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RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

INTRODUCTION

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 25 health plans offering over 550 plan benefit packages (PBPs) and 175 contracts through special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs). These plans have over 3 million beneficiaries enrolled in 47 states and the District of Columbia—totaling more than 60% of the national SNP and MMP enrollment. Our primary goals are to improve the quality of service and care outcomes for complex populations and to advance integration for those dually eligible for Medicare and Medicaid.

The mission of the SNP Alliance is to improve the lives of adults with complex needs, including those with multiple chronic conditions, behavioral and functional support needs, and those with social risk factors. Our members serve some of the highest risk beneficiaries. Their members have significantly higher HCC risk scores and struggle with greater disparities and inequities than the average enrollee in Medicare Advantage. We applaud the focus CMS has made towards addressing Health Equity and Inclusion. Our comments within this letter will further expand on these principles and offer recommendations to improve both data capture and quality measurement.

While we appreciate the broad scope of the issues raised in this Advanced Notice, please note that in this letter we are only commenting on **Attachment IV. Updates for Part C and D Star Ratings** (p. 89-113) of the Advance Notice.

Overarching Comment on Part C & D Star Ratings

<u>Time for Overall Re-Examination on the MA Quality Measurement System</u> - We call on CMS to review the MA quality measurement system. It is a crucial time to analyze the methods, assumptions, variables, and prediction models in light of the impact of the pandemic. We believe that we are in a window of time (MY 2020, 2021, 2022) where the effects of the pandemic are impacting the foundational assumptions and structure of the MA quality measurement system. These were developed pre-pandemic. For the impacted measurement years, do these assumptions continue to be valid, reliable, accurate, and useful? Or have the changes in the environment and in people mean that CMS must temporarily modify the quality measurement in MA? COVID-19 has shone a glaring light on the impact of socio-economic and other disparities in the society. These effect all systems and institutions, people, providers, and the health care and social support systems.

CMS has an opportunity to re-examine and perhaps improve models, methods, and measures. This is the time if there ever was one.

<u>The Environment has Changed</u> – There is strong evidence that the healthcare environment has experienced substantial changes in capacity and in how/when people access providers. There is strong evidence that the pandemic has had unequal impact on segments of the US population. We see the real impact of complexity characteristics and social risk factors of the beneficiary which may not fully be appreciated in the current measure specifications or quality rating model. This particularly impacts individuals who are low income, disabled, dually-eligible, and who have high social determinant of health risk issues on top of medical, behavioral, and chronic conditions.

We are concerned that the underlying assumptions and coefficients in various predictive models are insufficient to fully address these patterns and this new environment. These inequities impact plans such as special needs health plans more profoundly than health plans that have a low rate of disabled/low-income/dually eligible individuals. The MA Quality Measurement system should not add to the inequities in resource allocation. If CMS remains committed to having only one set of measures, cut points, and ratings for all MA plans, then adjustments must be adequate to account for beneficiary characteristics and factors outside of plan control which impact measure results.

<u>Case Mix</u> - As part of the overall review, we ask that CMS examine the case mix adjustment methodology currently deployed in measure adjustment to determine if the SES and beneficiary-level variables and data currently used adequately capture the influence of important beneficiary characteristics impacting measure performance during the pandemic. There have been changes in care-seeking behavior and care-providing patterns by providers—these are now more fully documented.

Measure Specifications, Exclusions, Adjustments - We understand that this requires a measure-by-measure examination as well as attention to the scoring and aggregation. It is an undertaking—but so important to do. The pandemic has fundamentally changed peoples' lives and providers' way of offering care and treatment. Disparities have been exacerbated. There is unequal access to care including telehealth visits, preventive screenings, and diagnostic or treatment processes. Yet measurement specifications, models, and scoring methods have not changed. The MA quality measurement approach has not changed other than some measure exclusions, temporary holds, and a "best of measure" one-year temporary stay in MY 2020. This is insufficient to address continued changes observed in people and in providers and in communities in 2021 and now 2022. Such changes impact measure results which would be attributed to the health plan unless CMS implements additional adjustments.

Consider Complexity Characteristics - We urge CMS to focus on both complexity characteristics and social risk factors among beneficiaries, to analyze potential explanatory effect of additional variables to create more robust beneficiary-level profiles. This would have long-term value. We recommend including complexity of medical conditions/diagnoses, behavioral health conditions, functional limitations, frailty and social risk factors, the need for long-term services and supports, and neighborhood characteristics such as area deprivation at the 9-digit zip code unit.

Even if no measure-level specifications or methods are changed—please conduct the analysis and report results. This would offer the opportunity to see differences in contract enrollment profiles and examine differences in measure results. It would offer some information to assess if disparities are emanating from existing beneficiary characteristics and point out where providers, plans and beneficiaries are able to achieve better health outcomes despite these characteristics. We could use this information to work collaboratively with communities, providers, beneficiaries and other stakeholders toward improvement in care-seeking, care-providing, and in evaluating and reporting on results. We believe that information will help move us forward toward greater health equity.

Stakeholder Involvement, Education, and Transparency - Finally, we request that CMS hold a series of webinars and stakeholder calls on MA quality measurement in 2022 to answer questions and clarify the current requirements. We also ask that CMS update their website to clarify the Star Rating rules and provisions on at least a quarterly basis. There have been so many changes with notification in so many ways (memos, IFC, FR, PR, AN, etc.) and at so many times during the year that is it is hard to keep track of everything that health plans are supposed to attend to and remain up to date on current rules and regulations. It also would be preferrable to have rules issued through a formal rulemaking process with at least a 60-day comment period in order to provide sufficient time for analysis.

Reminders for 2023 Star Ratings (p. 89)

Summary of CMS statements - *CMS finalizes an increase in the weight of patient experience/complaints and access measures from 2 to 4 for the 2023 Star Ratings. The*

Rheumatoid Arthritis Management measure is removed. Part D Statin Use in persons with Diabetes is recategorized as a process measure with a weight of 1. Controlling Blood Pressure is moving off the Display page to 2023 Star Ratings with weight of 1 and then weight of 3.Guardrails are now applied for 2023.

SNP Alliance Comments:

<u>Measure Weights -</u> We strongly recommend CMS delay the proposed increase of measure weights for the patient experience/complaints and access measures. Our recommendation is due to the impact of COVID on access and on individual behaviors which would logically more profoundly impact persons who have many conditions and/or health risk issues (such as special needs plan enrollees and dually-eligible/disabled/low-income individuals). Since these individuals typically interact with many providers and settings within the healthcare, behavioral health, and long-term care systems in a given year, they have likely experienced more instances where provider access was limited.

In particular, we recommend the following measures stay a "2" in MY 2022 and 2023 as they relate to provider processes, systems, and actions which are not primarily under the control of the health plan—and, assuming no further drastic public health episode—will take at least a year to "get back to normal." These include:

- Getting needed care
- Getting appointments quickly
- Rating of health care quality
- Care Coordination

The following measures are more under the control of health plan actions. We would support a delay (for just one year in rise of weights for these measures) to let the effects of the virus subside. Thus, these measures would rise to a weight of 4 in MY 2023 rather than in MY 2022. Again, we hope that next year (MY 2023) will not be impacted by COVID-19 or a new public health threat disrupt communities, beneficiaries, and providers.

