



# SNP Alliance

## **SNP Alliance Comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter**

*Submitted via email to [AdvanceNotice2018@cms.hhs.gov](mailto:AdvanceNotice2018@cms.hhs.gov).*

The Special Needs Plan (SNP) Alliance is a national leadership organization dedicated to improving total quality and cost performance through specialized managed care, and advancing integration of health care for individuals who are dually eligible for Medicare and Medicaid. Our membership includes representation from 26 health plan organizations and for the populations they serve. Our members offer more than 250 plans in 39 States and the District of Columbia and enroll over one million Medicare beneficiaries. SNP Alliance members serve over 50 percent of Special Needs Plan (SNP) enrollees with representation from all SNP types, including those serving: (1) beneficiaries dually eligible for Medicare and Medicaid benefits (D-SNPs); (2) those diagnosed with a severe or disabling chronic condition (C-SNPs); and (3) those living in or eligible for nursing home care (I-SNPs). About three-quarters of the Alliance's members operate fully-integrated, dual-eligible SNPs (FIDESNPs) or plans in the CMS Financial Alignment demonstration (MMPs).

We welcome the opportunity to comment on the 2018 Advance Notice and Call Letter. We respectfully submit comments on the following areas: SNP Specific Networks, Star Ratings and Social Risk Factors, Health Disparities, Encounter Data, Fee-for-service (FFS) Normalization, and Medicare-Medicaid Integration.

### **SNP SPECIFIC NETWORKS**

The SNP Alliance is encouraged by CMS' exploration of SNP specific networks. We feel that properly constructed SNP networks could help SNPs better tailor their networks to their high-need, high-risk enrollees. The SNP Alliance encourages CMS to implement SNP specific networks that are more flexible than current MA network requirements and that are more appropriate than current MA network requirements to meet the needs of the populations SNPs serve.

We feel that SNP specific networks should follow several parameters and guiding principles. For one, the development of the SNP specific networks should be a collaborative and transparent process between CMS and SNPs and CMS should employ a multi-step stakeholder process. CMS previously engaged in a collaborative effort that included stakeholder input and review when the agency



developed the current HSD tables. CMS should again employ a collaborative effort and provide ample periods for SNPs to discuss CMS' initial thinking about SNP specific networks and any questions about SNP networks that the agency may have. CMS should then provide SNPs with opportunities to comment and review both the interim and final SNP specific network regulations. Second, SNPs should not have more network adequacy requirements than general MA plans and the SNP specific networks should not be more restrictive or more difficult to achieve than the requirements for general MA plans. The purpose of the SNP specific networks should be to tailor SNP networks to their target population, not to pile on unnecessary additional requirements. To this end, we advise CMS to use parsimony as a guiding principle when developing the SNP specific networks. Finally, we note that our subsequent comments apply to MMPs in addition to SNPs. Although MMCO has made advances towards flexibility for MMPs, more flexibility and tailoring for networks is needed, particularly the recognition in the provider type requirements and exceptions process that not all providers accept Medicaid and therefore won't accept duals.

CMS should develop SNP specific networks that are more flexible than current MA networks, particularly in the following areas:

Time and Distance Standards: We note that CMS' current emphasis on time-and-distance standards can often be overly prescriptive and ultimately limit plans' ability to serve certain geographic areas and harder-to-reach members. Any new standards for SNP networks should not unduly emphasize inflexible time-and-distance metrics, and must not have the unintended effect of making it harder for plans to serve Medicare's most vulnerable beneficiaries.

We recommend that the time and distance standards for SNP networks should vary based on characteristics and needs of SNP enrollees, including prevailing patterns of care. SNP specific time and distance standards should be reasonable, supply-based, and not more stringent than the available supply of providers. Finally, the standards should account for the fact that some providers do not accept Medicaid and therefore will not accept dual-eligible beneficiaries. This has particularly been an issue for FIDE-SNPs, D-SNPs, and MMPs.

Provider types: The requirements on which provider types and the number of providers that must be included in a network should vary and be tailored to the SNP target population. CMS should recognize that SNPs are not FFS and the plans should be permitted to limit networks to providers that can deliver high quality care to SNP enrollees. For example, as stated above, not all providers accept dual-eligible beneficiaries. Similarly, not all providers want to, or are able to, provide high-quality of care to individuals with serious and persistent mental illness (SPMI). It is important for SNP enrollees that their plan's network consists of high quality providers that will accept them as patients. This is also necessary for SNPs to implement value-based purchasing arrangements. Lastly we note that when developing the provider type requirements for SNPs, CMS should change the minimum provider ratio and the beneficiaries required to cover, as appropriate to meet the needs of the target SNP population.

