SNP Alliance Comments on CMS 2022 Advance Notice I and II

Submitted via Federal e-Rulemaking Portal: https://www.regulations.gov

November 30, 2020 DRAFT

Demetrios Kouzoukas
Principal Deputy Administrator
and Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-2020-0093

SUBJECT: ADVANCE NOTICE OF METHODOLOGICAL CHANGES FOR CALENDAR YEAR (CY) 2022 FOR MEDICARE ADVANTAGE (MA) CAPITATION RATES AND PART C AND PART D PAYMENT POLICIES – PARTS I AND 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—about two-thirds of all beneficiaries enrolled in SNPs. 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.

SNP and MMP Members Serve a Higher Proportion of Vulnerable Beneficiaries

SNP and MMP enrolled populations are comprised entirely of individuals most at-risk of COVID-19 serious infections and most affected by the enormous societal upheavals we have all observed since March. Most beneficiaries are dually-eligible for Medicare and Medicaid, with multiple underlying chronic and disabling conditions and high social determinant of health (SDOH) risk factors. The severe and extended impact of changes in communities—including disruptions in health care, behavioral health, long-term services and supports, medical devices and adaptive equipment, nursing facility care, as well as challenges in accessing healthy food, reliable communication devices, transportation, personal protective equipment, and even informal support from family and friends—falls disproportionately on these individuals.

In response to this Advance Notice and to additional policies recently proposed by CMS, the SNP Alliance is submitting the following overall concerns and recommendations for stabilizing CMS policies and payments for SNP and MMP enrollees during this unprecedented pandemic. These are followed by additional detailed recommendations focused specifically on CMS' Advance Notice Parts I and II.

Overall Recommendation:
Because of the vulnerability of the population served by SNPs and the need for continuity of care during this difficult pandemic, we urgently request that CMS work with the current administration to extend the Public Health Emergency with its detailed features beyond the current expiration date of January 20, 2021. We appreciate all CMS has done to provide additional flexibilities and quick policy responses to this pandemic. Extension of the PHE and its policies will give plans, providers and beneficiaries the assurance of a stable platform for continuation of care and services as they struggle to cope with the devasting impacts of COVID-19.

***Overall Recommendation:* Ensure the Most Favored Nation (MFN) Interim Final Rule (IFR) Does Not Undermine Program Stability**
The MFN IFR establishes a mandatory seven-year demonstration project beginning on January 1, 2021, that limits the reimbursement for approximately 50 high-cost Medicare Part B drugs. We are concerned the IFR notes “total payments to MA plans over the 7-year course of the model will be substantially lower as a result of reduced FFS spending under the MFN Model.” Over the 7-year model performance period the CMS Office of the Actuary (OACT) estimates $49.6 billion MA payment savings because the benchmark is based on FFS spending. Not only are MA plans unable to participate in the demonstration, the IFR acknowledges manufacturers may take steps to increase drug prices in MA markets. We encourage CMS to make an adjustment to MA ratebook calculations to ensure the demonstration will not undermine the stability of the MA and Part D programs and result in higher overall costs, less benefits, and fewer plan offerings for MA beneficiaries’.[1]

***Overall Recommendation*: CMS Must Provide Clear Guidance Needed on Final Drug Rebate Rule that would Impact Bids for 2022**

As plans prepare coverage offerings for 2022, clear guidance is needed related to the U.S. Department of Health and Human Services (HHS) final rule on the removal of drug rebate safe harbors and creation of the new safe harbor for discounts. If the final rebate rule goes into effect, it represents a significant shift in how price concessions would work that are negotiated between Pharmacy Benefit Managers (PBMs) and manufacturers in the Medicare Part D program, and according to the regulatory impact analysis in the proposed rule, would result in increased premiums, consumer cost-sharing, and higher federal subsidies for prescription drug coverage.[1]

We are concerned that it remains unclear how a new chargeback system would work and manufacturers have not committed to convert existing rebates into discounts that can be reflected at the pharmacy. Furthermore, plans lack the technical guidance on the operational and program issues that would be impacted by the rule, including benefit design, beneficiary marketing and enrollment materials, and Medicare Plan Finder (MPF) submissions. The SNP Alliance requests guidance from CMS on how bids should be submitted amid this uncertainty.

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[1] CMS. “Most Favored Nation (MFN) Model.” November 20, 2020. https://innovation.cms.gov/media/document/mfn-ifc-rule.
[1] Regulations.gov. “Fraud and Abuse: Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees.” Accessed November 24, 2020. https://beta.regulations.gov/document/HHSIG-2019-0001-0001.

1. Regulations.gov. "Fraud and Abuse: Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees." Accessed November 24, 2020. https://beta.regulations.gov/document/HHSIG-2019-0001-0001.

EXECUTIVE SUMMARY:

Inclusion of COVID-19 Costs:

SNP Alliance members serve a disproportionate number of complex, frail, institutionalized, dually eligible and ethnically diverse members compared to other MA plans. These are precisely the groups who have been most impacted by the COVID-19 pandemic. The SNP Alliance is concerned that processes necessary to gather accurate data used for payment and risk adjustment have been disrupted by COVID-19, undermining payment accuracy and leading to increased premiums, decreased benefits, and less innovation and care coordination that could improve health outcomes for beneficiaries. Analysis estimates that a decrease in risk scores of 4 to 6 percent would lead to significant cuts in supplemental benefits and reduced availability of $0 premium plans.[1,2]

The SNP Alliance recommends that CMS must accurately account for the costs of the pandemic by:

- Re-evaluating the accuracy of the FFS growth percentage in light of the pandemic.
- Requiring rate adjustments for COVID-19 costs imposed on FFS to carry through to MA.
- Including FFS costs that MA plans will be required to pay in 2022 such as vaccine administration, distribution and management costs, drugs, and treatment costs in benchmarks.
- Following a rebasing schedule for county FFS rates that is more closely aligned with the ACA minimum of once every three years.
- Providing additional detailed bid guidance from CMS on how MAOs should consider the cost of COVID-19 treatments and a potential vaccine in the bid submission process.
- Providing temporary MLR flexibilities including elimination of sanctions caused by unpredictable utilization due to the pandemic, allowing administrative costs for COVID related care including to non-providers to be counted in the numerator as quality improvement, including patient safety, adjusting MLR parameters for COVID, and eliminating double penalties for plans.
- Avoiding increases to the coding intensity adjustment and providing stakeholders with opportunity to comment on any proposed changes to the Coding Pattern Intensity Adjustment (CPIA). .
- Make adjustments to normalization factors to assure COVID-19 costs are fully recognized.
- Implementing encounter data as the diagnoses source for 2022 supplemented with diagnoses from Risk Adjustment Processing System (RAPS) inpatient records, while continuing to address specific improvements in encounter data processing as recommended below.
- Adding COVID-19 to an existing HCC in the risk adjustment model, while developing a standalone COVID-19 HCC.
- Considering two years of diagnoses data for non-curable chronic conditions.

[1] Avalere. "COVID-19 Pandemic May Reduce MA Risk Scores and Payments." November 5, 2020. https://avalere.com/insights/covid-19-pandemic-may-reduce-ma-risk-scores-and-payments.