- Rating of health plan
- Complaints about the health plan
- Members choosing to leave the plan
- Plan makes timely decisions about appeals
- Reviewing appeals decisions
- Call Center – Foreign Language Interpreter and TTY

Additional considerations on these plan-related measures include:

- Some health plans have been harmed by complaints made in the measurement year (e.g., for health plan A) that were actually for another health plan (e.g., health plan B) with which the individual had experience prior to or following their enrollment in health plan A. In these cases, we ask that CMS allow for removal of the complaint—or re-assigning it to the health plan in keeping with the beneficiary intent.
- Some health plans have informed us that they do not own their own TTY service, but contract for that service. At times, that service provider equipment has not worked properly and the health plan is not aware of the problem or the vendor/service indicates they are working on restoring the TTY service, but there is an unavoidable delay in getting the necessary supplies/equipment/labor. We ask for CMS to consider some way of recognizing these situations.

Guardrails - We request that CMS publish analysis of the 2021 measurement data that would provide insight on the effect of applying the Tukey method and the guardrails. We understand that the Tukey method is based on the assumption that the distribution of measure results is a normal, bell-shaped curve. Is this still so? A scatter plot would be helpful.

We are unsure about the effect of applying guardrails during these anomalous years (2020, 2021, and 2022) with the pandemic effects still apparent. Has CMS determined that the underlying assumptions are still sound, and that the method does not cause unintended harm to certain plans (such as SNPs)? Will the method result in equitable and fair scoring such that plans with high DE/LIS/Disabled populations are not harmed? Or will it exacerbate disparities?

We would appreciate modeling and publication of those results to ensure that plans with high-risk populations are not unduly impacted. For example, if measure cut points are set at the levels observed last year (in 2021) with all of the additional exclusions and exceptions that CMS made due to the effect of COVID-b 19, will the 2022 cut points then be artificially high –compared to the 2023 measure results? Will this have the result that many fewer plans can reach the 4, 4.5, or 5 star thresh holds? Are plans with a high proportion of DE/LIS/Disabled enrollment more affected by this application of guardrails during these anomalous years? We request that CMS provide more information in order to properly educate stakeholders and to avoid unintended harm.

Measure Updates for 2023 Star Ratings (p. 90)

SNP Alliance Comments: Categorical Adjustment Index (CAI)- We have several requests:

1. Review methodology - First, similar to our comment on the need for measure-level review of models and assumptions, we request that CMS review the CAI case mix adjustment methodology including the variables in the model to determine if the model adequately captures the influence of beneficiary characteristics impacting measure

performance during the pandemic. We believe the environment has caused substantial changes in care seeking and care providing patterns which are outside of the health plan control. This particularly impacts individuals who are low income, disabled, dually-eligible, and who have high social determinant of health risk issues and complexity characteristics. The model may need refinement to incorporate these new patterns.

2. <u>Consider effects of wider variation in many measures with heavier impact on LIS/DE</u>. - In trying to assess measure level changes, we've reviewed the CAI variation charts across MA and PDP contracts. We compared the 2023 variation chart and the 2021 variation charts to try to understand changes that may be due to pandemic related issues. We found a wider range and higher standard deviation in many measures indicating more variation in 2023 than in 2021. Some measures showed quite a bit of change in variation and mean, such as Colorectal Cancer Screening, Annual Flu Vaccine, Osteoporosis Management in Women who had a Fracture, Improving Bladder Control and Medication Reconciliation Post Discharge. The poorer performance on the LIS/DE side may be due, in part, on the external changes impacting access and behavior.

3. <u>Request for Decile Table Ranges be Reconsidered at Levels 9 and 10</u> – Please consider adjusting the Categorical Adjustment Index DE/LIS decile table ranges at levels 9 and 10. We believe that the decile tables cut-offs regarding DE/LIS are unnecessarily narrow at the top tier therefore blunting the potential benefit of the CAI as a whole. We request that CMS modify the level ranges slightly to include more plans in level 10. Currently level 9 pertains to contracts with 77.133401% to less than 100% LIS/DE. The upper range of level 9 should be reduced to 98%. Thus, plans with above 98% to 100% would be included in level 10. This would capture contracts that serve <u>only dually eligible individuals</u> such as FIDE-SNPs, but where there are circumstances where a few beneficiaries have temporary changes to their dual status due to changes on the Medicaid side or other administrative reasons. Has CMS reviewed such cases? If the level 9 and 10 LIS/DE ranges were adjusted, what kind of effect would that have?

4. <u>Add the 3 SNP Measures to the CAI</u> – We ask CMS to consider adding the three measures that are currently SNP-specific (SNP Care Management, Care for Older Adults – Medication Review, and Care for Older Adults – Pain Assessment to the Categorical Adjustment Index on a permanent basis. These measures pertain to high-risk older adults. CAI is intended to help address inequities in the measurement system that inadvertently harm plans serving primarily beneficiaries with high social risk. It seems these three measures are tailor-made for inclusion. They take a lot of effort and focus on important issues for older adults –regardless of what plan type the person is in.

5. <u>Add other measures into the CAI for 2023</u> - Additional measures that we ask CMS to consider including in the 2023 CAI are: "Members Choosing to Leave the Plan," and "Complaints about the Health Plan." There is some evidence that dually eligible beneficiaries have had more challenges during these last two years in navigating across the Medicare and Medicaid programs to try to access care. Home care services and clinic services have been curtailed and dually eligible individuals are more often impacted by the lack of capacity and challenges with access. These individuals may attribute these challenges to the health plan.

6. <u>Study Impact of CAI</u> - Finally, we would support a study of the impact and results of the CAI by independent researchers to ascertain whether the methodology is having the impact/effect that Congress intended. There are now seven years of data—which should provide ample information to determine the impact and inform Congress and other stakeholders where further refinements are needed.

Our goal in making these recommendations is to enhance the utility of the CAI. We understand that Congress intended SES/SDOH factors and effect be recognized—that these factors have been rigorously shown to impact quality measure results under Medicare. We understand that the CAI is supposed to be the way that CMS recognizes high social risk populations in the quality measurement system to ensure that there is not a punitive effect on plans that serve a high proportion of such individuals. We urge re-evaluation of the CAI overall --since it was to be an interim strategy when it began seven years ago. Until there is a replacement to CAI, we hope these modest adjustments will be made and recommend that study of the impact be done and published to inform stakeholders and Congress about whether the methods has achieved the stated objectives.

Extreme and Uncontrollable Circumstances Policy (p. 94) - *CMS proposes to amend § 422.166(i) to specifically address the 2023 Star Ratings, for measures derived from the 2021 HOS survey only, by adding § 422.166(i)(12) to remove the 60 percent rule for affected contracts. CMS proposes to include three remained HOS-derived measures:*

- *Monitoring Physical Activity*
- *Reducing the Risk of Falling*
- *Improving Bladder Control*

SNP Alliance Comments:

SNPA is concerned that the current methods and policies around Extreme and Uncontrollable Circumstances needs to be examined. We are concerned that the methods are inadequate to deal with the effects of the pandemic on people, providers, and communities. There are significant and substantial changes in the environment. This is changing many aspects of care in unpredictable and uneven ways. The patterns of care, and the abilities of people and providers to

address regular monitoring of chronic conditions and/or patient education or prevention have changed. This especially pertains to measures focused on disease screening (e.g., breast cancer, colorectal cancer), and items such as improving bladder control, or identifying/educating about risk of falling.

Do not Support Use of HOS During this Time – For these reasons, we cannot support this proposal to remove the 60 percent rule and include these three HOS measures in 2023 Stars. We cannot support the use of the HOS instrument and methods during the measurement years of 2020, 2021 and 2022 as the impact of the pandemic continues. We believe use of the HOS is ill-advised at this time.

The virus and mutations remain present in communities and the impact on healthcare, social service, mental health and other providers in the measurement year has been profoundly negative. This has affected the ability of providers to conduct screening, communicate directly with their patients, and has impacted beneficiaries' experience of care. Such external environmental factors have a direct effect on the self-report of the beneficiary around issues such as in these three HOS-derived measures. In some areas within the measurement year, providers were closed, then there were extended wait times for screening appointments; clinic and diagnostic visits were extremely limited.