Exceptions process: The exceptions process for SNPs should be flexible and reflect the unique needs of SNP enrollees. There are some lessons to be learned from the Financial Alignment Demonstration about moving towards a more flexible exceptions process. However, the exceptions process for both SNPs and MMPs needs to be cognizant of the fact that target SNP populations are different than the general MA population. In particular, the exceptions process for SNPs and MMPs should recognize that not all providers accept Medicaid and therefore will not accept dual eligibles. The exceptions process should also consider that primary care providers typically provide certain services, such as behavioral health, dermatology and allergy care, when

specialists are not available in a market or the existing specialists will not accept SNP populations (e.g. dual eligibles or individuals with SPMI).

Similarly, we believe that the exceptions process for C-SNPs and I-SNPs should be more flexible to recognize that some provider types who are willing to contract with a general MAOs would be unwilling to furnish services to the population served by the C-SNP or I-SNP. In addition, there are some C-SNPs, such as those who enroll HIV/AIDS patients or persons with serious and persistent mental illness, that may believe a particular provider that is identified by CMS may be unsuitable for the population that they serve. CMS should ensure that these SNPs have the opportunity to request an exception in this circumstance.

CMS should also permit additional health care delivery modalities to be included in the exceptions process. Telemedicine is one example. Mobile units are another modality that should be recognized as suitable for home-based beneficiaries, low-income beneficiaries, or homeless beneficiaries. These additional health care delivery modalities are particularly important in rural areas and underserved areas where availability and access continue to be challenging, especially for behavioral health and dental services. CMS should also work closely with plans and states when developing the exceptions process and should also continue to streamline network adequacy requirements between Medicare and Medicaid. Where appropriate, CMS should look at how states work through exception processes to promote continued alignment.

I-SNPs: Network access requirements for I-SNPs should be based on accessibility to the facilities, rather than the entire county. Moreover, providers who furnish services in facilities should be counted for purposes of meeting access requirements.

## **STAR RATINGS AND SOCIAL RISK FACTORS**

The SNP Alliance appreciates CMS' recognition of the seminal ASPE report to Congress with its findings showing that dual status is a significant predictor of poor Star Ratings, independent of plan or provider performance. We appreciate that CMS acknowledges the need to account for social risk factors in the Star Ratings program and wants to work to do so. The ASPE report confirms SNP Alliance plans' experience that high enrollment of dual eligibles negatively affects a plan's performance on quality measures independent of provider or plan actions. We recognize that there are many challenges to developing a quality measurement system for MA plans, and one that is not biased by social risk factor. However, we must start now, particularly with the release of such compelling evidence.

We believe that CMS should adopt a population-based focus on quality measurement and improvement, recognizing that population characteristics affect individuals' health and care delivery. The characteristics of the special needs populations should drive quality measures and improvement. Dual and non-dual Medicare beneficiaries exhibit significantly different characteristics. Therefore, the quality measurement system that is focused on populations of general MA plans should not be applied across plans with very different enrollee populations. CMS should also create an environment where quality is compared for similar populations.

The SNP Alliance strongly urges a more robust approach to adjust for social risk factors than CMS proposes for the 2018 plan year. CMS needs to recognize that the CAI is ineffective. The plans most impacted by social risk factors are still being harmed from the biases in the Star Ratings and quality management system. When developing a methodology to account for social risk factors in the Star

Ratings program, CMS should be guided by the ASPE research findings, as the ASPE report provides robust testing and offers methodological options to address social risk factors in Stars.

We offer the following short-term and long-term recommendations on addressing social risk factors in the Star Ratings.

#### Short-term Recommendations on Social Risk Factors and Stars for 2018 Plan Year

Recognizing the impact from the ASPE report that dual-eligible beneficiaries have on Star Ratings, CMS should implement a short-term adjustment to the Star Ratings to account for the impact of social risk factors. We recommend CMS implement a half-star adjustment for SNPs that have a 3.5 Star rating and above and a majority enrollment of dual-eligible beneficiaries, until such time that a methodology that fully accounts for the adverse effects of social risk factors can be thoroughly tested and implemented. The half star adjustment would serve to offset the negative impact on Star Ratings arising from dual enrollee characteristics that affect health status and outcomes independent of plan actions.