[2] Avalere. "Impact of Lower Risk Scores on Availability of $0 Premium Medicare Advantage Plans and Supplemental Benefits." April 30, 2020.

- Extending deadlines for risk adjustment data submission by holding open the data collection for the 2020 final payment period until January 2022, instead of the typical timeframe of January 2021, to reduce the burden on providers working to stop the spread of this virus.
- Expanding how audio-only telehealth encounters can be received and eligible for risk adjustment.
- Working closely with stakeholders to stabilize costs and payments during the pandemic and subsequent post pandemic transitional periods.
- Revising the rate book based on costs for beneficiaries eligible for both Part A and Part B.

Additional detail on these and related recommendations is provided in the Advance Notice Part I and Advance Notice Part II, Attachment I. and II. sections below. COVID-19 will impact not only 2020 payments, but also payments for 2021 and beyond. To prevent disruption and loss of plan choices for beneficiaries, the SNP Alliance recommends that CMS work with SNPs and other MAO stakeholders to adapt the current payment process to enable accurate payments to continue over the course of the PHE and during the transitions required to return to normalcy thereafter.

Updates on Part C and D Star Ratings

The SNP Alliance urges CMS to signal its commitment in forthcoming rules or notices to recognizing the disparate and outsized impact of this pandemic on special populations—particularly low income people, those with high social risk factors, and populations of color—and to ensure that the Agency will examine this impact with analysis of the effect on quality measurement and performance evaluation under both Medicare and Medicaid programs. This is the time to support providers, plans, service organizations, and communities that explicitly reach out and serve these populations.

Quality measurement data collected from measurement years 2020 and 2021 should be carefully reviewed to determine if there were factors arising from the pandemic, outside of health plan control, that impacted measurement results and if special needs health plans and those with a high proportion of low-income, dually eligible, and disabled beneficiaries were particularly affected. In this spirit the SNP Alliance offers the following specific recommendations:

- Examine measure results to determine if there is outsize impact on the high DE/LIS/Disability plans.
- Suspend changes to HEDIS and CAHPS Star patient experience/access measure weight changes.
- Carefully examine cut points for each measure using 2020 and 2021 data and conduct peer grouping to separate results for high DE/LIS/Disabled plans from low DE/LIS/Disabled plans.
- Continue to improve the Categorical Adjustment Index.
- While we support vaccination for COVID-19 once the testing has shown the vaccine to be effective, floating this measure concept seems premature and should be reconsidered until additional information is available
- We do not recommend provider directory accuracy as a Star measure but are offering suggestions to better facilitate access to the right provider at the right time.
- Consider additional community/environmental factors in determining or extending criteria for "Extreme and Uncontrollable Circumstances".

More detail on these recommendations is provided in the Advance Notice Part II, Attachment IV. section below.

SNP ALLIANCE COMMENTS AND RECOMMENDATIONS:

Advance Notice Part I.

Introduction: Notice of a Potential Change in the Schedule for Publication of the Rate Announcement for CY 2022

***Overall Recommendation*:** The SNP Alliance appreciates the release of both parts of the Advance Notice for comment on this earlier schedule. We recommend that CMS release the Rate Announcement (or as much of it as is possible) in January as CMS has proposed and discussed. Given the urgent need for additional time to prepare bids because of uncertainties caused by the COVID pandemic, it would be particularly helpful to receive information such as bid pricing tools, worksheets and Out of Pocket Costs (OOPC) models as early as possible.

Advance Notice Part II.

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2022

2022 Growth Percentage Estimates

The SNP Alliance appreciates that the 2022 Fee-for-Service (FFS) proposed growth percentage of 4.52 percent is higher than the 3.64 percent rate finalized for 2021, however, we remain concerned about the need to ensure all FFS COVID-19 costs are included for application to MA rates. We provide additional recommendations and details further below.

Overall Recommendation: CMS should re-evaluate the accuracy of the FFS growth percentage in light of the pandemic. We are concerned the current estimate does not include adequate adjustments for the anticipated impact of COVID-19. We request that CMS provide greater transparency into the development of the FFS growth percentages for 2020, 2021, and 2022 to enable plans to understand assumptions and calculations leading to the estimate of the 2022 FFS growth percentage. To promote accuracy and transparency, CMS should provide more detailed information about the factors and assumptions CMS is using to calculate the growth percentages and confirm that the FFS growth percentage takes into account all COVID-19 related costs. We look forward to obtaining more information about the individual factors driving estimate changes and the assumptions used to calculate the growth percentages.

Recommendation: We request that CMS validate the accuracy of the FFS growth percentage and share additional information on the actuarial assumptions that underlie the calculation of the FFS growth percentage. We are concerned with CMS actuaries' assertion that "compared to the corresponding projections in the 2021 Rate Announcement, the current estimate of the non-ESRD FFS CY 2020 USPCC is down 12.1 percent. Most of the reduction is due to care that is projected to be forgone or deferred to CY 2021 due to the effects of the COVID-19 pandemic." The estimate is based on assumptions of

foregone care due to the effects of the pandemic, however the update is based on a lower observed and anticipated FFS utilization trend than MA experience.

Recommendation: We also request additional detail on the specific drivers of the FFS growth percentages and encourage CMS to include the full impact of COVID-19 costs to improve the accuracy of the FFS growth percentage and the stability of the program for MA beneficiaries. CMS should ensure the FFS growth percentages accounts for all COVID-19 related services, including the COVID-19 vaccine administration. Specifically, we request CMS consider the following points:

- We are concerned the 2022 FFS growth percentage is based on a FFS utilization trend that is lower than observed MA utilization trends. We ask CMS to provide additional detail on the underlying FFS utilization trend assumptions and consider an adjustment to reflect the impact of COVID-19 on FFS vs. MA utilization.

- SNPs have not had significant COVID-19 related declines in health care utilization. If CMS applies trend using 2020 or 2021 as the baseline year, this disparity between SNPs' and FFS delayed care could lead to inequitable rates. We recommend CMS analyze SNP utilization in 2020 and determine if it would be more equitable to use 2019 FFS data as the baseline year since it is not impacted by COVID-19.

- COVID-19 positivity rates continue to climb in many areas of the United States (U.S.) and the pandemic will extend into 2021. A recent Centers for Disease Control and Prevention (CDC) study estimates 40.9 percent of U.S. adults delayed medical care in 2020 due to concerns about contracting COVID-19.[3] Furthermore, the study revealed the prevalence of care avoidance was significantly higher for adults with two or more chronic conditions. Medical care avoidance could ultimately lead to an increase in costs due to pent-up demand, and subsequent rebound, of delayed care.