Special needs populations are particularly impacted. Individuals, particularly those with complex conditions and high vulnerability to the COVID-19 virus continue to experience difficulties in reaching their providers other than for specific acute symptoms or treatment related to their diseases. Providers have not been able to fully address or coach patients on prevention activities. We are therefore concerned that data collected during these years from the self-report HOS to generate measures may indicate changes in provider practice or beneficiary behavior (e.g., reluctance to go into an office and inability to access telehealth given lack of technology) rather than health plan actions. In addition, survey response rates may not be representative of the enrolled membership in the plan.

Instead, we encourage CMS to remove HOS-generated measures *temporarily* from Stars for the 2023 Star Ratings calculations and instead present them as Display only. In this way the information can be compared to previous years to determine if the patterns are anomalous, and further action can be taken to restore the accuracy and validity of the measures.

 Additional Comments on Stars 2023

The SNP Alliance also strongly recommends CMS take additional action around quality measure adjustment for Stars 2023. We've already recommended examination by CMS with

outside experts around the MA quality measurement system and the methodology, predictive models, and assumptions to see if these need to be adjusted.

Since time is short for 2023 Stars, we've been searching for additional options that offer relief but retain some utility for performance review. We believe this is a time to separate out the plans with the highest proportion of individuals who have been most severely affected by COVID-19, pandemic disruption in care, and community impact and make a temporary adjustment. We call this a "high impact plans interim strategy."

High Impact Plans Proposed Interim Strategy - In outlining an interim strategy, we have worked to balance the need for some kind of adjustment with the need for administrative consistency, and therefore offer this one strategy with five steps. No new data collection would be needed. CMS already also uses the methods for aggregating measure results and calculating five Star-levels. We do not propose any change to these methods. We are requesting only that the highest impact plans be separated out for 2023 and that these plans receive a separate set of cut point thresh holds with the option to be scored with peers and also to be held harmless in the Star ratings for this one year. We believe this would offer some relief to the hardest hit plans. Our assumptions would need to be verified by CMS. CMS could use data from last year's measure results to model this approach. It does not seem like a substantial lift, but we do not know all of the details involved or methodological issues might arise.

We these caveats, we offer a recommendation which recognizes "High Impact Plans." The six steps for CMS are outlined as follows:

First, *temporarily return the measure weights to pre-pandemic levels* for all measures and for all health plans, since the pandemic continued its impact on all communities in 2021 and is still doing so in 2022. This helps even out some substantial measure weight changes that were made before the pandemic had occurred and before such dramatic impact had occurred in so many communities. This will help avoid huge swings in measurement scores that would arise from administrative weight (coefficient) changes by CMS rather than actual changes in quality. We believe the doubling of weights could have a particular hard impact on plans serving the most vulnerable.

Second, *separate out the measure into two plan cohorts*. Plan Cohort 1 would be comprised of plans with DE/LIS/Disabled in Levels 1-7 of the CAI decile tables and Levels 1-3 in the CAI Disabled tables. Results from all high-dual and high-disabled plans –those at Levels 8, 9, and 10 in the CAI decile table and those at Level 4 in the CAI quartile table would make up Plan Cohort

Third, *calculate the cut point thresh holds for Cohort 1 and Cohort 2*. Inform plans in either cohort of the resulting cut point thresholds for each measure in each cohort.

Fourth, *apply the cut points and calculate Star ratings* for each Cohort, and provide opportunity for plan review as usual.

Fifth, *allow the high impact plans (Cohort 2) to be held harmless*—that is, if they would have achieved a higher Star rating through the general MA cohort, they could remain in this general cohort.

Finally, note the "High Impact Plans" (Cohort 2) with *a new icon on the Medicare Plan Finder* indicating the characteristics of the enrolled population served within these plans and indicate where these plans achieved higher than average Star ratings (more than 3.0 within this Cohort), despite the impact of the pandemic and the challenges faced by individuals within these plans.

We offer this as an interim step toward greater recognition and attention to plans with a high proportion of the DE/LIS/Disabled population. We think this information would be valuable for many stakeholders including these plans, their beneficiaries, providers, state agencies, advocates, measure developers, and researchers. This would advance other work, such as on person-reported outcome measure development, social risk screening and targeting resources, and quality improvement collaborative efforts for special populations.

Changes to Existing Star Ratings Measures in 2023 and Future Years

Complaints about the Health Plan (p. 97) - *CMS is proposing to add a marketing misrepresentation component in the measure specification.*
SNP Alliance Comments: We support CMS including a marketing misrepresentation component in this measure. We are observing marketing tactics which are confusing, especially to dually-eligible individuals. Many industry experts and advocates are discussing the potentially adverse practices and misleading marketing materials. This harms beneficiaries through misinformation and erodes trust in health plans overall. This is damaging to the industry as well as to the consumer.

In addition, we recommend that CMS develop more consumer-facing information materials, checklists, and FAQs to guide individuals, advocates, volunteer counselors who assist older adults in selecting an appropriate plan, and others to increase the chance that the beneficiary gets the information they need and does not inadvertently enroll in a plan where they expect a benefit but are unlikely to receive. This guidance coming from CMS would be very helpful as a trusted source. We believe that marketing and communication experts with experience in working with older adults and with persons in Medicaid could provide valuable advice on using images and graphics so that the information is more accessible and understood by beneficiaries with varying levels of health literacy. Focus groups of the intended audiences are usually very revealing and can be useful in such design and communication efforts. This would help the consumer and the

advisors understand how to assess differences in the proliferating number of plan options they have.

Medication Adherence for DM for HTN (Part D) (p. 98) *CMS is testing risk adjustment for SES or SDS of medication adherence measures.*
SNP Alliance Comments: We support CMS on this work. In fact, we have been asking for this kind of adjustment for some Part C measures and would be interested in what CMS learns and how this can be applied to other measures. We recommend that CMS model Part C measurement adjustment and attend to SDS and SES characteristics that impact outcome on measures. In addition to capturing beneficiary-level SDS characteristics of DE/LIS/Disabled status, we recommend CMS consider frailty and functional status characteristics. We applaud work to stratify the measures by beneficiary-level characteristics to identify disparities and help all stakeholders understand how the member/patient population mix is affecting measure rates. This is an important step forward. We would also endorse additional modeling and testing of this approach with transparency and thoroughly reporting all findings.

Colorectal Cancer Screening (Part C) p. 100) - *CMS is proposing to add a rate for persons age 45-49.*
SNP Alliance Comments: We support this; keeping consistent with medical practice and clinical guidelines.

Statin Therapy for Patients with CV Conditions (Part C) (p. 100) – *NCQA is considering an exclusion for individuals who cannot tolerate statins.*
SNP Alliance Comments: We support this work in keeping with medical practice and clinical guidelines and to recognize patient characteristics impacting treatment.

Breast Cancer Screening (Part C) (p. 100) - *CMS indicates that NCQA is proposing to remove the administrative reporting method and transition to ECDS for MY 2023.*
SNP Alliance Comments: Based on remarks about the readiness in the field, we cannot support this. The data are not sufficiently available. Providers and health plans need more time to put processes and infrastructure in place to support ECDS reporting for BCS. We suggest a hybrid for at least another two years, using administrative and ECDS data while CPT or other coding is developed/revised and to allow some providers to further develop their capability to capture and report electronic clinical data for BCS.