Starting in the 2018 plan year, the agency should improve the effectiveness and extensiveness of the CAI. At a minimum, CMS should do the following: a) add additional Star measures into CAI; b) add one or more social risk factor(s) into the methodology for CAI; c) add one or more care complexity and functional factor(s) into CAI; and d) test one or more of the adjustments modeled in the ASPE report, running the model simultaneously to the current method and then comparing results for plans that serve large numbers of dual-eligible beneficiaries. These interim changes will offer some opportunity for moving toward a more equitable and accurate quality measurement system for beneficiaries served by high-dual plans.

Beyond the CAI, we ask that CMS increase the number of measures adjusted for social risk factors, starting with the all-cause readmission measure—since that measure extends across plans and providers. CMS should also use geographic data at the most granular level possible to adjust for social risk factors and should require measure developers to use this geographic data in measure retesting. We also recommend that CMS use the exceptions and exclusions of individual measures to tailor measures to dual-eligible beneficiaries.

#### Long-term Recommendations on Social Risk Factors and Stars

The SNP Alliance offers the following longer-term (e.g. beyond the 2018 plan year) recommendations for CMS' consideration. As CMS undertakes the process of accounting for social risk factors in the Star Ratings system, the agency must be transparent and include plans and other stakeholders at all stages of the process.

*Create High Dual and Low Dual Peer Groups.* With respect to an adjustment for social risk factors in the Star Ratings, the SNP Alliance recommends that CMS create High Dual and Low Dual peer groups. Consistent with the ASPE report, the High Dual peer group would consist of plans in the upper quintile of enrollment of dual-eligible beneficiaries (e.g. 80 percent or more enrollment of dual eligible). CMS should separate plans into High Dual and Low Dual peer groups for the purpose of comparing quality and determining bonus payments. According to the ASPE report, dual status can serve as a proxy for a host of social risk factors. The ASPE report also demonstrates the critical need to separate out analyses by High Dual and Low Dual peer groups as a start. We believe that separating plans into High Dual and

Low Dual peer groups ensures greater accuracy and recognition of social risk factors in the Star Ratings program. This strategy is also a starting point for population-based quality measurement, starting with the duals.

CMS should use the ASPE report as a guide when determining the methodology for creating the peer groups and how Star Ratings will be calculated for the peer groups. In addition, CMS should allow plans, at the sponsor/parent organization's discretion, to request CMS to provide that organization's SNP with a new contract number, or H number. This would help group plans into High Dual and Low Dual peer groups and facilitate data reporting that captures differences in subpopulations served for more meaningful measurement.

*Adjust individual measures for social risk factors, beginning with the all-cause readmission measure.* All Star Rating measures need to be fully and consistently tested for social risk factors using identified variables, scientific methods, and public reporting of results for retesting, validation, and transparency. CMS should issue guidelines and require measure developers and stewards to re-test their measures that are included in the Star Ratings—with consistent minimum sample size that includes oversampling of duals, a minimum set of social risk factors to be tested, and direct the steward to utilize the smallest geographic unit of analysis available—at the near neighborhood level. CMS should also require the measure developers and stewards to separate the results between duals and non-duals and report their findings for these two groups. We believe transparency is important and fundamental to ensuring that the measures fairly assess the element of care across Medicare beneficiary groups—including those who are low income, of limited English proficiency, and who have multiple medical, behavioral, and functional limitations.

*Develop a new measure set based on population-based measurement, starting with dual eligibles.* CMS should commission the quality agencies and measure developers to work with stakeholders (e.g., SNPs, safety net hospitals, FQHCs, behavioral health Medicaid providers) to review each Star measure and the measurement set as a whole to determine the appropriate measurement set for dual eligibles that best captures the characteristics for quality of care that is meaningful. CMS should also use a smaller set of more targeted measures for High Dual SNPs. CMS should also improve the accuracy of measures for dual-eligible beneficiaries by identifying Star Rating measures that do not match the dual-eligible beneficiary population well and removing and/or replacing these measures from the overall Star Rating. When developing the revised measurement set, CMS should recognize the investments plans make towards improving quality and aim for stability. Frequent changes hamper quality improvement efforts, which require sustained time and resources to achieve full effect from the efforts.

We would like to acknowledge the work being done by MMCO for MMPs in working to develop a quality rating system for duals that is population-based and tailored. We encourage CMS to continue moving in this direction. We have previously provided comments on principles to guide MMP quality management system development and would welcome the opportunity to participate further.

