not appear to have any plan or timetable for addressing SDOH and SES issues in Star Ratings beyond implementation of their proposed interim solution in 2017. While we appreciate the interest shown by CMS in working side-by-side with ASPE as they prepare their report to Congress for October 2016, we note that the full report to Congress is not due until October 2019. This seems an extended length of time to wait to address methodological and measurement specificity issues that are affecting health plans, providers, and beneficiaries now. Any adjustment to individual measures also appears to be left up to the owners and developers of

measures without direct guidance or leadership from CMS for addressing SDOH/SES issues. This hands-off approach does not serve the field. It is likely to result in unnecessary uncertainties, and delays. There is opportunity now to make progress in addressing known disparities that affect the accuracy of some measures, such as the all cause hospital readmissions measure.

To be clear, in making these recommendations, the SNP Alliance has no interest in masking true differences in quality or lowering expectations for health plans serving those most in need of quality care. Our position is quite the opposite. We believe that the existing Star Ratings system actually masks the well-documented burden that people with poverty and low socioeconomic circumstances have now in achieving levels of health and health care outcomes, especially when compared with people of average or greater resources.

The SNP Alliance restates its concern that this interim proposal, which results in modest impacts on only 11 contracts, could become the long-term policy. CMS has an opportunity to work collaboratively with other units of the federal government, with States, and with Congress to actively explore more substantive solutions that will move farther in recognizing the changing demographics and needs of our nation's elders and the growing understanding of how social determinants affect health outcomes. We offer our support to further this effort under CMS leadership.

ii. **Changes to Star Measures and Deferment to Measure Stewards (page 108)**

Discussion. In this Advance Call Letter, CMS indicates that they defer to NCQA and the measure developers to determine if re-specification of measures is warranted. We note, however, that measure developers, such as Pharmacy Quality Alliance (PQA) and the National Committee for Quality Assurance (NCQA) work under contract with CMS. As a result, both organizations are likely to follow CMS's guidance in prioritizing and addressing issues related to adjusting their measures for social determinants of health.

Recommendations.

1. **We recommend that CMS take a stronger leadership role in ensuring that Star measures appropriately, and in a timely manner, account for factors that affect health and healthcare outcomes.** CMS is the designated government agency with authority and responsibility to ensure that performance measurement appropriately addresses issues of paramount concern in serving Medicare beneficiaries. There are decades of solid scientific research documenting that a broad array of socio-economic, demographic, and environmental factors adversely affect a person's health status and healthcare outcomes. We believe it is imperative that CMS assume a stronger leadership role in addressing these concerns.
2. **We also recommend CMS secure access to and make available demographic and socioeconomic data at the neighborhood level, which is needed to actually measure the impact on outcomes.** It is critical for measure developers to have full access to all data that is potentially relevant to capturing the full effects of social determinants of health on health and health care outcomes. It has been shown repeatedly that free census data at the five-digit zip code level is not granular enough to capture the health effects of various population characteristics. However, Inovalon research has shown that more precise data (e.g., 9-digit ZIP data) provides

exponentially greater data-points, allowing for more accurate modeling. A challenge is that these data sets are expensive. Instead of putting each measure developer in a position of having to separately purchase these data in order to test the effects on their measures, CMS should enter into a relationship with a vendor to secure the data and provide it to the developers so a true test can be done. CMS should also make available information such as dual status of members and other key factors included in MMR files. With these additional datasets, better modeling on SDOH/SES effects is possible, allowing for better risk adjustment that will truly reflect population differences.

3. **Finally we recommend that the measurement burden on SNPs be eased.** It's important to note that Special Needs Plans have four additional quality measures in their required Stars measure set that are not required of other general MA plans. While we see the value and relevance of these SNP measures, it is also true that having to report on four additional measures places an undue administrative and resource burden on SNPs. We request that CMS consider how to equalize this measurement burden so that SNPs and general MA plans are on a more level playing field.

c. New Measures and Other enhancements (p 139-151).

i. Display measures.

CMS discusses display measures as follows. Our position is stated briefly, following each measure proposed.