Cross-Cutting: Frailty & Advanced Illness Exclusions (Part C) (p. 100) – *CMS indicates that NCQA is considering narrowing the Frailty Value set to reduce over-identification. They are also considering whether more than one code would be necessary. If they proceed, this would be applied for MY 2023 and Stars 2025.*
SNP Alliance Comments: We do not agree with this proposed reduction—narrowing of the Frailty Value Set or requiring two codes. In fact, we believe quite the opposite should occur.

There are not enough providers currently capturing frailty codes and indicators. Making it more difficult on providers to have to seek out particular codes or indicators will have a dampening effect on discovering and recognizing people who are frail. Frailty is an under-recognized condition. Perhaps because it most often exhibits in older adults and indicates an age bias in our systems?

We recommend that CMS take the alternative approach and work with others to highlight the importance of recognizing frailty factors. These characteristics impact treatment, care plans, service approaches, and how to assess outcomes. We request that CMS focus on ways to better, and more comprehensively capture frailty. Some of the SNP Alliance members have done work in this area to incorporate attention to frailty and guide care planning. Please re-consider the importance of this issue.

In addition, we believe that this would be considered a substantive change. As such, this would need to proceed through a rulemaking process. NCQA needs to provide more information about what they are proposing to be eliminated or narrowed. Such action could have substantial impact, and—as we have pointed out—could result in less attention to frailty issues. This runs counter to the direction we believe care should be heading.

Diabetes Care Measures (Part C) (p. 100) – *CMS indicates that NCQA is considering new measures on eye exams and controlling blood sugar and exploring if they can use ECD and incorporate information from CGM and GMI.*
SNP Alliance Comments: We have discussed this with subject matter experts who are concerned about this and would prefer measures remain unchanged. Providers and plans working with people with Diabetes explain that often these individuals do not believe their eyesight will be affected until it is late in the disease process. Individuals may not prioritize getting eye exams, particularly in light of other conditions they believe are more serious. In addition, subject matter experts explain that COVID has an additional negative effect on beneficiary behavior. One plan with a quality improvement effort explained that they are working with providers to increase the acceptability of a Diabetic Eye Exam to the individual—and are making progress. However, this organization recommends that NCQA not change the measure until the impact of the pandemic further recedes. They recommend including clinical experts (ophthalmologists and endocrinologists) and beneficiaries to comment on Diabetes measures.

Controlling Blood Pressure (Part C) (p. 100) – *CMS intends to transition CBP off the Display page to 2023 Star Ratings with weight of 1 and then moving thereafter to a weight of 3.*

SNP Alliance Comments: We recommend that CMS provide more information to guide how clinicians should utilize ECD on BP readings and how BP control will be determined before proceeding. We have heard providers and plans voice the following questions:

- Is this to be an average of readings over time?
- How frequent should the readings occur?

- Will patient self-report be acceptable when they use a home device?
- How will the patients report? When?
- How will the clinician determine that the BP pressure cuff is properly calibrated?

We also are reminded by geriatricians that managing BP tightly can run counter to what is most beneficial for the frail older individual or others who have additional medical complexity. We recommend further consultation with clinical experts to guide measure exclusions and specification changes so that there is not unintended harm.

<u>Care for Older Adults (Part C)</u> (p. 101) - *Currently COA includes three indicators – Medication Review, Functional Status Assessment, and Pain Assessment. CMS indicates that NCQA is conducting an environmental scan and exploring the evidence to determine if updates are needed to the three indicators. They are also considering the feasibility of digital formats.*

SNP Alliance Comments: We have canvassed members. They appreciate NCQA's plan to conduct an environmental scan. They also strongly recommend that NCQA and CMS attend to the who/what/when/why/how of these assessments. They describe a variety of settings and providers who conduct these assessments and where they are captured and how the data is stored. We've heard from subject matter experts that in many cases there is not a digitization of functional assessment data, and likewise they find variable capacity/capability and formats among providers for where pain and medication review assessment data is housed. They strongly urge attention to the feasibility issue—there needs to be extensive improvement in electronic record systems to "go digital." For the foreseeable future, multiple formats will need to be acceptable to accurately capture the work that is going on in the field in functional status assessment, pain assessment, and medication review.

Display Measures

<u>Cardiac Rehab (Part C)</u> (p. 102)– *CMS is considering posting the HEDIS Cardiac Rehab measure on the 2023 Display page (4 rates are reported) – and including this in Star Ratings in the future.*
SNP Alliance Comments: We have discussed this with plans. Those who have worked on this measure in cardiac rehab explain that it does not have high rates of compliance, in part due to post-cardiac surgical patients' avoidance or non-adherence. There is some research around patient-identified barriers to complying with recommended cardiac rehab programs. There is some research suggesting that there is weak evidence that interventions to increase cardiac rehab compliance are effective. There is a study on patient satisfaction as an indicator of quality which was also associated with marginally better compliance with cardiac-rehab programs. The evidence suggests that this measure may need more work and additional exploration about what drives compliance. If there is not clarity on how health plans can improve adherence to cardiac rehabilitation the measure may not be a ready candidate for inclusion as a Star measure in the MA Star Ratings.

Physical Functioning ADL (Part C) (p. 102) – *CMS explains that this is a longitudinal measure derived from HOS and has been on the Display page for 2021 and 2022. There are two physical functioning questions (limitations in moderate activities and in climbing stairs) with 6 ADLs. Baseline is compared to responses two years later (as in the MCS and PCS measures). CMS states that most commenters requested additional information before the PFADL measure is added to Stars. Some commenters recommended additional testing on SDOH risk issues and segmenting by age. CMS is exploring adjusting the PFADL measure for certain respondent characteristics not under health plan control, such as age, education, gender. They said they also explored "living alone" as another variable but did not see an impact on scores. They are asking for feedback. CMS is also exploring other HOS-derived longitudinal measures, such as the % of members with a BMI of 30 or greater, the % reporting 14 or more Mentally Unhealthy Days. They are asking for feedback.*

SNP Alliance Comments: We believe this is ill-advised. SNPA continues to advocate for improvements to the HOS instrument and methods (wording of questions/items, survey methods, sampling methods, linguistic and ethnic accommodation/tailoring of the items). Creating new measures when the limitations persist may deepen the inequities and biases in applying the measures and using them in Stars. Therefore, we recommend further refinement of the instrument to ensure the items are appropriate and meaningful for the intended respondent.

Until the HOS instrument and methods are improved, we do not recommend it as the source document for longitudinal measures. When the characteristics of the population are so diverse and the samples so variable—this raises many questions. We are concerned that there is not adequate information to validate predictive models needed to support a longitudinal design--to ensure that measure results from a sample of people can be compared to a subset of the sample two years later, and that results from different plans with different enrollment characteristics can be compared to each other in a quality measurement system. There are too many confounding variables that are not in the predictive model.

Additional Comments around HOS

Additional Case Mix Variables **-** We are encouraged that CMS recognizes additional characteristics should be taken into account to adjust the results prior to determining a score. In addition to segmenting by age, education, and gender, we would add disability status, income status, and living in a poor neighborhood as variables to consider. Those who live in neighborhoods that are considered deprived (unsafe, lacking in green spaces, inadequate grocery stores or other amenities to support healthy living)—will have a harder time maintaining physical functioning. These environmental deprivations also add to poorer mental health status. We suggest adding cognitive impairment   to this list—as individuals who do not have sufficient cognitive capacity for planning and executive decision-making may not be able to follow through with movement/physical activity recommendations by providers.