*Develop system-wide performance measures that account for collective performance across multiple providers serving the same person, across settings and over time.* It is important that CMS assume a leadership role in breaking down the silos among performance measurement systems that serve the same high risk/high need person over time—with metrics and methods that capture the collective performance of health care providers serving these individuals to facilitate collaborative efforts and address needs that evolve over time, with appropriate sharing of responsibility and accountability.

## Other Changes to the Star Rating System

Outside of the issue of social risk factors, we submit the following recommendations on changes to the Star Ratings program.

*Self-report and survey Data.* The HOS and CAHPs surveys are a flawed source of data collection for dual-eligible beneficiaries and other diverse subgroups. The survey designs and methods do not reasonably accommodate nor match the dual population or other diverse subgroups, such as non-English speaking members and individuals with low health literacy and high social risk factors, resulting in many of these beneficiaries being left out of the survey. Consequently, SNPs are disproportionately affected by the flaws in the HOS and CAHPs. Moreover, these survey data captures individuals' perceptions of their health care, rather than actual health outcomes. Going forward we urge CMS to rely more on outcome measures than on self-reported survey data.

The SNP Alliance recommends that CMS improve the accuracy of the HOS and CAHPs surveys for dual eligibles and other diverse subgroups. For one, CMS should oversample dual eligibles, low income subsidy populations, individuals with disabilities, and language-diverse populations, and ensure that the sample collected accurately represents the enrolled SNP population. Second, CMS should report the HOS and CAHPS results separately for dual eligible and non-duals and should report the plan-specific results separately for High Dual and Low Dual plans. CMS should also consider reporting the survey results separately for other key subgroups of Medicare beneficiaries, such as those with serious and persistent mental illness, HIV/AIDs, or severe dementia.

*Increasing the weight of the Part C Care coordination measure.* The SNP Alliance believes that care coordination is a critical component of SNPs and should be an area of focus. However, as previously stated, we believe the flaws in the CAHPS survey – the underlying data source for this measure – weakens this measure and results in it not accurately capturing data on care coordination. CMS should implement the improvements to the CAHPs survey that are described above. CMS should not consider increasing the weight of this measure until after those changes have been made and the survey has been tested to ensure that it is valid and not biased against any SNP populations.

*New care coordination measures:* The new care coordination measures that CMS is considering should apply to all MA plans and all beneficiaries, as coordinating care is important for anyone requiring care and services from multiple service providers over time. However, new care coordination measures must be flexible enough to allow for tailoring elements to specific subgroups. For example, there could be variance in structure and process metrics or exceptions and exclusions where differences of population segments drive differences in how care coordination is set up, who is involved, when, and how such coordination is done. CMS should consider developing variances of the care coordination measures for subgroups that are more homogeneously defined in terms of their underlying characteristics, such as: healthy seniors, frail elders, adults with physical as well as developmental or mental disabilities, younger beneficiaries with behavioral health issues that are disabled, and beneficiaries with specific high risk conditions.

CMS must engage key stakeholders in the measure development process, including SNPs, safety net providers serving low-income and diverse populations, providers serving distinct complex care subgroups, and consumer advocates-- including individuals with disabilities and those who advocate for

health equity. CMS should test the measures in high-need, complex care, distinct population subgroups to ensure that they work across settings and over time. The results of the testing should include attention to resource requirements needed to accomplish care coordination measure specifications, particularly for complex care populations. For example, coordination of care for those with chronic care needs across three or more providers, such as behavioral health, physical/medical health, and social services requires greater resource intensity and capacity than coordinating care for a person with a time-limited episode that needs coordination between hospital to home only. Such resource intensity requirements are important to know when determining effective structure, process, and outcome results. The result of the measure development and testing process should be a common set of care coordination measures with flexibility that can extend across settings and facilitate collaborative quality improvement efforts for diverse population subgroups.

*HEDIS Transitions of Care.* Regarding the timeframe for documentation of notifications of admission and receipt of discharge information, we recommend that CMS further examine the feasibility of a one-day notification timeframe. Information from providers and plans may indicate that a one-day timeframe is not possible given the current infrastructure. CMS may need to consider a longer timeframe since notification timeframes vary for reasons outside of a plan's control. For example, primary care providers and hospital providers are not always operating within the same EMR and state health privacy and data exchange standards or state contracts may dictate timeframe and methods for notification. Further, transitions of care for SNP populations are complex and can involve multiple providers and settings of care. CMS should also consider expanding the measure specifications to include all providers who can appropriately support a beneficiary during a care transition.