- There are currently several COVID-19 vaccine candidates in the testing phase of the Food and Drug Administration (FDA) authorization process. CMS shared the FFS growth percentage for 2020 assumes 52 percent of FFS beneficiaries will be utilizing the vaccine, there will be an average of 2 doses per utilizer and the average cost per dose will be $88. We request additional information on the assumptions, and the sources of data underlying the assumptions for the costs associated with the vaccine administration included in the 2022 FFS growth percentage. Given that the costs for the vaccine are uncertain, we are concerned that actual costs will be higher than projected costs without an appropriate adjustment to the benchmark, especially given the following:
    - Sixty-eight percent of Medicare beneficiaries received a flu vaccine dose in the 2018-2019 season [4]; and,
    - The CDC has included people over 65 years of age in its critical population targeted for initial vaccination.[5]

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3 Czeisler ME, Marynak K, Clarke KE, et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns – United States, June 2020. MMWR Mob Mortal Wkly Rep 2020;69:1250-1257. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a4.
4 MedPAC. "Medicare coverage for vaccines." September 4, 2020. http://medpac.gov/docs/default-source/meeting-materials/medpac_medicare_coverage_for_vaccines_sept_2020.pdf?sfvrsn=0.
5 CDC. "COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations." October 29, 2020. https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

- Data indicates beneficiaries who have recovered from COVID-19 have higher claim costs than those with no diagnosis. Although health experts have much to learn about the long-term impact of contracting COVID-19, evidence suggests an increased risk for respiratory, cardiac, neurological, and kidney problems. We ask CMS to share to what extent COVID-19's long-term health effects were included in the 2022 FFS growth estimate.

Attachment II. Changes in The Payment Methodology for Medicare Advantage and Pace for Cy 2022

Section A. MA Benchmark, Quality Bonus Payments, and Rebates

Applicable Amount

Comments: CMS intends to rebase the county FFS rates for 2022 using FFS claims data from 2015 through 2019 with all of the adjustments normally applied. CMS continues to rebase county FFS rates on an annual basis. We appreciate CMS' desire to ensure FFS rate accuracy, but we also note the importance of consistency and stability for Medicare plans and beneficiaries. As CMS is aware, rebasing every year can result in large year-to-year fluctuations in rates, which is challenging as Medicare plans try to maintain consistent plan design and benefits for enrollees.

We are particularly concerned about the potential for significant volatility if CMS rebases county FFS rates in 2022. Our members report their data has already shown the disproportionate impact of rebasing across different counties within a state. This effect could be exacerbated if counties also experience significantly different impacts from COVID-19. The combined effect of the pandemic and rebasing could lead to extreme disparities across counties.

In some cases the effect of rebasing county FFS rates nearly offsets the effect of the estimated growth rate. In these instances, plans struggle to maintain benefit stability. We anticipate that CMS does not intend this and so we urge the agency to develop a policy that restrains the impact of rebasing to ensure it does not offset the effect of the growth rate.

Recommendation*:* To help balance accuracy and stability, we suggest CMS follow a rebasing schedule for county FFS rates that is more closely aligned with the ACA minimum of once every three years. If CMS is unable to revise the rebasing schedule to once every three years, we recommend the agency at least pause rebasing for 2022 due to the potential large variations in counties' COVID-19 related costs. In addition, we ask CMS to consider limiting the impact of rebasing as it relates to the growth rate

Cap on Benchmarks

Recommendation*:* As we have in the past, the SNP Alliance urges CMS to use its administrative authority to lift the cap on benchmarks imposed by the ACA to ensure MA beneficiaries receive the full benefit of high Star Ratings. We appreciate CMS' acknowledgement of concerns previously raised by stakeholders regarding the cap on benchmarks imposed by the ACA. We note that this policy directly harms beneficiaries, particularly those enrolled in high-quality MA plans rated 4 Stars or higher. Because these plans may not receive the full Quality Bonus Payment (QBP) they have earned, enrollees do not receive supplemental benefits or lower cost sharing plans would have provided with those QBP dollars. We

encourage CMS to explore ways in which the agency can use its administrative authority, including its demonstration authority, to lift the benchmark cap.

Section B. Calculation of FFS Cost

Require Rate Adjustments for COVID-19 Costs Imposed on FFS to Carry Through to MA Rates

Overall Recommendation*:* We recommend that CMS reconsider their projections for 2022 in light of the recent and rapid increase in COVID-19 cases in order to ensure additional COVID-19 FFS costs for treatment and testing carry through to MA rates in 2022, and future rate setting processes. In addition, we request detailed bid guidance from CMS on how MAOs should consider the cost of COVID-19 treatments and a potential vaccine in the bid submission process. CMS has acknowledged that COVID-19 costs are not factored into 2021 MA rates. In addition, FFS payment increases mandated by Congress are increasing MA costs, but were not accounted for in payment benchmarks in 2021.

CMS is required by statute to account for mid-year changes in FFS benefits. If there is a national coverage determination or legislative change mid-year that will result in significant changes to costs for MAOs, and such costs were not incorporated into rates, then FFS must pay the additional costs until the end of the contract year, when they can be incorporated into rates.

MA payment benchmarks are set in each county as a percent of FFS costs. We share member concerns that MA rates will be inaccurate in 2022 due to COVID-19 payment increases that are not included in MA benchmarks. In addition, studies show COVID-19 testing, vaccines, and treatment are expected to cost billions every year.6 When MA payment rates are not aligned with FFS, payments are not actuarially equivalent, undermining access to affordable care for MA beneficiaries.

On May 11, 2020, CMS issued guidance that the agency will not reimburse MAOs for implementing a FFS payment increase though the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that increases the Inpatient Prospective Payment System weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the PHE. Given that many MA contracts tie reimbursement to FFS rates, and many MA plans must pay the increased FFS rate for both contracted, and non-contracted hospitals, CMS should account for the FFS payment increases in MA.

Section H. Medical Loss Ratio Credibility Adjustment

Comments: The SNP Alliance is concerned that the unstable health care utilization environment resulting from the COVID-19 PHE will make it difficult for some MA plans to meet the 2020 MLR thresholds, resulting in sanctions, prohibition on enrolling new enrollees, and contract terminations. This will mean fewer plan choices for beneficiaries and possible disruptions in care. The COVID-19 pandemic has resulted in deferred health care utilization including postponement of non-essential elective surgeries because of shelter in place and social distancing requirements as well as lower rates of preventive screenings. In the early days of the pandemic, beneficiaries were not seeing their doctors, however, in the latter half of 2020 health care utilization has started to increase. Yet with states

6 AHIP. "New Study: COVID-19 Testing Costs Could Reach $25 Billion a Year for Diagnostic, $19 Billion a Year for Antibody." June 10, 2020. https://www.ahip.org/new-study-covid-19-testing-costs.

implementing more restrictions due to the most recent spikes, utilization for the rest of the year is even more unpredictable.

While plans have shifted resources to improve beneficiaries' care under these unique circumstances, plans have limited levers to address this issue and new spikes in COVID at the end of 2020 are rapidly adding even more volatility that is outside of plans' control. To ensure stability in pricing and benefits for beneficiaries, it is necessary to modify MA MLR requirements to accommodate these unprecedented fluctuations in utilization.

Further, given the high proportion of SNP and MMP enrollment with social determinant of health risk issues, care complexity, and vulnerabilities to the effects of the pandemic, the resources these plans have expended to reach members and bridge gaps that occurred in care, services, support, and follow-up are substantial. As we head into the winter months and try to forecast how 2021 will unfold, the needs are likely to increase. Unfortunately, the challenges with reaching and providing services will increase as well.

