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Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-2020-0003

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II

The Special Needs Plan Alliance (SNPA) is pleased to offer our comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for the Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies – Part II*.

The SNP Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent over 400 special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs), with over 2.2 million enrolled members. Our primary goals are to improve the quality of services and care outcomes for the complex populations served and to advance integration for those dually eligible for Medicare and Medicaid.

In our response, we have limited our comments to specific sections, and we have identified the sections where we offered these comments using page numbers and section titles.

Pg. 26: Section D – ESRD Rates. The SNP Alliance encourages CMS to expand the list of C-SNP conditions to include advanced stages (States 3 and 4) of chronic kidney disease (CKD). C-SNPs are able to target specific care and support to address chronic conditions, and have shown improved outcomes (<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0998>). By providing Medicare beneficiaries the option of participating in a C-SNP for CKD, individuals could better manage their disease and delay, or potentially avoid, progression to ESRD.

Pg 33 -34: Section I – Frailty Adjustment for PACE organizations and FIDE SNPs. Table II-4 and II-5 outline the Frailty Factors counts associated with the 2017 and 2020 CMS-HCC Models.

SNP Alliance Comment

We appreciate and agree that attention to frailty factors continues to be important when considering costs that are not explained by diagnoses. However, we have some concerns about the impact of the blending on plans that serve a high proportion of individuals who have 3 or more ADL/IADL limitations.

Provide Information on Impact - We note that the coefficients for the ADL counts in Table II-5 associated with the 2020 CMS-HCC model have gone up from 2017 to 2020-- for individuals with 0, 1-2, 3-4, and 5-6 ADL limitations on the Non-Medicaid side. However, the coefficients/factors on the Medicaid side have all been reduced. The reductions seem fairly substantial, and as the blend of 25% 2017 CMS-HCC Model with 75% 2020 CMS-HCC Model is used, we are concerned about the impact—does this reduce the positive effect of the adjustment for recognizing the influence of functional limitations on costs as experienced by plans with a substantial proportion of individuals with greater levels of functional impairment? The analysis later in the Advance Notice on impact indicates a reduction in payments. Does this disproportionately affect plans serving the most functionally limited individuals in the “Medicaid” category? We would appreciate greater clarity as this may especially impact FIDE-SNPs with the most complex and functionally impaired populations who are dually-eligible. Thank you in advance for providing more information about the impact.

Pg 60-66. Categorical Adjustment Index (CAI)

SNP Alliance Comment

CAI as an Interim Step - The CAI was to be an *interim* method to take into account the strong evidence that socioeconomic status (SES) and social determinants of health (SDOH) affect health outcomes and performance measurement within the quality ratings, including Star ratings, independent of plan performance. While we appreciate this interim step and the gradual inclusion of more measures for CAI adjustment, we are concerned that there is not more information, testing, or modeling on the next phase of work that is to create a more robust approach.

We continue to be concerned that even with CAI adjustment, the resulting measure scores do not adequately take into account beneficiary characteristics including dual eligible, low-income, and disabled status.

Possible Inaccurate Categorization of Plans - We refer to the tables given which separate plan contracts by proportion of LIS/DE or by Disability. A key point of concern, based on receiving information from plans who serve only dually eligible beneficiaries, is that the plan serves 100% dual beneficiaries—yet the plan is placed in the L9 group versus the L10 group by CMS’s categorization process. These plans hypothesize that perhaps this is due to temporary loss of Medicaid eligibility status due to State records/processes? They point out that beneficiaries who temporarily lose Medicaid eligibility status (for example because paperwork/status updates were

not filed timely or the State files with address changes or other administrative actions were delayed in being updated) may temporarily fall off the DE rolls. This does not mean that person's needs, conditions, or services have changed—often they are reinstated as DE the following month and the plan continues to count them and serve them as an enrolled member. Therefore, the plan is responsible for their care throughout the period and should be placed in the L10 category.