*Follow-up after Emergency Care.* We support CMS considering the measure of follow-up after emergency care as it is an important measure for SNP populations. With respect to the type and timeframe for follow-up, we believe a patient's needs and the severity of their medical or behavioral conditions should guide the timeframe for follow-up. Access, accommodation, and amenability issues for persons with complex medical, behavioral, and social risk factors should also guide the decision about the type of follow-up.

*Pain management.* We support CMS considering this measure. We recommend that CMS take into account the need for management for both chronic and acute pain and for a constellation of medical, mental health, and other issues/conditions that are the sources of pain. We also encourage CMS to take into account stakeholder input from many types of providers—including SNPs, long term care, hospice, palliative care, behavioral health, mental health, and chemical dependency providers. Finally, we are encouraged that both pharmacologic and nonpharmacologic approaches are being considered.

## **HEALTH DISPARITIES**

The SNP Alliance fully agrees with CMS that health disparities are a real concern. We welcome the opportunity to work with CMS further on this topic and we encourage CMS' willingness to target special need populations, whose health care is challenged by social risk factors. Our previous comments on changing the Star Rating program, individual quality measures, and self-reported survey data to address social risk factors are also applicable to health disparities. Accurate quality measurement tools will help CMS identify health disparities and measure their trends over time.

As health disparities arise from complex environmental, societal, community, personal, and health system interplay, SNPs are collaborating with other community partners and individuals and advocates to identify potential solutions in their marketplaces. We offer the following examples from SNP Alliance members to give CMS an example of activities plans are undertaking to reduce health disparities: [a homeless initiative](#) from UPMC, [a tobacco use reduction](#) and other prevention efforts in diverse communities initiative from Blue Cross Blue Shield of MN, and a [medication adherence initiative](#) from LA Care Health Plan. SNPs have also been examining their datasets to determine what key social risk factor information is consistently collected on enrollees. They are using enrollment data and health risk assessment information to identify some social risk factor issues and to target complex and high intensity care coordination efforts. These data can help signal where social risk factors are impacting the beneficiary's ability to address medical and behavioral health issues.

## **ENCOUNTER DATA**

We are concerned about CMS' use of encounter data in the MA risk-adjustment system. There are numerous flaws with the encounter data system and these flaws disproportionately affect SNPs. According to a recent study by Milliman, 2016 median EDS risk scores were lower the RAPS risk scores by 4 percent, translated to an approximate reduction of \$40/per member per year. However, the difference between EDS and RAPS was more pronounced for SNPs, with EDS scores that were 8.4 percent lower than RAPS at the 20<sup>th</sup> percentile and 5.1 percent lower at the 50th percentile. A study by Avalere of eight MA organizations constituting 30 unique plans and 1.1 million Medicare beneficiaries found similar results. This study estimates that a 90/10 blended rate reduced 2016 risk scores by 1.6 percent and a 75/25 blended rate reduced risk scores by 3.9 percent. Moreover, the study found that EDS resulted in the identification of fewer HCCS for chronic conditions, such as diabetes, COPD, and CHF, and serious mental health disorders (major depression, bipolar, and paranoid disorders).

The SNP Alliance recommends that CMS not continue to use encounter data for payment purposes until all the flaws and challenges in the system can be identified and resolved. We understand that no longer using EDS might be administratively cumbersome for CMS and would require the agency to acknowledge the flaws with EDS. However, EDS is having a real, negative impact on SNP risk scores and payments and should no longer be part of the payment system until related problems are resolved. Moreover, relying solely on RAPS might be administratively less burdensome for CMS than keeping the phase-in of EDS and having to develop and implement an industry-wide adjustment on the fly. Moreover, since SNP payments have been lower for the 2016 and 2017 plan year solely due to the flaws in EDS, we ask CMS to retroactively adjust payments to SNPs for 2016 and 2017.

If CMS does choose to keep EDS phased-in and develop an industry-wide adjustment, we recommend the adjustment be plan-specific rather than industry-wide. Since EDS negatively affects SNPs more so than other plans, an industry-wide adjustment would be a blunt instrument that would continue the disproportionately negative impact on SNPs. The adjustment should fully account for the gaps between EDS and RAPS.

Finally, with respect to CMS' compliance activities on encounter data, we feel it is too soon for CMS to implement compliance activities on encounter data. CMS has not yet resolved the flaws with EDS and rather than jumping to compliance actions, CMS should work with plans to better improve the data.