- Medication Reconciliation Post Discharge (Part C) – The SNP Alliance supports CMS' plans to include this measure on the display page and include it in the 2018 Star Ratings.
- Hospitalizations for Potentially Preventable Complications (Part C) – We have stated and reiterate here that our primary concern about this measure is that it is new and we believe CMS is moving too quickly to consider it for inclusion in the 2018 Star Ratings. This new measure will require physician, hospital, and other providers to implement interventions that are: (1) evidence-based or evidence-informed, (2) require enhanced and ongoing care coordination across settings and between clinicians/social services personnel from different organizations, where there may not currently be a system or structure for cross-organization shared accountability; and (3) require personal/private health data exchange between organizations where there may or may not be information security protections or agreements in place. We note that health plans will only have relevant HEDIS data at the end of May 2016, leaving little time to assess the effectiveness of provider delivery system response to this issue.

Recommendation.

1. We encourage CMS to provide technical assistance and support to health plans and provider systems first around this measure, keeping it on the display page through 2018, and then moving it to the Star Ratings when there is greater understanding of effective practice.
2. We also recommend that this measure, similar to the all cause readmission

measure, be tested for bias and that inclusion of SES risk adjustment factors be considered.

- Statin Therapy for Patients with Cardiovascular Disease (Part C) – We appreciate CMS’ decision to gain two years of experience with this measure before including it in the Stars Ratings.
- Asthma Measures (Part C) and Statin Use in Persons with Diabetes (SUPD) Part D - We appreciate CMS’ decision to gain experience with these measures before including them in the Stars Ratings.
- High Risk Medications (HRM). This measure is flawed, as we have previously commented. As a principle, we believe that thorough field testing should be done prior to implementation. We further believe that changes to the Stars Rating measures should be implemented prospectively rather than retrospectively. We also recognize that plans and providers are currently expending significant resources to address the HRM measure. Our SNP members are challenged by having to implement the HRM measure, even with the flaws, and working with providers as they are operating mid-contract. This is an example where the premature inclusion of a measure or the inclusion and then subsequent early withdrawal creates an undue burden on plans and instability in the field. This can call the integrity of the Stars Rating system into question.
- **Recommendation.** We strongly support more complete measure development, testing, and review of this HRM measure. In seeking to improve on a measure that is going to be withdrawn, CMS should be sensitive to the use of plan resources in seeking to improve on a measure that is going to be withdrawn at the same time not require plans to report on a measure known to be flawed. We ask that CMS allow the measure developer time to conduct such testing in the field on the newly revised measure to determine appropriate adjustments and that all measures be fully vetted prior to inclusion in the future. We also recommend that CMS not include the measure as a “display measure” until they have worked through the issues and problems.

ii. **Forecasting 2018 and Beyond (p. 142)**

Care Coordination measure (Part C). In forecasting the future, CMS describes additional measures for consideration in 2018 and beyond. Care coordination is of particular importance and central to the work of the SNP Alliance and its member plans.

Discussion. The SNP Alliance strongly supports CMS’ efforts to develop a care coordination measure or set of measures that are shown to reflect improved practices and quality of care. The SNP Alliance has long held the position that effective care coordination--across settings, disciplines, services, and over time--contributes to improved outcomes as compared to non-coordinated care. We note that desirable “health outcomes” will be defined both by medical/clinical standards and by beneficiary goals and preferences.

We agree that it is a significant undertaking to determine the best practices for: coordinating care and ensuring seamless transitions across settings, appropriate

follow-up after hospitalization/ER use, effective communication across providers, settings, and services; domains and survey items to be included in comprehensive assessments, and the relationship between the health plan and provider delivery network in care coordination—including where and how authority and accountability is determined. We recognize that there are many stakeholders with personal, legal, financial, and professional interests in defining and measuring effective care coordination for beneficiaries. This is a significant issue that must be addressed with full involvement and with full transparency, so that there are usable, accurate, and defensible results.

While we appreciate the outline of the approach to have NCQA and an independent contractor chosen by CMS lead this effort through examining research and reviewing existing medical care and administrative data, we believe this approach may unintentionally limit the examination. Part of the issue is that, by limiting study to an examination of what data has been collected through MA encounters, this may restrict the utility and applicability of the measure(s) that will be developed. We also note that there are problems with ensuring for the accuracy of encounter data. We previously have noted the limitations of the various types of data used to assess effectiveness of plans' care management approaches; for example, CAHPS self-report survey data. Likewise, there is a heavy burden when requiring medical record review—both on health plans and on providers.