When considering this issue, we wondered if this may be due to two or more contracts being consolidated into one for purposes of the CAI application. If there is only one PBP in the H# contract, then this would not be the case. However, if an H# contract has more than one PBP within it and both plan products do not have 100% DE enrollment, we could see that the whole contract would be placed in the L9 category. Additional clarification would be helpful to the field regarding this point.

Options for Improvement – If the issue remains for other reasons, here are two options as possible solutions:

- (1) Revise the categorization tables so that L9 upper limit threshold is set at up to 98.0 % (or something above the 95% corridor in order to capture these temporary Medicaid roll administrative issues), which would mean the L10 category is also revised accordingly (e.g., from 98.00001 to 100.000 % or similar)
- (2) Add a step for calculation that accounts for temporary loss of Medicaid status—such as if the individual was reinstated within 3 months, the person will count as DE in the categorization.

Thank you for providing more information.

Maintaining the “Disabled” Status When Individual Ages into Medicare - An additional point we would like to make is to ask CMS to ensure that persons who became eligible for Medicare due to a disability prior to age 65 are able to retain their “disabled” status even when reaching their 65th birthday—as their disability surely continues and switching them to Medicare “aged” reduces validity and suppresses appropriate application of CAI adjustments.

Modeling Options While Awaiting ASPE Report - Finally, we understand that CMS is awaiting further study results including the final ASPE Report to Congress on effect of social determinants of health on quality measurement and health outcomes and recommendations on how to improve adjustment methods. The report is now overdue by several months.

We have offered ideas and would be pleased to be part of a group to lay out steps that the agency could take right now that are not dependent on further research or final decisions on an adjustment approach for social risk factors.

Extreme and Uncontrollable Circumstances Policy

Pg. 66

The SNP Alliance appreciates the policy CMS has developed for extreme and uncontrollable circumstances. However, the current eligibility criteria is limited to FEMA major disaster declarations. However, multiple regional and wide-spread events such as floods, wild fires, and public health emergencies such as the COVID-19 outbreak cause considerable distress and negative impact to beneficiaries, and impacts plans and providers in the Start Rating programs.

SNP Alliance Comment

We request the expand eligibility for the policy in the event of a state or local public health or other disaster-related emergency, if the State Governor or the Secretary of Health and Human Services declares a public health emergency, or in the event of a FEMA emergency or Fire Management Assistance Grant declaration for which public or individual assistance is available.

Changes to Existing Star Ratings and Display Measures

Page 68 *Care for Older Adults Functional Assessment Indicator*

SNP Alliance Comment

We understand the purpose of the reduction in options for meeting the measure requirement is that the field is moving toward use of standardized assessments and domains for ADL and IADL. We agree with the premise that standardized tools which were tested for validity and reliability in an older adult population for assessing functional status would be preferable to having only selected functional domains assessed. We appreciate the process of having a two-year timeframe to allow plans to work with providers and others to modify their approach around functional assessment or ensure they are using a standardized instrument.

Page 69 *Transitions of Care*

SNP Alliance Comment

Transitions of care is a very important focus. This is particularly important for people with multiple complex care needs. We appreciate NCQA's desire to create a measure of effective transitions of care and work done to date. However, this composite measure still focuses on documentation of events rather than the substance of the transition experience. There are still methodological and feasibility challenges associated with this measure—even with the modifications suggested—which suggest that this will primarily measure information exchange capacity/technology and the current variability in resources among providers.

Measure Challenges- We briefly review some these challenges which were previously enumerated over the last few years as the measure was being developed. The challenges

primarily pertain to the current reality and variability in health information transfer (capacity and effectiveness) between/among providers and from providers to health plans:

- Provider health information systems and exchange capacity and functionality varies substantially across the country and, particularly in areas where there are many small practices and for patients who see multiple providers who provide follow-up care, information exchange is most likely not part of one integrated data system or platform.
- Documentation of admission or readmission and discharge involves both timely information from the admission/discharge setting (e.g., hospital) and then timely receipt by the provider (e.g., PCP or specialty physician, etc.) which should be dated in the providers' health records. We have heard that the receipt may occur within the timeframe, but not be entered into the health record system within the window of time specified. The date noted may be when it was entered into the clinic/health record system rather than when the information was actually received (e.g., via secure FAX or via a health information portal) by the clinic/setting.
- The principle provider who is most important with regard to admission or discharge for a given beneficiary may be a specialist (e.g., a cardiologist) who is most central/involved in that event (e.g., heart attack). A person who has multiple conditions, may have various specialists involved in care. Thus the “ongoing care provider” may vacillate for the same person from event to event. The follow-up care provider may be one of these specialists, rather than a primary care physician. Unless both the primary and specialty physicians are part of the same medical group sharing one health information platform, the follow up visit with the patient (by the cardiologist) would not show up in the primary care provider's health record system. We assume that, with the changes shown, any health record that is used by the follow-up care provider meets the requirement. Moreover, we assume that if notification of admission to a PCP is timely, notification of discharge to a specialist is timely, and follow-up by any relevant care provider is timely, the measure intent has been met—even if these are three separate people with three separate record systems and across three separate organizations. Is it then up to the health plan to piece together this episode and trace the pathway and timeliness of information exchange?
- The health plan can educate providers on the measure and request or even require timely discharge and receipt notification for all transfers of care—but this does not mean the health plan can control these activities. Plans cannot drop providers from their networks because of non-compliance, for example, and still maintain requirements around provider network standards and accessibility, as required by CMS.
- For many providers/plans, finding the necessary information means labor-intensive chart review. There are various fields within the chart where such information may show up, including progress notes. Fields that are not standard have to be manually reviewed—particularly if the information is in a pdf/image/scan. Finding the correct dates when information transfer and receipt as well as follow-up occurred, for each transition episode

could add substantially to the provider burden and administrative costs. This may not be an added expense the provider can recoup through claims/contracting.

- Patient engagement documentation regarding follow-up is likewise challenging, particularly if the follow up is by yet another service provider (e.g., home health care agency) that has been ordered by the discharging physician. This follow-up home health care visit may be in yet another record system—since patients must be given choice of home health care provider and the discharging hospital cannot require the patient to accept a home care agency that is part of its medical record system or under the same organizational enterprise/ownership.
- Patients sometimes do not follow through on discharge recommendations and may refuse to see recommended provider(s) or receive treatment within 30 days, particularly if there are visit co-pays involved. There should be some way to document patient/member refusal or address this issue in the measure specification.

Move to Display Page - We believe these modifications in the Advance Notice are substantial changes to the measure specifications and, while moving in the right direction, do not address all of the concerns raised. Given these ongoing concerns and recognizing that the changes meet the level of “substantive,” we recommend that this Transitions of Care measure be moved to the Display page for two years while plans work to educate and support providers who may have to implement new structures or technology as well as processes for health information exchange in order to meet the required timeframes. These changes may be a significant undertaking for some providers—there should be some recognition of the burden that will be placed on them, particularly small practices who are not linked to larger health delivery systems. NCQA’s own analysis on current rates associated with the four parts of this measure shows limited performance at the present time in three of the four parts (16% for Notification of Inpatient Admission, 10.8% for Receipt of Discharge Information, and 52.7% for Medication Reconciliation Post-Discharge). One step that could improve provider awareness around this measure would be to include it as a measure within MIPS and offer additional bonus points for performance based on achieving a benchmark.

Page 70 HEDIS Cross-Cutting Exclusions

SNP Alliance Comment

Endorse Palliative Care Exclusions - We have been advocating for these cross-cutting exclusions for palliative care and for individuals who are at a nursing home level of care. We applaud the proposed measure exclusions for palliative care (currently under review and comment period through NCQA).

Extend Exclusions to Individuals who are at a Nursing Home Level of Care but Live in the Community - We urge NCQA to also extend appropriate measure exclusions to individuals who are at a nursing home level of care and live in the community. Right now, individuals at a nursing home level of care are already excluded from such screening measures, such as breast

cancer or colorectal cancer screening—but only if the person lives in an institutional setting and is enrolled in an I-SNP. It should not matter where the individual lives. If the measure is inappropriate given potential for harm or not within clinically appropriate guidelines, then it should not be applied.