In addition, the MLR threshold creates what is effectively a one-sided risk-corridor on underutilization, but does not protect against excessive losses; thus, making it riskier to keep premiums lower. Under §1135 of the Social Security Act, the Health and Human Services Secretary has the power during a PHE to modify Medicare requirements to increase access to health care items and services. In addition, CMS has the authority to interpret its regulations in a manner consistent with these policy imperatives, including what CMS views as quality improvement activities, including efforts to promote patient safety. To the extent that CMS believes it is necessary to amend its regulations to address these significant and legitimate concerns, as CMS is aware, it has the authority to waive notice and comment requirements in the public interest. Thus, outside of the PHE CMS could explore use of regulatory authority to address these issues. With volatility in the marketplace that could not have been foreseen, we encourage CMS to provide guidance and flexibility on sanction calculations in 2020 to avoid penalizing beneficiaries with fewer high-quality plan options. Specifically, we encourage CMS to provide the following flexibilities related to the MLR calculation during and immediately after the COVID-19 PHE.

Recommendations: The SNP Alliance makes the following specific recommendations for additional temporary flexibilities in the calculation of MLRs to address these unique PHE circumstances. Additional detail on each item is provided below:

- Waiving the 2020 MLR from all sanction calculations;
- Allowing pandemic response expenditures to count towards the MLR; and
- Providing flexibilities through adjustments to MLR calculations by aggregating contracts and expanding the credibility adjustment factors.
- Avoid double sanctions on plans

Waive the 2020 MLR from all sanction calculations. We request that CMS allow MAOs to continue to remit funds to CMS over the MLR threshold, while, waiving the 2020 MLR year from any and all sanction calculations. For example, if a contract was in a liability position in 2018 and 2019, we request that the contract not be placed in an enrollment sanction if the 2020 MLR is under 85 percent due to COVID-19. In addition, since 2020 may be the first year of liability for many plans, uncertainty in 2021 and 2022 could also lead to enrollment sanctions. This would negatively impact beneficiaries' access to high-quality, low-cost plans, and unduly penalize plans for the unprecedented impacts of the pandemic. Therefore, we encourage CMS to exclude 2020 from any retrospective or prospective MLR sanctions.

Allow pandemic response expenditures to count towards the MLR: We urgently request that CMS expand the policy allowing incurred claims in the MLR numerator to include amounts paid to non-medical providers. Allowing administrative expenses incurred as part of the health plan's response to the pandemic (e.g. connecting members to testing resources, or scaling up telehealth capacity to ensure members get what they need during the pandemic, resources expended to reach members and bridge gaps that occurred in care, services, support, and follow-up, and costs related to safety and prevention of spread) to be counted as an essential and inseparable incurred expense or Quality Improvement Expense would increase fairness in the MLR calculation for plans serving populations hardest hit by the pandemic.

Provide flexibilities through adjustments to MLR calculations: We also request that CMS provide plans the option to adjust MLR calculations by either:
Aggregating Contracts. Regional differences have had disparate impacts on beneficiaries and health plans across the country. CMS should allow health plan MLRs to be aggregated across contracts to address regional impacts of the PHE; or
Expanding the Credibility Adjustment. CMS should expand enrollment-based credibility adjustment factors to the MLR calculation to account for the uncertainty related to COVID-19 utilization. An industry-wide factor would provide flexibility, especially for smaller plans, given the volatility of current MLR calculations and acknowledge that the pandemic creates uncertainty at the population level.

Avoid double-penalizing plans: We are concerned that CMS could double penalize SNPs for challenges associated with the pandemic through MLR requirements, as well as through the application of the Past Performance methodology. In addition to the enrollment and contract termination sanctions if a SNP has an MLR that is less than 85 percent, CMS uses a Past Performance methodology to evaluate plan applications annually. If a plan receives compliance actions (including sanctions), that are not remedied during the review period, additional "negative Past Performance points" are awarded to the plan. If a plan's Past Performance points exceed established thresholds, the plan is deemed a negative Past Performance point outlier, and the contract faces additional enrollment sanctions. We encourage CMS to provide SNPs with the opportunity to demonstrate actions to address compliance issues before determining negative past performance points

Section L. Medicare Advantage Coding Pattern Intensity Adjustment (CPIA)

Overall Recommendation: The SNP Alliance supports maintaining the coding intensity adjustment at no more than the statutory minimum. Should CMS consider methodology changes, we recommend the agency avoid changes to its methodology until at least 2024, after providing a notice and comment opportunity for any contemplated changes, particularly given the challenges associated with capturing diagnosis data during the pandemic.

Recommendation: Maintain the statutory minimum adjustment for 2022. It is fundamentally incorrect to assume that any observed coding differentials between the FFS and MA populations are driven by inappropriate coding on the part of MA plans. CMS should take into account that differences in coding stem from the fact that FFS is unmanaged and under-coded, and that the differences actually demonstrate the value of MA plans in diagnosing and appropriately managing members' conditions.

CMS has acknowledged that value-based payment models are incentivizing the reporting of more complete diagnosis codes in FFS. Despite demonstrating superior, value-based outcomes, MA plans face a negative CPIA to bring payments in line with a FFS system that does not provide the same value to beneficiaries.[7, 8, 9, 10] We urge CMS to recognize that higher coding—in relation to the under-coding in FFS—does not equate to invalid coding.

Recommendation: Provide stakeholders with opportunity to comment on potential changes to the CPIA. The Advance Notice Part 2 press release stated that for 2023 and beyond, CMS is reassessing how to calculate the MA coding pattern and what the appropriate level of adjustment should be. While we appreciate this review, because it is likely the methodology used to calculate the CPIA should be updated due to flaws, and lower coding trends due to the pandemic should be accurately accounted for, we recommends CMS avoid potential changes to its methodology until at least 2024, after providing a comment opportunity and listening sessions, particularly given the challenges associated with capturing diagnosis data during the pandemic. We are concerned that the information provided in previous Advance Notices for contemplated CPIA methodology updates has been outdated, insufficient, or both and that plans need significantly more detail about any potential changes to the CPIA calculation in order to provide meaningful and accurate feedback to CMS. CMS last published its methodology for calculating the CPIA in the 2010 Advance Notice, released February 20, 2009. In the intervening eleven years, the Medicare program (both FFS and MA) has changed considerably. Changes in enrollment, demographics, standards of care, treatment patterns, payment policies, and even legislation must be considered in first determining the relevance of the CPIA and then, if appropriate, the level of the adjustment. If CMS considers updating this methodology, we urge CMS to keep the following questions and concerns in mind:

- On what data should the adjustment be based? That is, what cohorts of beneficiaries? What years should be considered?
- To what extent do changing MA enrollee patterns make prior year trends irrelevant?
- How should CMS control for the disproportionate geographic dispersion of MA versus FFS members?
- How will CMS account for the CPIA in conjunction with downward adjustments the agency already applies to MA plans including FFS normalization, HCC model recalibration, encounter data, the MLR requirement and Risk Adjustment Data Validation (RADV) audits?
- Should the CPIA be recalibrated along with risk model recalibrations?
- Will CMS consider the appropriateness of the CPIA prospectively, rather than just retrospectively?
- How do the FFS normalization factors interact with the CPIA?