Social Isolation - We are also surprised to hear that CMS found no impact on scores for people living alone. We question this result—was there sufficient size in the sample? Were there confounding variables—such as the presence of a regular caregiver? Did this vary by age? We have observed that in persons age 80+, particularly among those with multiple chronic conditions, living alone is associated with poorer health, greater depression, and decreased functional status. We ask CMS to take another look at the impact of social isolation. We suggest re-testing with an alternative statistical equation or revised model. This might indicate insufficient data or missing variables rather than a lack of association between isolation and physical activity, mental health, or physical health status.

BMI, Unhealthy Days - Regarding proposed new measures such BMI or mentally unhealthy days, we believe these are useful focus areas, but do not agree that HOS should be the source of the data.

Health Equity Lens - Lastly, we urge CMS to take a look at the use of HOS from a health equity lens. Has the instrument been adequately tested in diverse populations? Do the methods accommodate low- income people with social risk factors? Does the language, culture, health beliefs, race or ethnicity of the respondent impact results? How? We believe it is time to re-examine HOS through the health equity lens.

<u>Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment (part C)</u> – (p. 103) *NCQA is updating the measure to change from "member-based" to "episode-based" and is lengthening the SUD history to 194 days to limit the #of individuals who are receiving ongoing treatment from being counted in the denominator. They are also: removing ED visits and medically managed withdrawal services from negative SUD history, removing the requirement that a psychosocial treatment encounter accompany pharmacotherapy, splitting the age stratification to 18-64 and 65+and updating the name of the measure to "Initiation and Engagement of Substance Use Disorder Treatment"*

SNP Alliance Comments: We were not able to discuss this with substance abuse treatment experts. We would advise NCQA/CMS to get the input from these clinicians and, equally important, from people who have had SUD and publish their findings. What helps these individuals engage and maintain treatment? What do addiction disorder providers describe as barriers to initiation and engagement of this treatment? What would they recommend should be modified regarding this measure? We also wonder what role they would say that health plans can play in encouraging people to seek treatment. Since personal decision-making is so important in the activity being measured, conducting this effort would inform all stakeholders as well as guide improvement in the measure.

<u>Stratified Reporting (Part C and D)</u> (p. 105)– *CMS is considering expanding their efforts to report differences in contract performance on additional Star Rating measures for subgroups of beneficiaries with social risk factors (SRFs), including providing stratified reporting by disability, LIS, and DE status.*

SNP Alliance Comments: Yes, this is a good step. The SNP Alliance has been calling for stratified reporting for years. We strongly support having this information with stratification by disability, LIS, and dual eligible status. This will be important to understand where to target efforts in quality improvement and reducing health disparities. We see this as providing information that will also help guide efforts to advance health equity goals. We support providing stratified data in public reports as well, as long as the information is clear and can be easily understood/interpreted.

Health Equity Index (Part C and D) (p. 106) – *CMS is developing a health equity index as a methodological enhancement to the Star Ratings that summarizes contract performance among those with SRFs across multiple measures into a single score. Disability and LIS/DE status would be included in the health equity score. CMS is considering other variables as well, such as the Area Deprivation Index. The goal is to improve health equity by providing incentives for plans (contracts) to perform well for socially-at-risk beneficiaries. The Health Equity Index would look at a subset of the Star Rating measures, such as measures included in CAI and CAHPS measures. The distribution of performance for each measure would be separated into thirds and the top third would receive 1 point, the middle, 0, and the bottom -1. More detail is provided, such as replacement of the current reward factor with this new HE index.*

SNP Alliance Comments: The SNP Alliance strongly supports health equity goals. We support development of a health equity index and approach. We see a connection between better understanding of social risk factors (and complexity characteristics) of an individual and understanding what barriers the person has to achieving optimal health. From an individual level understanding, this can inform macro-level change—to move toward achieving better health equity at a population level. Special needs plans report many collaborative efforts with others in their communities to address deficits in housing, food, and other services.

We offer the following considerations as CMS works to establish standardized social risk factor screening and set up a way to benchmark and evaluate. We encourage attention to current SRF screening and collaborative efforts. We are committed to use of accurate and timely information to guide care and evaluation of care including achievement of health equity. Here are several considerations we identified in considering social risk screening and health equity evaluation:

- Consider Top Risk Factors and Characteristics to Stratify Populations for Examination
- Support Work Underway (avoid unintended harm to existing efforts to address HE)
- Utilize Information from Validated Screenings/Assessments Already in Place
- Allow Multiple Sources of SRF and Complexity Data
- Cross-walk and Harmonize Data Sources for Equivalency
- Determine Exclusions or Adjustments Needed

- Test, Develop Methods for Evaluation or Benchmarking that are Fair, Equitable, and do not cause Unintended Harm

Regarding the Health Equity Index (HEI) outlined in the Advance Notice, we have several questions and additional thoughts for consideration. While we support the work and the development of an HEI, we would appreciate CMs providing additional information to guide analysis of the methods and potential impact/utility. We would like to understand the methodology better toward the development of this Health Equity Index. It would help if CMS could provide an illustration of how this would work and what measures could be included.

One concern is that the measure methodology (the variables within the model and the categorization of plans based on characteristics and proportion of enrollment) would not be sensitive enough to accurately assess plan performance nor divide/stratify the plans.

A second concern is around which measures are chosen. We recommend that CMS begin with the measures most directly under health plan control and test out the methodology. These could include:
- Rating of health plan
- Complaints about the health plan
- Members choosing to leave the plan

A third concern is around combining measure results into a single score – composite scores have the disadvantage of washing out high and low values or otherwise muddying clarity. Therefore, we lose key information around actual performance on each measure for the socially at-risk or other beneficiary groups. We don't think this is advisable.

An alternative approach would be to categorize the health plan contracts based on enrollment characteristics (stratify into plan cohorts), apply the model with the chosen variables, and then look at each of the selected measures separately. The set of measures included would be those most directly under the control of a health plans (such as those listed above)—at least to start. This information would be provided to each plan so that they would see the variation in performance, by measure.

In this approach there would be two groups of plans (high dual/LIS/disabled and low dual/LIS/Disabled). Each of these two cohort plan groups would only be compared with other like plans. (Plans with a high proportion such as 50% or more of DE/LIS/disabled individuals would only be compared with each other plans in that same cohort in terms of Health Equity).

The measure results could then be combined into a single score as proposed, and the proposed distribution/ranking/HE index score methodology be applied. There would be two HE cohorts –

with the top, middle, and lowest thirds and the positive or negative points applied as suggested.

In this way plans with a high proportion of individuals with high SRFs are compared to each other. This could provide a good starting point and a foundation on which to build. The information could inform CMS for the next phase of development of the HE index model and guide decision-making around potential inclusion of additional measures.

<u>Measure of Contracts' Assessment of Beneficiary Needs (Part C)</u> (p. 107) – *CMS is considering a performance measure that assesses whether a contract's enrollees have had their health-related social needs assessed using a standardized screening tool (AHC screening tool is mentioned).*
SNP Alliance Comments: The SNP Alliance has long called for recognition of social determinant of health characteristics which predominate in special needs populations. We support this with modifications.

We offer several recommendations and considerations that we hope will improve utility and advance the stated goals.

Consistent Screening for All Beneficiaries, Particularly Dually-Eligible Individuals - There is an extremely robust body of evidence indicating that social risk factors impact health and health outcomes across all population groups, and that people who are dually-eligible are especially at risk. We believe it is crucial that social risk screening be done for <u>all</u> beneficiaries, particularly dually-eligible individuals, at least once a year, whether they were enrolled in a general Medicare Advantage plan, SNP, or in Traditional Medicare. This foundational for understanding individuals and for building better systems of care and support—all beneficiaries in these programs may have hidden risk factors that we hope they will share with providers in the course of their health and social support care-seeking.