Background: In 2018 NCQA began excluding Medicare members who are enrolled in an I-SNP and who live long-term in institutional care settings from four HEDIS measures, as noted the following: *The measures are appropriate for the age-defined general population, but not always for people who are frail or have mobility or other functional limitations. NCQA undertook this cross-cutting effort to be sure the measure only includes patients who can actually benefit from the service.* ([NCQA HEDIS update 2018](#)). This was not extended to persons at the same level of care but who live in the community.

For HEDIS 2019, NCQA went from four to nine measure exclusions for these individuals and added an additional exclusion category of individuals who are 80+ AND frail. (<https://blog.ncqa.org/hedis-2019/>). This still leaves individuals who are under age 80 and frail and/or who are at a nursing home level of care and live in the community. We request that NCQA consider extending the measure exclusion. We had suggested two criteria: persons who are at a nursing home level of care as designated by the State (similar to I-SNPs) but who are enrolled in a FIDE-SNP. This seems to be an apples to apples match in terms of the characteristics of the individual that are the reasons for exclusion from the measures.

Page 70 Initiative and Engagement of Alcohol and Other Drug and Dependence Treatment

SNP Alliance Comment

Endorse the Need to Re-tool and Re-test the Measure - Health plans have provided information to the SNP Alliance indicating this measure has been problematic—where both providers and plans indicate revisions are needed. Plans have expressed concern about provider burden and the syphoning of resources to meet documentation/measure requirements which reduces resources for mental health support. The measure may not meet the tests of feasibility and utility. We welcome action by the measure developer to address some of these issues.

Potential New Measure Concepts

Page 73 Health Outcomes Survey Measures

SNP Alliance Comment

The focus on functional status is important. Likewise, gathering information directly from individuals to assess performance of providers and the health plan is critical. However, the questions and methods that are now part of the HOS survey and the processes used to generate measure scores continue to be problematic—calling into question the use of these measures to assess health plan performance.

Continued Instrument and Method Limitations of HOS Preclude Endorsement - Because of these ongoing issues, we cannot endorse the PFADL measure unless the items used, response scale, and composite measure are tested for validity, reliability, accuracy, and utility within dually eligible, low-income, disabled and diverse (linguistically and ethnically diverse) populations.

Likewise the methods, such as surveying, ensuring the sample is representative, and ensuring an adequate response rate, need to be examined for appropriateness in these sub-populations. The results from testing also need to be examined to affirm they can be tied to health plan actions and are modified by action at the health plan level to inform quality improvement efforts.

HOS Instrument & Method Analysis - We have previously provided extensive comment and analysis on the limitations of the HOS instrument and methods used to generate the PCS and MCS measures as applied to special needs populations (see [HOS White Paper](#)).

Though the HOS instrument was well-developed within the 65+ White U.S. veteran population and has been shown to be valid and reliable for the general Medicare population, the instrument needs retesting in diverse population subgroups. The demographic characteristics of the original and subsequent study populations do not match well the characteristics of diverse subgroups enrolled in Medicare Advantage special needs health plans.

Special Characteristics Need to be Considered - Health plans with a high proportion of individuals enrolled with the following characteristics are more likely to experience the limitations in the HOS measures and methods:

- Dually-eligible, disabled individuals
- Having multiple major chronic or significant degenerative conditions, such as ALS, Parkinson's disease, or advanced Alzheimer's disease
- Having significant social determinant of health risk factors such as: Non-English speaking, nonnative born, low-income, housing transient, food insecurity, lacking a regular source of transportation, communication device variability, low education/low health literacy
- Experiencing significant life events, such as loss of a partner, home, job, or a new diagnosis of a significant disease over the last two years
- Persons who have a terminal diagnosis or are on palliative care where goals and expectations differ around maintaining physical health status

These characteristics can and do affect responses to the following questions used to generate a score for "Improving or Maintaining Physical Health" (PCS) where the responses are gathered and then two years later the same respondent answers the questions again. Results are attributed to health plan care management or other health plan action. The six questions presented are:

1. In general, would you say your health is: [Excellent, Very Good, Good, Fair, Poor]
2. Does your health **now** limit you in these activities? If so, how much? [Scale: limited a lot, limited a little, not limited at all]
 - Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
 - Climbing **several** flights of stairs?
3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? [Scale: none of the time, a little of the time, some of the time, most of the time, all of the time]
4. **Accomplished less** than you would like.