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7 Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V. et al. "Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival." *American Journal of Managed Care* 23(2): e41-e49. February 2017. https://www.ajmc.com/view/value-based-contracting-innovated-medicare-advantage-healthcare-delivery-and-improved-survival.

8 Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. "Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service." *Health Affairs* 36(1): 91-100. January 2017. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1027.

9 Newhouse, Joseph P. and McGuire, Thomas G. "How Successful Is Medicare Advantage?" June 2014. http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12061/abstract.

10 Baicker, K., Chernew, M., and Robbins, J. "The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization." May 2013. http://www.nber.org/papers/w19070.

- What is the impact of ICD-10 coding on perceived differences in coding intensity between MA and FFS?
- How should enrollment in different plan types—general MA, SNPs, and Medicare-Medicaid Plans (MMPs)—be factored into determining a potential adjustment?
- Do state efforts to promote integrated between Medicare and Medicaid care have an impact? If so, how should state decisions regarding passive enrollment into Dual eligible-SNPs (D-SNPs) be factored into calculating the adjustment?
- What other elements not reflected in the historical FFS or MA data need to be adjusted before performing CPIA studies? For example, to what extent does $0 cost sharing for Medicare Supplement plans and dual eligibles distort comparisons between MA and FFS members?
- How will CMS review medical records (both MA and FFS) to determine the adjustment?
- Should the adjustment continue to be the same across the industry, specific to contracts, or specific to plans? How would CMS share that information with sponsors?
- Should risk score growth rates be considered a proxy for coding disparity? How will CMS' analyses evaluate whether differences in MA and FFS risk score growth rates are driven by demographics or morbidity?
- When the CPIA is no longer needed because the Part C risk adjustment model is calibrated based on MA plan data, how will the benchmark be calculated?

We look forward to CMS providing more information about how it intends to thoroughly review the necessity and appropriateness of a CPIA before proposing any changes to the calculation methodology.

Section M1. Normalization for the CMS-HCC Models:

Recommendation: SNP Alliance members are concerned that CMS is not adequately accounting for the impacts of COVID-19 on FFS risk scores in 2020. We ask CMS to make adjustments to the normalization factor to assure those added costs are accommodated and to provide more accuracy and predictability.

Section N. Sources of Diagnoses for Risk Score Calculation for CY 2022

Fully Implement Encounter Data as a Diagnosis Source for 2022

Comments: While we appreciate CMS' release of quarterly Encounter Data Report Cards, members have continued to raise operational issues with encounter data to CMS since 2016, and continue to see diagnosis information that would have been accepted by Risk Adjustment Processing System (RAPS) rejected by the encounter data system. Despite these operational issues, we are aware that blending two risk adjustment models and two diagnoses sources is challenging and burdensome for plans.

We encourage CMS to calculate 100 percent of risk scores using encounter data, FFS claims, and RAPS inpatient records in 2022. Capturing accurate encounters is critical to the stability and sustainability of the MA program and in particular to SNPs where plans serve disproportionate numbers of members with complex conditions and diagnoses which must be fully reflected in risk scores and payment sufficient to meet members' additional needs. Continuing to

Recommendation: The SNP Alliance supports CMS' transition to a risk adjustment system fully based on encounter data as a diagnosis source while continuing to utilize supplemental data from RAPs to calculate risk scores for payment in 2022. As they have been doing, CMS should continue to utilize RAPs

data to fill gaps in hospitalization data related to COVID-19. CMS should continue to work to ensure technical and operational issues are resolved, and that the data can be certified as complete and accurate to prevent surprise bills, benefit cuts, or premium increases for beneficiaries. CMS should involve SNPs and MA plans in developing robust and relevant data monitoring standards after the transition, while consulting plans to address operational concerns as they arise. In conjunction with this transition, we also support alignment of use with full implementation of the 2020 CMS-HCC risk adjustment model to calculate risk scores.

Recommendation: Assuming CMS adopts the full encounter data as the source for the source of diagnoses, the SNP Alliance encourages CMS to fully implement the 2020 CMS-HCC risk adjustment model in 2021. The utilization of different transition periods would introduce unnecessary operational complexities by expanding the number of data sources and calculations in the risk adjustment process. This could be largely eliminated by the complete transition of both the 2020 model and the use of encounter data as a diagnosis source in 2022.

The SNP Alliance supports member suggestions for addressing these challenges and increasing transparency including:

> ***Recommendation***: Include a diagnosis check in duplicate filtering logic: Plans continue to see duplicate rejections on items that have passed through claims validation. These items are appropriately paid and are not true duplicates or new day claims on previous submissions. However, due to a lack of diagnosis codes in CMS' duplicate logic, data is inappropriately rejected. For example, a provider may be submitting multiple bills for different services, but only one service is approved. To help resolve this issue, we ask CMS to include a diagnosis check in duplicate filtering logic. We also ask CMS to publish all front-end reference tables. It would be beneficial for SNPs to learn the specific reason information is rejected from the reference tables.
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> ***Recommendation:*** Remove hard rejection edits from situational data elements: We encourage CMS to remove hard rejection edits for situational data elements, and limit edits to required data elements. Currently, if a SNP sends a situational data element to CMS and it is wrong, the item or service is rejected. However, if the situational data element is not included, CMS will accept the item or service, creating a perverse incentive to submit less information. This modification would have a direct impact on completeness and revenue as situational data elements are not typically a requirement for claims adjudication logic and calculations. The following are two specific examples:
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> - The encounter will not fail if an incorrect facility type code (place of service) for ambulance transport information or certification is not present, but will fail if certification is present and the type code is not correct.
> - The encounter will not fail if the member's middle name is not present, but will fail if the format is not consistent with CMS rules.

Recommendation: Improve timely communication with stakeholders: We encourage more continuous communication between CMS and stakeholders on encounter data issues. Specifically, when an issue is identified, we request the issuance of a Health Plan Management System (HPMS) memo detailing the issue, as well as the plan and the timeline for remediating the issue. We also request greater responsiveness from the encounter data and risk adjustment mailboxes when stakeholders reach out with questions or concerns. When CMS answers questions, we encourage Q&A documents to be publicly disseminated in a timelier manner through the HPMS system, as the current 3 to 4 month lag can significantly impact MAO operations given that data issues can date back 2 to 3 years.

Recommendation: Establish milestones for successful implementation: We also recommend establishing milestones including the need for testing the filtering logic prior to bid submission and development of robust and relevant data monitoring standards. Establishment of milestones requires plan engagement and CMS transparency to successfully collect, process, and use encounter data for risk adjustment.

Accurately and Fully Account for the Impact of COVID-19 on Risk Adjustment

Overall Recommendations**:** The SNP Alliance is concerned that that without the ability to collect medical records delays in receipt of data, and due to fewer in-person provider visits, MA risk adjustment data will be incomplete and MA plans will be challenged to fully account for beneficiaries' health status and expected medical costs during the pandemic. In addition, emerging evidence indicates impacts of COVID-19 on beneficiaries' chronic conditions may lead to additional costs of care in future years. To address this challenge, we encourage CMS to adapt the current processes to enable accurate risk adjustment payments to continue.