Finally, we are very concerned that both Medicare and Medicaid are pursuing parallel efforts to develop such methods. This particularly impacts D-SNPs and MMPs and their enrolled beneficiaries. These plans and consumers might be faced with overlapping but separate processes for assessment, care planning, documentation and location of care plans, designation of a care coordinator, and duplication of other processes and functions, such as member material descriptions and surveys. Such duplicative and uncoordinated processes would not serve the goal of improving care coordination across time, setting, and provider — and in fact could exacerbate complexities and create poorer outcomes. We are certain this is not the intent. We note that the Medicare-Medicaid Coordination Office (MMCO) may be especially well positioned to offer leadership in coordinating such parallel initiatives so as to minimize duplicative or redundant efforts that unnecessarily expend resources or create unwarranted complexity that does not add to better outcomes.

We urge a wider framework and examination, starting with a set of stakeholders and relevant data that would represent the care coordination environments and practices for superior beneficiary care management and support extending over time and across settings. We believe that MMCO can provide important leadership.

Recommendation.

- 1. We again urge CMS leadership in this area—particularly with MMCO playing an active lead. We suggest that CMS convene and lead a technical panel with representation from health plans, provider delivery systems, long term services and supports, and consumer advocates that have special expertise in beneficiaries with needs that require care coordination across the continuum.** The stakeholder experts and relevant data sets would be part of the discovery process to yield important intelligence prior to attempting measurement development using only what is currently available through MA encounter and administrative data. This wider examination by CMS would then inform work by NCQA or others to

understand what practices are evidence-based and replicable within the current policy, practice, and payment environments and what measures are possible and valid.

2. **We recommend that the MMCO play an active role in developing care coordination measures and that CMS does more to coordinate current parallel Medicare and Medicaid efforts within the Agency to develop care coordination measures.** As we are continuing to learn from the Medicare-Medicaid alignment efforts, there are a number of regulatory/policy, administrative, and legal barriers to coordinating care across and between provider and service settings. We note the importance of coordinating efforts between Medicare and Medicaid and especially with State Medicaid Offices, to avoid duplication or conflicts for integrated plans. This particularly impacts D-SNPs (both full dual and partial dual plans), but also impacts beneficiaries and providers—particularly in terms of survey burden, data collection, information exchange, and data reporting.
 3. **We suggest that a starting point for defining care coordination measures be the four additional relevant measures that are required of SNPs.** This would include the SNP Care Management and Older Adult measures. Since these measures are already developed and are being used in the field, they seem to be a relevant starting point.
- **Depression Measure (p. 142)** – NCQA has adapted a depression remission measure that is built from the PHQ-9 instrument and CMS proposes this measure for use in HEDIS 2017 with further development thereafter to prepare for use in the Star Ratings.

We applaud CMS for its focus on depression. This is an important and significant condition, especially among the population groups enrolled in Special Needs Plans. However, we note several concerns. First, we recognize that not all primary care clinics are routinely collecting PHQ-9 screening data yet—although many are moving toward this screening as a standard component of care based on triggers (e.g., annually or by a set of defined patient indicators). Consistent depression screening at the primary care provider/clinic level is still being embedded in care practices and in information systems of providers. Second, data availability relating to follow-up practices may be lacking given privacy protections and patients’ rights concerning mental/behavioral health. Third, those providers and plans that are predominantly serving populations with multiple social determinants of health vulnerabilities and low SES are likely to be disproportionately negatively impacted by this measure. Some beneficiaries may utilize their designated primary care clinic ineffectively due to a variety of social determinants of health, health literacy and other issues, thereby reducing the proportion of attributed patients who have been screened at the primary care level. This, in turn, limits the denominator for gauging depression remission—meaning that the plans and providers (e.g., federally qualified health centers) that serve a disproportionate share of low SES and vulnerable beneficiaries will score poorly on the measure of depression remission. This is an example of when CMS should tread carefully to avoid unintended consequences. These same issues will be at play with regard to other proposed outcome measures that are based on assumptions of how beneficiaries are using the health care system.

Recommendation. We recommend that CMS first consider adopting a depression screening measure before moving to an outcome remission measure.

- **Fall Risk Management** (p. 146) – The SNP Alliance sees this measure as an improvement to the HOS questions. Falls can lead to permanent decline, functional impairment, and even death. We appreciate the work to modify this measure, however, we note that a continuing challenge with the proposed measure is that it will be based on results that rely on beneficiary recall. This can be problematic in individuals with memory impairment or other conditions that affect memory and judgment. For some beneficiaries a proxy may be needed.