5. Were limited in the **kind** of work or other activities.
6. During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)? [Scale: not at all, a little bit, moderately, quite a bit, extremely]

These questions about climbing stairs, golfing, and performing household tasks such as vacuuming may not be perceived as relevant to persons with physical disabilities or frail elderly people. Such individuals may receive daily assistance for activities of daily living. People who use a wheelchair and other medical adaptive equipment may read these questions as not pertaining to them. The respondent may skip the item or may feel that the instrument was not thoroughly vetted for persons like them. This can affect not only the specific item response but elicit other negative reactions which can affect additional responses in the remainder of the survey, including the person's decision to end the survey prior to completion.

The measure on Improving or Maintaining Mental Health (MCS) is also the result of asking a respondent the following six questions and then asking that person again two years later:

1. **During the past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? [Scale: none of the time, a little of the time, some of the time, most of the time, all of the time]
 - **Accomplished less** than you would like
 - Didn't do work or other activities as **carefully** as usual
2. How much of the time during the past 4 weeks: [Scale: all of the time, most of the time, a good bit of the time, some of the time, a little of the time, none of the time]
3. Have you felt **calm and peaceful**?
4. Did you have **a lot of energy**?
5. Have you felt **downhearted and blue**?
6. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)? [Scale: not at all, a little bit, moderately, quite a bit, extremely]

Additional Challenges Based on Scientific Findings - Wording and format issues may be particularly important in non-native born and non-English speaking persons. Bias can arise from language, wording, or methods of administration which do not properly accommodate the intended respondent. For example, non-native born people may not understand that the word "blue" is used to mean "sad." They may not have any experience with golfing or bowling as hobbies and therefore mis-interpret the question or conclude it does not pertain to them. The format and response scales can also be confusing.

Current Challenges with Utility of Results - SNPs have provided additional feedback articulating the difficulties with interpreting the results from these measures when applied to populations with the special needs characteristics previously described. One criticism is that there is such a long time-lag--over three years--between data collection and measure reporting. In frail populations as many of one third of the population may have already died.

Another criticism of these HOS measures is that they attribute the improvement or decline in a person's self-report of status to the health plan actions, and do not provide context (for example

information on the person's care needs or transitions, episodes, or significant health events) that have occurred in the two year period between the first survey and the second. Therefore, the measure score on its own does not provide enough information that is actionable for targeted quality improvement efforts. Plans often report they are unable to explain either a rise or decline in their HOS scores—stating that neither the population characteristics nor their care management actions—have changed much within the two years. Yet, they report fairly sizeable swings in HOS measure results.

Call for Further Work or Selection of an Alternate PRO Measure - For these reasons, the SNP Alliance requests that further foundational work be done to modify and re-test the HOS instrument. The measures of physical and mental health status and the proposed new measure for functional status (PFADL) need to be tested in diverse and complex care populations. The results of such testing will provide the necessary evidence that the items and measures are relevant, valid, accurate, and reliable for the intended population and that the methods adequately accommodate the diversity and characteristics of the beneficiary respondents and can be tied to health plan action to inform quality improvement.

We strongly urge that more work be done before the proposed new functional measure is applied and before the existing measures are used to assess care outcomes among people with disabilities, age 18-64. In the interim, there may be other self-report measures which are valid and reliable and have received the necessary testing in the disability community or among diverse and dually eligible, complex chronic care populations. CMS may wish to begin testing the application of these measures as an alternative to or in addition to HOS.