## **FEE-FOR-SERVICE NORMALIZATION**

It appears there is something aberrant about the growth in FFS risk scores between 2015 and 2016. This concerns the SNP Alliance because it disproportionately affects ESRD SNPs, causing payment instability to plans that serve very high need and high cost beneficiaries. The impact of unexplained and unpredictable changes in FFS risk scores is particularly problematic for the calculation of the ESRD normalization factor, in large part because of the lengthy projection period. As CMS acknowledges, the agency compounds the annual trend by a factor of nine to arrive at the 2018 normalization factor—magnifying the effect of any data points that are not in trend with previous years. The ESRD FFS growth rate and projected risk scores are disconnected, even though they should be correlated and paint a coherent picture of beneficiary risk and spending trends. Overall, CMS' proposed approach results in a substantial reduction in ESRD SNP payments for a small, high-need beneficiary population. CMS should look into this issue to make sure there is not an error in the agency's calculations.

CMS must take steps to ensure that the risk score and spending growth adjustments are more closely aligned in order to maintain stability of benefits and premiums for this particularly frail population. To that end, we offer two recommendations for CMS' consideration: (1) CMS should discard the most recent year of FFS risk score data (2016) when calculating the ESRD normalization factor, or (2) CMS should use 2017's normalization factor for the ESRD model (which was 0.994) and adjust to achieve a new 2018 factor. Either of these recommended approaches would achieve the needed alignment with the ESRD growth rate, as referenced above, and result in greater stability for ESRD patients. This stability is critically important, particularly in light of the fact that MA plans that serve ESRD patients have experienced significant swings in payment rates over the last several years. These frequent and significant fluctuations in payment policy have a direct impact on beneficiaries by making it incredibly challenging to design stable benefit packages that limit year-to-year changes for our members.

Dramatic swings in rates, combined with CMS' proposed changes for the 2018 ESRD normalization factor, do not support program stability or adhere to CMS' goal in improving beneficiary health. Given these concerns, we request that CMS take steps to provide year-over-year stability for the ESRD population—either of the options listed above would achieve this goal, ensuring that plans can continue providing the coordinated care ESRD beneficiaries require.

## **MA BENCHMARK CAPS**

The SNP Alliance supports the removal of the MA benchmark cap as it results in some quality plans receiving artificially lower quality bonuses. We agree with CMS's concerns over the negative incentives the MA benchmark cap places on MA plans. The SNP Alliance believes that CMS has the authority to lift the MA benchmark caps through the agency's longstanding Medicare payment demonstration authority. We ask that CMS implement such a demonstration for the 2018 plan year.

## **MEDICARE-MEDICAID INTEGRATION**

The SNP Alliance appreciates CMS' inclusion of MMPs in the Call Letter. We would like to take this opportunity to urge CMS to further integrate between Medicare and Medicaid and to export some of the administrative enhancements in the Financial Alignment Demonstration to D-SNPs and FIDE-SNPs. CMS should take the following steps to improve Medicare and Medicaid integration:

- Align procurement and contracting schedules and processes among plans, states, and plans;
- Integrate delivery and notification of benefits and services;
- Coordinate and align enrollment and enrollment processes, including use of a single enrollment card;
- Enable joint CMS and state review and simplification of member materials and coordination of member notices and communications;
- Integrate plan assessments and model of care requirements;
- Align program oversight, performance measures, data collection and reporting, consumer protections, and grievances and appeals;
- Align payment methods and incentives; and
- Enable modification of care strategies to better serve major high-risk and high-need population segments.

Additionally, our members who operate both MMPs and D-SNPs or FIDE-SNPs report that the MMP Member Handbook has made important gains towards Medicare and Medicaid integration. We ask CMS to permit D-SNPs and FIDE-SNPs to create the more integrated Member Handbooks that the MMPs use. Dual-eligible beneficiaries should be able to receive integrated and easier-to-understand member materials whether they are enrolled in a D-SNPs, FIDE-SNP, or MMP. We also ask CMS to have a meaningful comment period for the Member Handbook or any other administrative enhancements that are exported from MMPs to D-SNPs and FIDE-SNPs.

We look forward to continuing to work with CMS on these and other issues that affect chronically ill and dual-eligible beneficiaries enrolled in Special Needs Plans. Please feel free to contact me at [Rich@nhpg.org](mailto:Rich@nhpg.org) with any questions.

Best regards,



Rich Bringewatt  
President and CEO  
SNP Alliance