Therefore, we recommend CMS:

- Use two years of diagnosis data for non-curable chronic conditions;
- Add COVID-19 to the risk adjustment model;
- Expand how telehealth diagnoses codes can be received; and
- Extend the deadlines for risk adjustment data submissions.

Additional detail on each of these requests is provided below:

Recommendation: Use two years of diagnosis data for non-curable condition**s**
PHE restrictions and concerns about contracting COVID-19 have made it challenging for some beneficiaries to obtain care in 2020. In addition, COVID-19 cases are currently surging in many states making it increasingly likely that medical services will continue to be delayed. To accurately account for beneficiaries' conditions we ask CMS to use two years of diagnosis data to identify beneficiaries' non-curable chronic conditions, supplementing missing diagnosis data due to the pandemic in 2020 with 2019 data, and accounting for missing diagnoses in 2020 and beyond due to COVID-19 related delays in care. Using two years of diagnosis data to identify non-curable conditions will dampen the impact of fewer opportunities for providers to code diagnosis due to the pandemic, leading to more accurate risk adjustment calculations.

Non-curable chronic conditions captured in 2019 should be acknowledged in CMS' risk adjustment methodology due to changes in health care utilization trends in 2020. FFS beneficiaries are also obtaining less in-office care in 2020 and the risk adjustment model is based on FFS costs, therefore allowing the use of two years of MA risk adjustment data better aligns the risk adjustment model data inputs and outputs. A 24-month look-back would better capture chronic condition disease burden during the pandemic than the current 12-month look-back period given that beneficiaries have been likely to access care in 2020.

We encourage CMS to leverage previously reported data from MAO's prior data collection that supports the diagnosis of chronic conditions that cannot be cured, as such chronic conditions are not, by their nature acute and will not change from year to year. Chronic conditions such as diabetes or amputeeism cannot be cured from one year to the next so it is logical to assume the beneficiary's condition is still present even if a provider was unable to confirm the diagnosis with an office visit in 2020.

Using two years of diagnosis to pull forward provider confirmed diagnosis of beneficiaries' non-curable chronic conditions will ensure payment accuracy for MA plans to target preventive and care coordination programs to beneficiaries who may be avoid provider's offices in 2020. We encourage CMS to enable a more fair and accurate capture of beneficiary morbidity during the pandemic.

Recommendation: Add COVID-19 to the risk adjustment model
As more becomes known about COVID-19, data indicates beneficiaries that contract the virus have longer hospital stays and higher mortality rates. According to the Centers for Disease Control and Prevention, people age 65 and older account for eight out of 10 COVID-19 deaths. While the lasting effects of the virus are unclear, emerging evidence indicates the impacts on beneficiaries' chronic conditions may lead to additional costs of care in future years. It is critical that the risk adjustment model accurately account for the immediate costs of COVID-19 care, and the long-term impacts of COVID-19 on beneficiary health. Members' internal data shows members with COVID-19 continue to have higher claim costs than members without COVID-19. We expect this to continue through the end of 2020 and into 2021 and beyond.

Therefore, we recommend CMS adding COVID-19 costs to an existing infectious disease HCC such as HCC6 for Opportunistic Infections to improve risk adjustment accuracy until data becomes available to develop a COVID-19 HCC that can be added to the MA model. We also encourage CMS to add COVID-19 to an existing HCC in the ESRD risk adjustment model. ESRD beneficiaries, particularly in urban settings, have had some of the highest hospitalization rates with greater disease severity in Black and Hispanic populations.[11]

For future years we encourage CMS to develop a COVID-19 HCC by studying the short-term and long-term costs associated with the condition, and enabling stakeholders to comment on how long the HCC should remain in the risk adjustment model. There is precedent for developing an HCC with limited data, such as when the cost of Sovaldi was added to the Part D risk adjustment model to treat hepatitis C. In addition, we encourage the use of more sources of data in the model such as home health and Skilled Nursing Facility (SNF) data to improve the accuracy of cost estimates associated with risk adjustable conditions.

Recommendation: Expand how telehealth diagnoses codes can be received
We encourage CMS to allow audio-only telehealth visits as valid encounters for the documentation of diagnosis codes used for the calculation of MA risk scores. Such guidance is consistent with CMS' decision to allow audio-only telehealth for 90 FFS services in this rule, and with the agencies' acknowledgment that telehealth encounters are providing access to care for many beneficiaries by substituting for face-to-face visits during the PHE.

The HPMS memo entitled, "Applicability of Diagnoses from Telehealth Services for Risk Adjustment," allowing MAOs to accept telemedicine visits as valid encounters for reporting diagnosis codes used for the calculation of risk scores has been extremely helpful. The policy change enables beneficiaries to follow social distancing guidelines and helps prevent the spread of the virus.[12]

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[11] Journal of American Board of Family Medicine. "The CMS COVID-19 Brief: Unsettling Racial and Ethnic Health Disparities." 2020. https://www.jabfm.org/sites/default/files/COVID_20-0450.pdf.
[12] CMS. "Applicability of diagnoses from telehealth services for risk adjustment." April 10, 2020. https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf.

In addition, we appreciate CMS' acknowledgement that the use of audio-only services is more prevalent among Medicare beneficiaries than previously considered. Audio-only services are serving as a replacement for care that would otherwise be reported as an in-person or telehealth visit, negatively impacting the accuracy of the risk adjustment methodology. Therefore, we ask the agency to expand the telehealth guidance to allow for the collection of diagnoses for risk adjustment purposes from audio-only encounters starting in calendar year 2020.

Many Medicare beneficiaries, particularly those populations most likely to enroll in SNPs, have challenges accessing video. In particular, we are concerned dually eligible beneficiaries often have multiple complex conditions, and are less likely to have access to video and audio technologies than other groups of MA beneficiaries, increasing the risk of complications if they contract COVID-19. We are also concerned that audio-only telehealth reimbursement in FFS has been expanded to 90 codes, and while MA is required to cover these telephone-only services, health plans can't use the information collected to document a diagnosis for MA risk adjustment purposes. Such a misalignment creates challenges for providers, beneficiaries, and CMS to sort out which encounters are audio-only, and how such encounters may be reimbursed.

We are concerned that risk scores will be understated if beneficiaries continue to avoid doctors' offices and cannot or do not utilize audio and video telehealth. We encourage CMS to ensure risk score accuracy and stability given concerns about the potential for deferred utilization in 2020 and increased utilization in 2021 and beyond. Due to the impact of the pandemic on how health care will be delivered going forward, we support permanently allowing audio-only encounters, where clinically appropriate, for the collection of MA diagnosis data for risk adjustment.

We understand that recent discussions with CMS may have indicated that the agency is considering allowing the capturing of audio-only diagnosis for the purposes of risk adjustment. However, we are concerned the guardrails CMS may be contemplating will be not be operationally feasible. Specifically, current data does not allow for the identification of diagnoses initiated by a patient, and there are many complexities associated with a potential lab test result list. Opportunities to comment on specific definitions, medical criteria, and operational issues associated with the potential guardrails are needed. We look forward to collaborating with CMS to ensure appropriate guardrails are in place to obtain audio-only risk adjustment data so plans can capture accurate diagnoses from beneficiaries during and after the PHE.