We'd recommend that CMS work to incorporate social risk factor (SRF) screening consistently across the Medicare and Medicaid programs.

Additional Risk Factors Are Very Important – In this and other rules, CMS is proposing enhanced social risk factor screening, on housing instability, food insecurity and transportation barriers. Based on working with special needs populations we recommend additional risk factors be included in this effort. Additional assessment around factors such as functional status, frailty, spoken language, and health literacy as these characteristics strongly impact both beneficiary behavior and care/treatment approaches. Moreover, the risk of social isolation has been reported as one of the most critical issues facing special populations.

Relationship between SRF Screening and HE - Social risk screening and Health Equity need to be considered together. Understanding a person's social risk and complexity of care factors, such

as functional status, frailty, health literacy, helps providers and plans understand some of the barriers to health for that person. Some of the barriers are in the environment. Some are related to service access or quality that providers and plans can work together to address. Social risk factors and barriers at the individual level are likely also key impediments to achieving health equity at a population level. Social risk screening and follow up may not get us all the way to achieving health equity at the population level, but it is an important step.

Need to Utilize Data from Many Sources - We recommend that CMS work with stakeholders to harmonize and standardize SRF data obtained from many sources--so that where-ever and when-ever the individual beneficiary chooses to answer SDOH/social risk factor questions, there will be a standard way to score/interpret the information and capture/transfer this to an electronic record. Again, understanding a person's social risk factors helps understand some of the barriers to health for that person. Such barriers are also likely some of the impediments to achieving health equity at a population level.

Requiring a Standard Tool or Standardizing Information? - Over the last decade there have been efforts to develop, test, and use SDOH screening and assessment tools in all settings (including the AHC tool referenced). These efforts and the SDOH information generated have been welcomed by SNPs and MMPs. Many good tools, processes, and scoring algorithms have been developed. We have seen their use in clinics, FQHCs, social service agencies, care management programs, counties, government agencies, and other settings including by health plans—by physicians/primary care providers, care coordinators, county case workers, community health workers, and other disciplines. This work needs to continue and should be supported.

CMS is proposing to require three SRF items to be included on the HRA in their Proposed Rule issued in January 2022 to be applied to D-SNPs and this Advance Notice indicates NCQA is also developing a SRF measure for these areas. While we support standardization of SRF data, we believe requiring the use of one tool and focusing only on the HRA as the instrument and only on health plan as the screener will miss many opportunities to understand the beneficiary's risk issues and therefore will have limited impact. Utilizing multiple sources and creating a crosswalk from various data sources to a common standardized scale might be preferred if the goal is to have a timely and accurate picture of social risk factor vulnerabilities.

The SNP Alliance supports standardizing the scoring/scaling for key social risk areas and this direction by CMS. We do not know if the AHC screening items on housing, food, and transportation are widely used by providers or plans. We do know that providers and plans, as well as others, such as nonprofit advocacy or community organizations, counties, Medicaid agency case managers, are also conducting social risk screening.

CMS is encouraged to work with stakeholders to harmonize and standardize data obtained. This may be on top of a standardized HRA that plans administer once a year.

We have several recommendations along this line to improve the utility, feasibility, and accuracy of this effort:

1) Recognize the top risk factors experienced by dually-eligible individuals. Based on those enrolled in special needs plans, these top risk factors are: (*1*) *social isolation, (2) food insecurity*, and (*3*) *housing instability* (transportation is not ranked by SNPs we've surveyed as in the top three)

2) *Support the work already being done*—screenings, assessments, scoring, processes—are often already being done to obtain SDOH risk factor information directly from the beneficiary. We recommend using what is already collected and captured in a data set in a standardized way, and that providers, state or county agencies or others who work with the beneficiary must provide these data to the health plan (under Medicare and Medicaid, particularly for dually-eligible beneficiaries).

3) Recognize multiple sources of SDOH information, not only that which is collected from an HRA once a year; *allow these sources to populate that portion of the HRA* when the information is still timely/relevant/recent.

4) Develop a *sound methodology for cross-walking and harmonizing SDOH risk factor information* for each target item (e.g., housing instability, food insecurity, social isolation, etc.) across the frequently used validated instruments to allow for a consistent risk factor score/scale

5) Consider when/if there need to be *exclusions or adjustments*, such as if a person permanently resides in a nursing facility—the risk factors of housing and food insecurity may not be applicable.

Each one of these points is discussed in more detail to provide CMS with additional information and analysis from special needs health plans. We've worked to organize our comments to offer important and practical considerations to increase the utility and value around stated goals.

Top SDOH risk factors in the SNP and MMP populations –We've surveyed SNP and MMP members for five+ years on the many sources for SDOH information that they use to better understand these risk factors facing each member. These plans already use multiple sources, starting with the member (usually in conversation with their care manager, community health worker, primary care provider, or other regular social services provider). NOTE: *The HRA is not the primary source of SDOH information, nor should it be.*

As observed and reported by the care manager and clinical services teams as well as outreach specialists, the SDOH ranked priorities (in addition to addressing poverty) are: (1) social isolation, (2) food insecurity, and (3) housing instability. Transportation has not been as high on the list of observed needs/risk areas--perhaps because many SNPs provide transportation as a supplemental benefit, knowing that their members need access to transportation for medical appointments, and key daily living needs, such as getting food.

Allow Multiple Sources - We recommend that health plans be able to receive SDOH information from multiple sources and then crosswalk this to the standardized items preferred by CMS and use this information to populate the HRA. We do not believe requiring the use of one instrument at one time of administration by a health plan designee will recognize all of the important work and current sources, people, and timing for when SDOH items are queried.

SNPs already mine the following data sources for SDOH information:
- Care management interactions, care management records
- ICD-10 z codes
- Member surveys
- Member services contacts (phone and other communication)
- Provider records/EMR or EHRs
- Enrollment forms
- HRA
- Claims data
- Encounter data
- MLTSS or State Medicaid data - For fully integrated plans where the state provides that information

This information comes from a variety of individuals who work with the member, and in the form of electronic data, manual records, and also may be generated from A.I. algorithms that are based on patterns of access, use, and other behavior by the member. The beneficiary is the primary source of data on SDOH. These other sources listed can provide "early warning signals" for the provider or plan to act earlier than might occur if waiting for an annual HRA to be completed. These multiple data sources are used for outreach, member support, care management, interdisciplinary teams, individualized care planning, service provision, treatment, and other purposes.

For example, if a dually-eligible person is receiving SNAP benefits to address food insecurity and is nearing the date when that person needs to re-apply, the care manager working with the individual may receive an alert one month early to ensure that the application is completed and submitted in time. This helps avoid a gap of weeks or months where the individual no longer has food assistance. In this example, the care management system is the SDOH risk factor data source—and the plan can use the information already collected to address this risk area. With all

of the work put in place already by systems, providers, advocates, government agencies, and others, we assume CMS does not want to dismantle or supersede these efforts.

<u>Support SDOH Pathways and Validated Screening/Assessments Already in Place and Recognize the Beneficiary Preferred Contact</u> –
Consider the Beneficiary –The beneficiary may be willing to report on their SDOH risk factors to a trusted provider, case worker, or other person who is involved in their care and have this information be included /considered in the Interdisciplinary Care Team communication, and incorporated into care planning, care management, and service provision. This would not rely on a once-a-year HRA process to obtain this SDOH information for health plans to be compliant. If the information from the member to a trusted provider would be acceptable to be transmitted to the health plan, then the health plan would be able to use this in HRA, ICP, ICT and other care coordination and outreach efforts.