Recommendation. We support this proposal and encourage research to test the validity, reliability and use of self-report information from persons with memory impairment or other conditions that affect memory and judgment.

- **CAHPS Measures (p. 146).** The SNP Alliance notes that a primary concern about use of CAHPS is that there is insufficient accommodation for non-English-speaking individuals, such as a “language block” that advises beneficiaries the survey may be available in other languages and where to call to obtain a translated version. Including such critical information so that all Medicare beneficiaries can participate would make this survey instrument more accessible. Health plans are restricted from utilizing their interpreter services to assist beneficiaries with the survey questions, even when the beneficiary calls requesting information about the survey. These limitations serve as barriers that particularly affect beneficiaries in low SES, ethnically-diverse communities where English is not the primary language, and where health literacy may be poor. Such language-related barriers can artificially depress response rates and call into question the accuracy of surveys and full representation of the population in the results.

Recommendation. As we have previously commented, we recommend that CMS attribute greater weight to data-driven measures where development has been based on rigorous scientific evidence, versus measures constructed from enrollee surveys that may not have been tested fully on beneficiary subgroups, such as ethnically-diverse and low-income members. We are concerned that the surveys contain subjective questions and response scales which may not be well understood or are open to interpretation and which require accurate recall from beneficiaries. This is especially relevant for populations where health literacy and educational levels are low or where cognitive impairment is high. The validity of self-reported data in these circumstances can be questionable. Specific recommendations relating to CAHPS and HOS survey items and administration include:

1. **Re-examine the fit of self-report surveys with the increasingly diverse Medicare beneficiary population**—especially the fit with low-income individuals who typically make up a larger proportion of the enrollment in SNPs.
2. **Adjust problematic survey items or methods of surveying to take into account cultural, ethnic health beliefs, and language differences among beneficiary groups and ensure that individuals who are poor or transient are still able to participate**
3. **Shorten the length of the survey.**
4. **Allow the survey to be completed by a proxy when the beneficiary has a diagnosed memory disorder.**

2. Innovations in Health Plan Design (page 154).

Discussion: The SNP Alliance appreciates and supports CMS efforts to develop and test new models to improve care for MA beneficiaries with certain chronic conditions. This is totally aligned with SNP

Alliance interests as imbedded in the C-SNP model. However, as CMS is aware, the SNP Alliance was very disappointed that CMS did not allow SNPs to participate in the first year of the VIBD demonstration, as flexibility provided to VIBD plans goes beyond what C-SNPs currently receive and disadvantages SNPs providing benefits and services in the seven states participating in the VIBD model.

Recommendation.

The SNP Alliance requests that CMS consider allowing SNPs to participate in this demonstration beginning in the second year. We believe that the decision by CMS not to allow SNPs to participate in this demonstration was based on a misunderstanding of the degree of flexibility that SNPs have to address the issues that gave rise to this demonstration. Because SNPs can target a particular population, SNPs have some design flexibility to craft cost sharing, benefits, and formulary features to meet the needs of the population that it serves. However, this flexibility is more limited than what is being allowed for general MA plans participating in the demonstration. In spite of their specialty care mandate, SNPs are subject to the same uniformity of benefits and cost sharing rules that other MA plans are subject to outside of the VIBD demonstration.

CMS should currently provide SNPs at least as much flexibility as CMS offers plans under the VIBD demonstration.

3. **Low enrollment plans (page 158).**

Discussion. In the Draft Call Letter, CMS reiterates its policy to pursue the non-renewal of small MA plans absent a clear justification for their continuance. CMS notes that the threshold for SNPs is an enrollment of fewer than 100 enrollees for three successive years. The SNP Alliance commends CMS' appreciation of the unique value that SNPs can contribute to the Medicare program and that there are a variety of circumstances where an exception to this policy is clearly justified, including I-SNP plans and C-SNPs that target special populations.

Recommendation. The SNP Alliance encourages CMS to continue this flexible and reasonable approach in the future.

4. **Connecting Beneficiaries to Care (page 174).**

Discussion. CMS invited suggestions and input around existing or potential approaches through which MAOs can further engage enrollees and connect them to preventive and needed care.

We are pleased to see CMS' interest in this issue. MMPs and D-SNPs that are required to develop MOCs and to conduct HRAs and MLTSS assessments for Medicare-Medicaid beneficiaries can attest to the complexity of this topic, particularly for the very diverse population they serve, and have employed many strategies that may be instructive for all MA plans.