Finally, if the video requirement is maintained for telehealth encounters for risk adjustment, we encourage CMS to clarify if both the Place of Service (POS) 02 and the modifier 95 should be used to report a telehealth encounter accurately. The guidance stated diagnoses for risk adjustment payment from telehealth encounters can be submitted with either the POS 02 or the Current Procedural Terminology (CPT) telehealth modifier 95 with any POS. We are concerned the use of POS 02 alone is not restricted to audio-visual encounters, and could allow for the payment of audio-only encounters.

Recommendation: Extend the deadlines for risk adjustment data submissions
We appreciate that CMS expanded the risk adjustment submission window for 2019 dates of service through August of 2021. However, we recommend CMS hold open the 2020 final risk adjustment payment period until January 2022 because we are concerned that COVID-19 is preventing the collection of complete diagnosis data, and it may not be immediately clear which care and services can be attributed to the virus. Given the lag in data caused by the pandemic, we recommend the 2020 final

payment period be held open until January 2022, instead of the typical timeframe of January 2021, to reduce the burden on providers working to stop the spread of this virus.

In addition, we encourage CMS to delay submission deadlines for risk adjustment data. CMS should extend the deadline to submit RAPS and Encounter data for 2019 dates of service beyond January 2021. The timeframe for the deadline extension should be comparable to the timeframe in which COVID-19 will impact MA beneficiaries. Plans would appreciate the flexibility to redeploy resources to focus on urgent COVID-19 tasks and members' immediate health needs.

Calculating FFS Costs Using Only Enrollees in Medicare Part A and Part B

Comment: The current methodology for calculating MA benchmarks is actuarially inaccurate because it includes FFS beneficiaries who are not eligible to enroll in MA. MedPAC has raised concerns that Part A-only beneficiaries spend less than half on Part A than those with both Part A and Part B spend on Part A, and nationally the share of Part A-only beneficiaries is increasing.[13] As a result, the Commission has recommended CMS calculate the MA benchmarks based on FFS beneficiaries enrolled in both Parts A and Part B. We appreciate CMS' announcement that a request for information on this topic will be released soon. We will look forward to more accurate accounting of MA beneficiary costs in FFS benchmarks to fix the inaccurate calculation and improve plan resources to expand benefits, improve care, and lower costs for beneficiaries.

Recommendation: The SNP Alliance supports CMS' proposal to revise the MA ratebook so that benchmarks are based on beneficiaries with Part A and Part B instead of those with Part A or Part B as beneficiaries with only Part A tend to have lower costs, artificially reducing rates in many counties. As the number of beneficiaries with Part A-only grows, MA benchmarks have been artificially reduced in many counties, undermining plan resources to expand benefits, improve care, and lower costs for beneficiaries.

Attachment IV. Updates for Part C and D Star Ratings

MA Star Ratings

Overall Recommendation*:* Examine measure results to determine if there is outsize impact on the high DE/LIS/Disability plans.

The SNP Alliance urges CMS to signal its commitment in forthcoming rules or notices to recognizing the disparate and outsized impact of this pandemic on special populations—particularly low income people, those with high social risk factors, and populations of color—and to ensure that the Agency will examine this impact with analysis of the effect on quality measurement and performance evaluation under both Medicare and Medicaid programs. During this difficult time, we see that existing population health inequities are exponentially exacerbated and that the burden of this disease is disproportionately falling

13 MedPAC. "Medicare Advantage program: Status report." January 12, 2017. http://www.medpac.gov/docs/default-source/default-document-library/ma-jan-2017e31f10adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.

on populations of color and low-income individuals.[14],[15],[16],[17] This is the time to support providers, plans, service organizations, and communities that explicitly reach out and serve these populations. Quality measurement data collected from measurement years 2020 and 2021 should be carefully reviewed to determine if there were factors arising from the pandemic, outside of health plan control, that impacted measurement results and if special needs health plans and those with a high proportion of low-income, dually eligible, and disabled beneficiaries were particularly affected.

Specific Recommendations:

Measure Updates for 2022 Star Ratings - Changes to Existing Star Ratings Measures in 2022 and Future Years *(page 78)*

Recommendation: Suspend changes to HEDIS and CAHPS Star patient experience/access measure weight changes.

Given the multiple confounding variables in the measurement years of 2020 and expected for 2021, we recommend that CMS maintain the weight of 2 applied to the experience and access measures in the 2022 Star Ratings, delaying progression of these weights for two more years while the pandemic effects remain pervasive and to allow necessary examination of the measurement data to determine confounding variables arising from factors outside of health plan control. It would be prudent to carefully examine the CAHPS data that will be collected this year and next—and analyze for patterns based on individual characteristics, comparing these results to the data collected in years prior to COVID-19 pandemic from these same patient/member groups. It is reasonable to hypothesize that the pandemic has an effect and that the effect is different among different patient/member groups and across different geographic regions. Such analysis will be very important to inform decisions on use of HEDIS and CAHPS data—for comparison, quality improvement, reporting, and scoring.

Recommendation: Carefully examine cut points for each measure using 2020 and 2021 data and conduct peer grouping to separate results for high DE/LIS/Disabled plans from low DE/LIS/Disabled plans.

We are very concerned that the impact of the pandemic and public health emergency, with rising virus rates, hospital bed shortages, beleaguered healthcare workers, staff shortages, and PPE scarcity as well as reduction in transportation options, food insecurity, and impact on regular activities of daily living --is having substantial negative effect on special needs populations. Given their condition complexity and social risk factors coupled with access to care including screenings, follow-up care, mental health, physical health, behavioral health, and long term services and supports—there are many measures within the Part C and Part D Star Ratings which are likely to be impacted. This impact is likely to disproportionately affect the special needs populations. In addition, we know there is continued difficulty experienced by some providers in reaching their patients and getting them to agree to screenings, in transmitting timely data to plans, in providing access for chart reviews required by some

[14] Kaiser Family Foundation https://www.kff.org/report-section/racial-disparities-in-covid-19-key-findings-from-available-data-and-analysis-issue-brief/

[15] Centers for Disease Control and Prevention https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

[16] Emory University Health Equity Dashboard https://covid19.emory.edu/

[17] CNBC https://www.cnbc.com/2020/05/14/how-covid-19-exacerbated-americas-racial-health-disparities.html

of the measures, and in timely transfer of information from hospital to primary care provider for follow-up.

Given the high probability of these and other external factors influencing measurement results—we urge CMS to uphold the purpose and integrity of the quality measurement program by making additional adjustments to the system.

First, we ask CMS to conduct additional analysis of measurement results and determine high DE/LIS/Disabled plans are disproportionately impacted.

Second, we recommend that where measure results are shown to be impacted by external factors outside of health plan control due to effects of the PHE, the affected health plans are "held harmless." This would mean that the affected scores are not used in the Star ratings or that the health plan's prior measure scores are used from years not impacted by COVID-19. This would also help ensure fair access to quality bonus payments for these affected plans. It is very important, especially for low income, disabled, dually-eligible, and special needs populations, that plans are able to access the QBP for providing supplemental and enhanced benefits to beneficiaries.