An important consideration is that of burden and burnout on individuals who may be asked these SDOH questions multiple times. These types of questions are often seen as private/intimate questions, and the person who has the greatest trust of the person is often the best person to ask the questions. Timing is important as well. The HRA is conducted one time a year and many people choose not to participate or are hard to reach—this is not the primary source of SDOH information used by health plans anyway. We would recommend that CMS recognize and support ways to populate standard SDOH items that would be incorporated into the HRA and other key elements of care, but not require one tool at one time.

<u>Data Standardization</u> - One consistently identified challenge reported by SNPs and MMPs is that there is no standardization in SDOH data definitions or harmonizing in scaling/scoring between instruments. To address this one can either require a specific instrument across all settings and providers as well as health plans (e.g. AHC) or allow for multiple instruments where items and scoring are cross-walked to create a universal scale. This is an important decision to be made around HOW to standardize data elements and items/scales to arrive at a comparable scoring method.

Standardizing after data collection using multiple sources would recognize and support the use of SDOH risk information already collected and will further the stated CMS objective: "*having a more complete picture of the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence,* " and also to*: "facilitate better data exchange . . .as well as facilitate the care management requirements."*

<u>Cross-walk Methodology and Harmonize SDOH Sources for Equivalency</u> - We recommend that CMS work with experts to conduct a cross-walk of the chosen SDOH risk factor items from validated instruments and then create an acceptable equivalence to harmonize, calibrate and connect the items, scaling, scores, and findings from the various instruments to one standardized

universal scale for each SDOH risk item. This can be done. The process would require experts in survey design, quality measurement, SDOH risk areas, health I.T., and providers, plans, government agencies and consumer stakeholders. This effort is fundamental. Many have called for this work to happen; the time is right.

HHS/CMS would serve in a leadership role to ensure the crosswalk meets acceptable scientific standards has the appropriate testing among various population groups and can produce results that are usable. In this way multiple instruments would be the source of information that populates the SDOH items in a profile of the member (which could be then included in the HRA). It would be used to populate part of the HRA as long as the information was collected according to some parameters (e.g., directly from the member within the last year or specified time period) as an alternative to asking the individual directly again. In other words, if they've answered these SDOH items, that information would populate these items on the HRA.

With more data sources and disciplines involved—the individual beneficiary's response and information collected has exponentially greater utility. With this information harmonized using the universal scale, it can be used by the provider, plan, social service and support agencies—those who have a relationship with the individual in care planning, treatment, service provision, and coordination. Important information already being collected would not be lost or discounted, and this would reduce beneficiary refusal and burden.

AHC Screening Tool - If CMS choses to go ahead with the AHC assessment tool and the requirement to focus on the three risk factors and use the items as they are now in the AHC tool, we have the following questions:

1. Will all MA plans (not only SNPs) be required to perform annual screening through an HRA?

2. Would the standardized questions be required at the initial, reassessment, and transition HRAs?

3. Would responses by the individual where a need is found then trigger specific action within a specific time period by a specific entity (such as referral to a county case worker to respond and assist with rental assistance)? Who will decide what action is necessary? Who/when is action/follow-up documented?

4. Have the AHC questions and scoring been tested with diverse population groups to ensure there is adequate understanding such as with persons having significant cognitive

limitations or linguistically/ethnically diverse communities? Can this information be shared?

5. Are there considerations around accommodation, translation, or method/format changes needed to reach diverse individuals and gather the information in an appropriate manner? We are thinking of the diverse populations—ethnically, racially, linguistically, culturally—served by SNPs and would appreciate insights on how these groups have responded to the AHC screening questions and follow-up.

6. If an individual refuses to complete the HRA, but this information is gathered in other ways, can the health plan continue to utilize these other sources to comply with the spirit of the intent? How can this be demonstrated?

7. Will CMS be developing a standardized set of items for all HRA questions, not just the social risk factor questions? (currently there is not a standardized set of items or scale)

8. Are there exclusions (for example, Nursing Home Residents) - We appreciate the importance of focusing on specific social risk areas and support this work. However, the housing, food, and transportation needs of people permanently residing in nursing facilities are already addressed. Would these questions be relevant for these individuals? There may be other important characteristics to consider as the measure is developed— such as contraindications, attention to beneficiary refusal and beneficiary rights/consent, and exclusions.

The improvement in consistent SRF screening, use of SRF data already collected, engagement of the person being screened, and aggregation of information to guide measurement are all steps that will be needed and capacity that must be built. We strongly support this work. These are building blocks for addressing health disparities and improving health equity.

Therefore, we encourage the efforts around SRF screening and Health Equity improvement and evaluation to be synchronized and aligned. Social risk screening, stakeholder outreach and engagement, measure development, and performance evaluation should be seen as components of a system to support health and health equity improvement.

In closing, we understand that CMS will be exploring with stakeholders the utility and feasibility of social risk screening. We hope that there is interest in the harmonization and universal scale for the chosen SDOH risk areas. We hope the agency will be open to the use of multiple instruments and reporters and recognize existing work that has been done to incorporate SDOH

attention into care planning documents, EHRs, outreach and service records, and other databases. We applaud CMS' commitment to working toward having standardized data around SDOH risk factors. We stand ready to assist in any way we can.

<u>Screening and Referral to Services for Social Needs (Part C)</u> (p. 108)*– NCQA is developing a new measure for MY 2023 that assesses screening for unmet food, housing, and transportation needs. The measure would be collected through ECDS.*

SNP Alliance Comments: We have discussed our recommendations for screening above. With regard to examining referral to services as a part of this measure, we support the concept and the intent, but have many questions. We focus on people who are dually-eligible, as that is primarily who SNPs serve.

We assume that the proposed measure would be a requirement for all MA plans, whether or not they are SNPs. It seems particularly important for dually-eligible beneficiaries who receive Medicare and Medicaid (medical, behavioral health, and long-term services and supports) to have social risk screening conducted.

A few of our questions in considering this measure concept are:
1. Are Medicare-covered and Medicaid providers able and willing to share their social risk screening data?

2. If the health plan conducts such screening, for example through case management or a once-a-year Health Risk Assessment, would this screening and referral to services duplicate what is already being done in the community and by many providers and agencies?

3. Who/how will the efforts be coordinated if more than one entity screens and refers? How will the health plan know?

4. Will health plans be able to use multiple sources of information on who/when/how screening happened and what the referral/follow-up was?

5. How will community-based programs that are not paid by Medicare participate in this?

6. Will community-based agencies, counties, and other screening entities be required to report their screening and follow-up to the individual's health plan? Who will enforce this? How will these entities know what health plan the individual is in?

As discussed above, there are many potential avenues and individuals who conduct social risk screening and assessments of beneficiaries—each person and setting and format has its purpose which we assume NCQA would support.

The person who has the greatest trust of the beneficiary and interacts with the beneficiary around care, services, and treatment goals, is usually the person who is best positioned to ask social determinant of health risk issues and evaluate how much the person is impacted and how fast the individual wants or needs attention/intervention. The risk screening may indicate need for immediate action (e.g., person in crisis – 48-hour window to respond), short-term action (e.g., within the month) or longer-term action (part of a goal that the individual needs help to reach, e.g., within the year).

As this discussion suggest, it is unlikely that screening done once a year by the health plan (usually a person unfamiliar to the beneficiary) such as through an HRA would reveal much information beyond what is likely already known to service providers, direct-care workers, and clinicians.

We therefore assume that the focus is on what is under the health plan's control, such as a once a year HRA. If a beneficiary agrees to be screened by a health plan representative, the resulting information might have a short "shelf life" and, more importantly, may be duplicative of existing screening information. The health plan could make a referral to community services and supports based on the screening result, but this might duplicate current efforts and service requests. We see the need for coordination here.