Successful enrollee engagement requires understanding of the many barriers to good health and care for the most hard to reach enrollees including those with: cognitive and physical impairments, multiple chronic conditions, frailty, end of life care status, mental and chemical health issues, low health literacy, limited financing, transportation and social supports, language and cultural barriers, and unstable housing. A disproportionate number of these challenges impact dually eligible beneficiaries.

Successful engagement involves an investment of time and effort beyond what is required in communicating with an average Medicare beneficiary, including identifying a beneficiary's appropriate address and phone number, addressing language differences and sharing changes in these items on a timely basis with CMS and states; enhancing the capacity of enrollees to understand their health conditions and care needs, training of care coordinators, education and engagement of clinic staff and

physicians around understanding the needs and capacities of the enrollees, greater interaction with interdisciplinary care teams (ICTs), and more extensive communication with enrollees and caregivers. Plans also may have to employ multiple strategies to address issues associated with different segments of the population to find hard to reach enrollees and to address a variety of cultural differences.

Recommendation. We believe CMS policies should take into account these additional complications that plans experience in serving dually eligible beneficiaries and those with complex communication needs. CMS should work with plans to assure accurate and timely data sharing between CMS, states and plans for names, addresses, phone numbers, including systems to monitor and communicate frequent changes in such data.

5. **Prohibition on Billing Medicare-Medicaid Enrollees for Medicare Cost-Sharing (pages 174-175).**

Discussion. MA plans, including D-SNPs, are already required to include balance billing restrictions in their provider contracts and must work with providers to clarify that these restrictions apply regardless of whether Medicaid is liable to pay the full cost sharing. SNP Alliance members are committed to efforts to notify providers of such requirements and take corrective action where providers do not comply.

Recommendation. It would be helpful if CMS could provide consistent messages about these requirements across all sectors of Medicare including FFS so that such requirements are clearly and broadly stated across all Medicare programs. This should be a shared responsibility across all of Medicare, and not just of MA plans. In fact, a national effort by CMS may be more effective than multiple messages from many health plans.

In particular, CMS should address the fact that QMB Only status is often hard for both enrollees and providers to understand and identify. Income levels for QMB Only status vary between states and may change each year, enrollees may not keep track of such information, or may not understand different eligibility terms that physician offices use to try to identify such status. Physicians and their front office staffs need more education and understanding of how to identify QMB-only beneficiaries in each state and a regular source of access to eligibility verification for that information.

In addition, CMS may wish to look to its July 2015 study entitled “Access to Care Issues Among Qualified Medicare Beneficiaries (QMBs)” for the root cause of the problem. This study documents that QMBs have reduced access to care as a result of lower provider revenues from reduced cost sharing. States are responsible for Medicare cost sharing for dually eligible beneficiaries. Federal statutes allow states to limit cost sharing to the lesser of Medicare or Medicaid rates, and most states do so. Providers are not allowed to balance bill dual eligibles and so must forgo that revenue. This means that providers are paid considerably less than Medicare rates for serving dual eligibles whose care needs are often more complex than typical Medicare patients. This is a serious and long standing issue, and we recognize that resolution of this problem would require Congressional action and significant appropriations. Nevertheless, we encourage CMS to take a stronger lead in the system wide enforcement of current policy.

6. **Integrated Dual-Eligible Special Needs Plans (page 177-178).**

a. **Continuation of CMS efforts to facilitate the integration of Medicare and Medicaid benefits.**

Discussion. The SNP Alliance appreciates CMS continued interest and efforts to use administrative flexibilities to facilitate the integration of Medicare and Medicaid benefits by D-SNPs. SNP Alliance D-SNPs providing both Medicare and Medicaid services are especially

appreciative of CMS efforts to streamline and simplify member materials applicable to Medicare-Medicaid beneficiaries.

Recommendations:

We recommend that CMS expand the use of modified Medicare-Medicaid Plan (MMP) member materials to other D-SNPs as allowed under the Minnesota D-SNP demonstration.

This would include the enrollment form, Member Handbook, provider directory, Annual Notice of Changes (ANOC), formulary/drug list, and Summary of Benefits. D-SNPs with experience with both the Evidence of Coverage (EOC) and the Member Handbook report that Medicare–Medicaid beneficiaries find the Member Handbook much easier to understand as evidenced by fewer questions and less confusion from members about the contents.