Third, we must continue to state our concern with the use of the PCS and MCS generated from the Health Outcome Survey from data collected during 2020 or 2021. It is very likely that beneficiaries in special needs plans who already have high social risk and care complexity issues to report that their physical or mental health has declined during these difficult times. This measure is weighted a "3" and therefore has a substantial impact on overall Star rating scores. We feel that the integrity, accuracy and validity of the MA Stars rating results would be in jeopardy in using these measures from these two years. There are many confounding variables, they substantially introduce bias, and the data as well as the methods to correct for their influence are unknown.

Fourth, we suggest that CMS consider a grace period for compliance around health risk assessment in the SNP Care for Older Adult – Care Management Measure. While we appreciate CMS guidance allowing for face-to-face flexibilities related to the Model of Care (MOC), initial HRAs are still required to be completed 90 days from the effective date. Some of the disruptions in daily life have resulted in additional challenges trying to locate individuals within the 90-day initial HRA time period. We suggest that CMS consider adding an additional 60-day window to this initial measure.

Recommendation: Continue to improve the Categorical Adjustment Index.

We reiterate that the CAI was to be an interim strategy while CMS awaited more evidence about the link between social determinant of health risk factors and health outcomes. In surveying our members, we find that while some improvement can be seen as a result of the CAI as it incorporated more of the MA Star measures, the overall impact is still very limited. However, it is better than not having this adjustment, so we support maintaining it while a more robust method for recognizing the influence of social risk factors is being developed.

It has been a few years now since National Academies of Sciences, Engineering, and Medicine have issued their five reports. Similarly the Assistant Secretary for Planning and Evaluation report that examined Medicare Advantage quality measurement data was issued in 2016. Over the last five+ years, other studies have now definitively demonstrated the connection between SDOH and health outcome

measurement results. Therefore we look forward to further work to adjust the CAI or replace it. Toward this end, we specifically suggest that CMS consider:

> The deciles (for LIS/DE) and quintiles (Disability) have a wide range at the upper levels (e.g., L9 & 10 or L5) and a very narrow range at the lower levels (e.g., L 1, 2) which means that health plans with quite different proportions of persons with low-income status, disability status, or dually-eligible status can be in the same cohort grouping within the CAI levels. This heterogeneity introduces the potential that the combined CAI groups with designated coefficients do not adequately take into account differences within the plan CAI cohort group. We recommend that CMS conduct further analysis for these upper level ranges and determine how the CAI could be further adjusted. Findings should be transparent/reported.
>
> The CAI model used should be examined to determine if additional social risk factors can be incorporated into the model, since there has been progress in the collection and standardization of data on specific risk factors. Risk factors beyond DE, LI, and Disability are now routinely incorporated into predictive models. For the special needs populations, plans explain that the interaction between both social risk factors and the person's level of chronic care complexity, including the severity and number of conditions, behavioral/mental health conditions, and functional status and frailty—is very important. These additional characteristics could be tested separately and in combination. We understand that one goal is to ensure that characteristics that are present before the health care episode and are not under the control of the health plan are taken into account in the quality measurement and evaluation system. We would advise testing these variables for incorporation into the model or in another model to determine how it can improve the results.

Potential New Measure Concepts for Future Years *(page 85)*

Provider Directory Accuracy (Part C):

CMS has asked for comments on a potential new Star Ratings measure on provider directory accuracy.

Recommendation: We do not recommend this as a Star measure.
We appreciate the value of having accurate information in provider directories. However, the providers are the entities which need to be accountable for updating their own information. Reflecting on this 2020 year, for example, we have seen opening and closing of offices, switching addresses, phone numbers, and other changes. There have been changes in provider availability—at times positively, such as through the increase in telehealth; some of whom may be outside the plan's geographic area but are available given remote access technology. All of this means that information is constantly changing. It is nearly impossible for health plans to track all of these changes by providers. Therefore, we recommend three things:

1) Work with providers to require them to use an electronic registry or directory. Providers should be responsible for updating their own information. An electronic registry allows for more timely updates, provides a consumer portal for easy and guided access, increases the level of accuracy, and facilitates better consumer education or support by health plans as they facilitate access so that consumers can choose providers and access the care they need. This addresses the real purpose and goal – which is to facilitate access to the right provider at the right time. For

example, CMS could assist providers to use the National Plan and Provider Enumeration System (NPPES) to alleviate the provider burden of having to update their data across multiple plans.
2) Consider this as a compliance or administrative requirement. This is not a health plan quality measure.
3) Engage States, H.I.E.s, and health information technology experts so that there are consistent standards and universal interfaces that provide seamless and easy access to the information for all stakeholders—consumers, plans, providers, government agencies.

COVID-19 Vaccination (Part C)

CMS has requested comments on a potential new measure concept related to the COVID-19 vaccination for the 2023 Part C & D performance measure display page published in Fall 2022 on CMS.gov and for potential inclusion in the Star Ratings program, pending rulemaking.

Furthermore, the Agency notes that it plans to concurrently develop and test question(s) to add to the CAHPS survey administered in early 2022, similar to the flu vaccine. Such question(s) may ascertain whether a beneficiary received the COVID-19 vaccine during a specified timeframe (e.g., in 2021) to therefore measure the percent of beneficiaries who received the COVID-19 vaccine. Health plans play an important role to help educate and encourage their members to get the COVID-19 vaccine.

Recommendation: While we wholeheartedly support vaccination for COVID-19 once the testing has shown the vaccine to be effective, floating this measure concept seems premature and should be reconsidered until additional information is available. In considering what we know of the vaccine testing, it is not being conducted in some of the population groups that are most likely to be enrolled in special needs health plans—frail elderly persons or those with complex multiple chronic conditions, people with medical or behavioral health complexity where their condition is unstable, or where their treatments or medications require careful monitoring, titration, and symptom management. We expect it will be some time before the vaccine is fully tested so that we can all be sure it will not cause unintended harm in these populations.

In addition to this primary concern, we advise CMS to consider the distribution issues around the vaccine including the necessary production, storage, and administration issues that providers will face, the reality of consumer resistance to getting vaccinated if there are reports of adverse effects, and the possible exclusions that have not even been determined yet by scientists and physicians.

It is for these reasons we believe it is far too early to add a question to CAHPS for administration in early 2022, unless it is for information gathering about consumer attitudes toward a COVID-19 vaccine. That kind of information would help guide public health and medical professionals, clinics, hospitals, health plans, and government agencies to consider factors in building a public health promotion campaign to increase acceptance and build public understanding about the utility and effectiveness of the COVID-19 vaccine. These steps need to be taken before expecting health plans to convince individuals to get vaccinated and having these plans measured based on how consumers respond.

Extreme and Uncontrollable Circumstances Policy

Recommendation: Consider additional community/environmental factors in determining or extending criteria for "Extreme and Uncontrollable Circumstances"

Communities (regions and groups of people) are not impacted equally by COVID-19 nor by other societal and natural upheavals disrupting health care, daily life, and access to basic human necessities during this public health emergency. It is time to consider other community and environmental factors in determining what meets the definition of Extreme and Uncontrollable Circumstances" and how to evaluate when to end or extend this designation.

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,

Cheryl Phillips, M.D.
President and CEO
Special Needs Plan Alliance
Washington, DC.
cphillips@snpalliance.org
www.snpalliance.org