Page 74 Diabetes Overtreatment

SNP Alliance Comment

Support Work - We support the recommended changes to conform to the recommendations of the American Diabetes Association and other experts in Diabetes care and look forward to learning more about this measure concept and how it can be operationally feasible, provide useful information, and ensure an accurate evaluation of good quality of care for complex populations with Diabetes.

Page 74 Cardiac Rehabilitation

SNP Alliance Comment

Considerations – The clinical quality teams from member health plans have raised several cautions about this proposed measure. As a starting point, they point out there is a national shortage of cardiac-rehab programs. Programs may be particularly scarce in rural areas. The standard for these programs require attendance in multiple sessions per week by the individual on an outpatient basis (e.g, over a 12-week period). This can be difficult for the individual, even if the person can locate a cardiac rehab program in their local area. The individual's ability to drive or get transportation three times a week for twelve weeks is often limited. Additional factors that would impact the ability to participate include: the person's frailty/condition status, other chronic conditions which may also require ambulatory visits or follow-up care—which conflict with the cardiac rehab schedule, availability of family or friend to accompany,

transportation reliability, and cost of travel (e.g., Uber, gas cost, time away from work by family member to go with, or suggested co-pay if there is one).

As the measure developer continues this work, the issues of accessibility, accommodation, availability—and other practical and contextual considerations—need to be considered. There is also the issue of patient engagement and choice.

Page 75 Home Health Services

SNP Alliance Comment

Considerations in Moving Forward - We are intrigued by the measure concept. Care coordination is very important for individuals with multiple complex chronic conditions. Any successful transition involves preparation of the individual and family/informal support system as well as the formal health and social support services systems and would be enhanced by better communication across service providers. The viability of a coordinated extended care pathway is quite dependent on real-time shared information across organizations that do not have access to each other's health record systems—requiring individual-to-individual communication and actions. This is often inadequate, even with the best of intentions.

Especially with populations who have multiple chronic conditions, including behavioral health issues, there are often multiple care coordinators involved along the extended care pathway—from the discharging setting (e.g., hospital social worker discharge planner), primary care or specialty medical clinic setting (e.g., PCP clinic care coordinator, or condition specific care coordinator such as for oncology, cardiology, etc. particularly after an invasive procedure), rehabilitation care coordinator, county or community case manager, behavioral health coordinator, and others. These individuals have particular pre and post event roles and duties.

For high risk members, the health plan may also have provided the beneficiary with a plan care manager for “one call” action. The plan care manager relies on the engagement of the individual to contact with his/her plan care manager or may be informed when a trigger event (such as hospitalization discharge) has occurred. By then the home health care service has often already been started and the plan care manager does not have the opportunity to be part of the preparatory phase prior to discharge to the home.

Finally, there is the skilled home health care nurse or occupational or physical therapist who provides the skilled care services during the prescribed timeframe according to the physician's order.

Given the array of individuals involved and their various assigned roles and duties, there could be many providers, institutions, and organizations involved in the extended care pathway. One measurement challenge we anticipate is how to connect all of the activity for an individual—especially as it is likely the person's care is recorded in different medical record systems with different patient identification numbers/codes. It would be ideal if the health plan were informed of the pathway events in real time, but it may be the case that they are aware of only when they are notified of an encounter or when claims are submitted for payment.

Perhaps a measure can be added to the Home Health Care Medicare quality measures so that home health care providers are required to inform the health insurer on the day of initiation of their skilled service and required to identify if there is a health plan care manager for follow-up—and send that person the information regarding initiating service. This would be a process measure. Though it would not address the “pre” or “post” parts of the pathway before skilled home health care services began, it would be a start at encouraging processes to connect those who have designated roles of care coordinator—starting with the health plan.

Conclusion

The SNP Alliance is committed to the quality and excellence in service delivery to the individuals enrolled in our member plans. We appreciate this opportunity to provide comment and seek to work together to enhance the lives and well-being of all Americans, including those with complex needs. We are happy to answer any follow-up questions or provide additional information, should that be helpful.

Respectfully,



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