In addition, we recommend that CMS consider extending application of the modified MMP network review process as utilized in the Minnesota demonstration to other integrated D-SNPs. There are two elements in this process:

1. Network criteria are based on the numbers, locations and needs of dually eligible populations served assuring that networks are specifically tailored to dually eligible members. Many of our members have experience indicating that for members with complex needs, smaller networks of committed providers with high degrees of communications and teamwork across services and settings employing integrated care coordination strategies can be much more effective than broad networks of unconnected providers.
2. State involvement in the exceptions process to verify information about local and state patterns of care, which has significantly reduced wasteful paperwork burdens required for the exceptions process.

b. D-SNP Non-Renewals.

Discussion. CMS stated that it is seeking comment from D-SNPs and states on how best to implement this exchange of information with states on pending nonrenewals, service area reductions and terminations. The SNP Alliance supports this proposal which recognizes the important partnership role states play in D-SNP contracting and the need for states and D-SNPs to be able to maximize time and planning for smooth transition of Medicaid services in the best interests of continued services to beneficiaries when D-SNPs are not renewed under the Medicare Advantage program. We note that some states already include requirements in their MIPPA contracts for such notice to the state by the D-SNP of these types of changes. Successful mechanisms may include requirements that states, D-SNPs and CMS mutually agree to certain confidential work plans and communications timelines to protect the best interests of enrollees, employees, plans and states for orderly and thoughtful transitions.

Recommendation. CMS should examine existing state contracts including such requirements for possible approaches. CMS should also provide clear guidance and direction to Regional Offices, which play a key role in these functions, on how they should work with states and plans to facilitate communications and transitions for these non-renewals. The SNP Alliance will work with its member plans to explore feasible approaches to provide further information to CMS prior to the final Call Letter.

c. **D-SNP Model of Care.**

Discussion. The SNP Alliance applauds CMS' recognition of the need to work with states to provide effective and efficient Models of Care (MOC) for Medicare-Medicaid beneficiaries in D-SNPs, especially for those whose MLTSS services are subject to often complex assessment, care coordination, care planning, care delivery, network and oversight requirements under separate sets of state and federal Medicaid regulatory requirements.

We agree that an effective MOC must "incorporate provision of those services and their integration with the medical and prescription drug benefits the D-SNP provides under its Medicare contract" and appreciate CMS' reminder that States have the ability, through their contracting with D-SNP sponsors, to require that the D-SNP MOC fully integrates long-term services and supports and coordinates the provision of all Medicare and Medicaid services. In order to avoid potential duplications and conflicts between often overlapping Medicare and Medicaid care coordination, care planning and assessment functions, it also makes sense that states have a role in incorporating MLTSS requirements in the MOCs along with the ability to participate in the review process without interfering with the NCQA requirements and criteria.

We caution CMS that MOCs tailored especially for MLTSS members may not include the appropriate flexibility required for application to non-MLTSS members. Applying the more stringent requirements appropriate for MLTSS members to non MLTSS members could result in higher costs and administrative burdens without improving outcomes of care.

Recommendation.

1. **CMS should make it clear that MLTSS MOC requirements should not become the norm for all members and that D-SNPs must be able to continue to differentiate and target their MOC interventions and care coordination systems efficiently to fit a wide variety of members' needs.**
2. **In addition, we note that this process will require that the current CMS medical and behavioral health model be flexible enough to incorporate social and LTSS requirements and interventions in the ICP, and to accept member-directed care as a core value in the Model of Care requirements.**

Discussion: It appears the process of incorporating MLTSS requirements and state reviews into the MOC process has worked well in the Minnesota demonstration and could be extended to some other D-SNPs and states with assistance and guidance from the MMCO. In the Minnesota demonstration, the state worked with D-SNP contractors and CMS to agree on a set of brief statements, including additional criteria that D-SNPs were required to address in their MOC submissions and that were added to key MOC elements (such as assessment, care coordination, care planning, training and Interdisciplinary Care Teams (ICTs)). These statements required that the MOC elements for members using MLTSS services incorporate or coordinate with related aspects of state Medicaid MLTSS requirements in order to enhance coordination, or avoid duplication or conflicts between provisions in the two programs. The state then reviewed each MOC and was allowed to approve or disapprove the MLTSS related additions through a template sent back to CMS. In that case, the state approved all of the added MLTSS MOC elements.

Due to the important role that states play in contracting relationships with D-SNPs, CMS should consider how recent changes in the MOC that allow one MOC at the contract level rather than the PBP level, are consistent with state specific dual eligible population subsets which states are

currently allowed to designate. While CMS has stated that each subpopulation and their special needs must be described and addressed in the MOC, and that services provided be tailored to those population needs, it is not clear how that is handled in the current MOC template which was designed for the PBP level. For example, we envision that there may have to be differences in how the MOC discusses an MLTSS population versus a non-MLTSS population versus a partial dual population, including but not limited to instances where the state has designated these as separate subsets and may have separate contracts for these populations. In addition the process would need to consider how state review of additions or changes in MOCs to reflect changes in populations or subsets would be handled. There should also be consideration of how differences in service areas, particularly multi-state service areas (thought to be a relatively small number of contracts) would be accommodated to allow reviews by multiple states in the process.

As long as most D-SNP contracts pertain to a single state service area and D-SNPs continue to be required to have D-SNP specific MOCs separate from C and I-SNPs, including specifications tailored to the various populations and subsets included in their D-SNPs, it appears that the process used in the Minnesota demo could be expanded to others. However, we have outlined a number of recommendations that CMS should consider as it develops and refines that process below:

Recommendations:

- 1. CMS should assure that the MOC and MOC templates will accommodate differences between populations and benefits and specific state subsets, where there are multiple PBPs or multiple populations served under the same MOC.**
- 2. CMS should consider a process for handling instances where a state might not approve the D-SNP responses to the state MLTSS related MOC additions.**
- 3. CMS should consider adding a process to accommodate state reviews for significant MOC revisions, including changes or additions to the population served under either individual PBPs, or within the overall contract.**
- 4. CMS should consider adjustments in the process to accommodate reviews by multiple states where D-SNP contracts operate in a multi-state service area. Further, CMS should consider requiring that D-SNP contracts be state specific including issuing separate H numbers for some D-SNPs.**

The SNP Alliance supports the continued work of CMS to advance integrated programs including coordination between the MMCO, Medicare and Medicaid to improve experience of beneficiaries under the FAI demonstration. We appreciate work of the Contract Management Teams in resolving operational and policy issues that arise on a day-to-day basis and suggest expanding its use. In its initial evaluation report of current FAI demonstrations, "Report on Early Implementation of Demonstrations under the FAI" the evaluator, RTI, stated the following:

"However, State officials more often reported in broad terms that a multitude of small and medium-sized areas of Medicare-Medicaid program operational misalignment are pervasive throughout the demonstration. State officials expressed the opinion that for a broad range of day-to-day operational policies and procedures where the Medicare and Medicaid programs differ, they have had limited ability to tailor administrative provisions to align with State policies and little choice but to accept Medicare processes. As implementation of the demonstration has proceeded, additional areas of Medicare-Medicaid program misalignment have surfaced, which are being referred to the CMT for discussion among CMS and State staff."

Recommendation: CMS should do more to make it easier for States and plans to pursue integrated strategies. To this point, we have the following recommendations:

1. **CMS should undertake a more proactive leadership role in promoting integrated Medicaid and Medicare managed care programs, including providing an ongoing process to support and encourage states and plans to pursue integrated programs outside of demonstration status, and implementation of program adjustments to simplify pursuit of integration.** CMS should more proactively publicizing and making available technical assistance guidance to assist States in developing and implementing integrated programs.
2. CMS should undertake a review of its MMP and D-SNP policies to identify further barriers to integration, design solutions and adjust policies to increase coordination with states and to provide support for integration efforts where authority exists to do so. This should include offering a modified version of the CMT as utilized in the Minnesota D-SNP demonstration to other states contracting with FIDE SNPs.
3. CMS should consider authorizing the MMCO to arbitrate internal issues between Medicare and Medicaid to find and implement additional administrative resolutions that advance integration when states and plans identify conflicts or issues that impact continuation or initiation of integrated MMP programs and/or FIDE SNPs.

7. **Medicare-Medicaid Plans (pages 211-215).**

Discussion. The SNP Alliance appreciates CMS' inclusion of this information in the Draft Call Letter as a convenience to our MMP members and to plans that sponsor a variety of MA products. Pointing out where MMPs are linked to related MA policies through this document should also provide useful context for states and others interested in MA programs.