We are not sure of the utility of this—more information is needed. It seems more important to know who conducted the screening (if the person gives the plan permission to know this) and what services were provided as follow-up—but this often crosses into the domain of Medicaid and of non-funded providers who are not under Medicare funding. This would include organizations such as food banks, shelters, faith communities.

We can see value of having the person share social risk information with a trusted person and get response. There may be opportunities within the health plan's care management system, such as with SNPs that serve exclusively dually eligible people and have the Medicare and Medicaid funding and have set up a trusted relationship with the beneficiary. We know that SNPs have employed or delegated care managers under contract and they do conduct screenings and provide referrals as part of their ongoing work with the beneficiary. For the most at-risk individuals, this already being done by SNPs. Thinking about dually eligible individuals, we believe that most states include social risk factor screening as part of their eligibility processes under Medicaid. Perhaps the state can share the results with health plans on their SRF assessments and what they determined should be services provided.

It seems that an important focus would be on coordinating efforts and sharing information (with permission of the beneficiary) across the Medicaid agency, and Medicare service providers—so that these would be sources of risk screening data accessible to the health plan.

In closing, we are proud of the work that many of our special needs health plan members have already done to focus on SDOH/social risk factors and to develop their approaches to reach people where they are, help modify their circumstances and lessen the impact of SDOH risk factors and serve them with care. We reflect on the RAND report contracted by CMS where researchers examined best practices in top quality rated health plans for addressing social determinants of health among dually-eligible beneficiaries. The case studies featured were all special needs plans and all members of the SNP Alliance (see: RAND-CMS 2018). These plans are leaders; their work provides an example for others.

Value-based Care (Part C) (p. 108) – *CMS is proposing a measure concept and measure development on how MA organizations are driving quality and transforming care through their value-based care arrangements with providers. They want feedback on how to structure a measure.*

SNP Alliance Comments: In the time provided for analysis, we received some feedback on this concept. The primary response is that value-based contracts and these arrangements are not a key driver on quality or transformation of care. It is a motivation, for sure on avoiding financial risk and/or gaining a financial reward.

We have a number of considerations to offer based on our discussions in considering this measurement concept:
- Acceptance of VB arrangements and ability of the providers to enter into such arrangements varies quite a bit across various regions of the country
- Smaller providers cannot take on as much risk. This does not mean they don't offer real value. This may be especially relevant/valuable as they provide care in rural areas where providers are few and far between.
- A health plan may have a strong provider network providing excellent care, but very little value-based contracts—what does this mean for "rating" the health plan?
- Larger provider systems or groups with more extensive resources and capacity, such as more sophisticated data systems, a larger outreach and patient engagement staff complement, greater data analytics ability and sophistication—these providers have a greater opportunity to "compete" for VB care arrangements. However, plans also include providers in their network who may not have these resources—but are good providers and popular with their patients. Should plans

favor the larger providers because they can take on risk and offer more complete data tracking?

- Since contracts may be proprietary with providers, we assume that in this VB measure, the plan would indicate the proportion of their contracts that are fully or partially VB, but not the details, nor specific provider names. Would this information be useful in some way?
- Another consideration is that these contracts may extend more than one year—it can take more than one year to produce value or change health outcomes, particularly in a complex, multi-morbid population with high SRFs. We assume that any information about performance would be over more than a single calendar year. How will this sync with the yearly Star rating timeframe?
- We wonder how specific the plan could be on performance. Would the plan report what proportion of its providers with VB arrangements "met" or "did not meet" the terms of the contract around quality or other performance indicators? Would this be useful or sufficient for rating a plan?

We know that CMS and other stakeholders recognize that realizing financial gain and improving quality of care are not synonymous. Quality measurement, even with case mix adjustment methods we have, is still limited in the ability to differentiate among providers. The measures and methods are not as sophisticated as we would all like them to be. Therefore, we see a focus on specific diseases, screenings, or treatment follow-up or self-reports on satisfaction with the provider—because that's where the measure development and testing has occurred.

Comparing measure results across providers may indicate superior quality in comparison—and this is important--but it may not. The measures we have may not fully or accurately assess performance or the "value" of care from the beneficiaries' perspective.

Even self-report measures such those derived from CAHPS focus on a limited scope of interactions—primarily with medical care providers. In CAHPS, there is no contextual understanding of the response by the person—it is not available. Items asked of the respondent, such as length of waiting room times, and ease of getting an appointment with a doctor may be heavily influenced by the number of people seeking care and other capacity issues including closed offices. Lacking wifi/broadband and access to technology by some beneficiaries are other realities restricting access—the pandemic has certainly showed us that.

Then there is the issue of attribution in analyzing the response given on some CAHPS items. For example, asking a person to rate "all of health care" is a tough question to answer if the person has several medical specialists, a behavioral health counselor, and receives in home long-term services such as a personal care assistant (which they see as a "health care" provider). When they

respond to this question positively or negatively, we don't know why. Who performed well? Who did not? Who added value? Who did not? This information is lost.

Focusing on SNPs - We note that special needs plans especially C-SNPs, have unique specialty groups (e.g., HIV/AIDS providers, TBI providers, etc.) that are important to their established chronic condition population specialty focus. They work with a network of providers where target performance indicators may be very different than for a general population. This would be important to note somewhere as a measure is developed. In other words, the important measure for the beneficiary and for assessing "value" of the provider may not be a measure that is included in Stars—such as managing a patient's viral load for HIV patients.

Since performance indicators may vary (behavioral health providers may have different performance targets than cardiologists, or primary care providers), it is unlikely that there would be one measure of performance. How does one compare, then? The measures may be different with different specialty groups—how do you compare achieving a goal on improving substance abuse disorder treatment follow up (by a behavioral health group) with reducing chronic kidney disease complications by an endocrinology group? If the plan has a partial VB contract with both, does this make the health plan "good"? What if neither group wants to contract with the health plan because it only has a small enrollment and will only send a few patients to the provider each year? Does this make the health plan "bad"? It is unclear to us.

It may be helpful for CMS give additional thought to the purpose and utility of the information and how CMS is proposing to gather, review, evaluate information and compare across plans. How does it see comparing one plan to another? CMS may have to find groupings or categorizations so they can compare like to like. Following this train of thought there would have to be some attention to provider characteristics, beneficiary characteristics, regional characteristics, and other variables in considering VB arrangements so that there was some kind of typology.

CMS is encouraged to work with experts to articulate the intended purpose and utility and determine empirically what information can be used in quality performance evaluation, and what is only an indicator of financial arrangements or contracting acumen. CMS is encouraged to consider how/when the two are the same or different.

CAHPS (Part C and D) (p. 111) – *CMS is trying to increase response rates for CAHPS and testing the effects of a web-based mode in addition to current mixed modes of surveying members.*

SNP Alliance Comments: We fully agree that low response rates are a big problem. We see this as a positive and would support this. We've all observed the steady decline in CAHPS response

rates—this has been alarming for years. Low response rates call into question the validity and accuracy of the information—how do these responses compare to what most beneficiaries experience? How is the sample biased? Why did others not respond? Were they more or less satisfied?

In other market research, it is the people who are less satisfied who more frequently respond—is this the case in health care? And how has this been affected by the pandemic? There are many stories of dissatisfaction as hospitals, emergency rooms, clinics and other providers did not have capacity to address patients who presented or wanted to be seen. Is this a signal with dissatisfaction with the health plan or with the societal impact of the pandemic and particularly the strain on the healthcare system? This is important to get the information on satisfaction and experience—but is it a measure of quality of our overall healthcare system or one provider and one plan? These are larger questions.

In focusing on the smaller question regarding electronic web-based surveys, we fully support the effort. We have several suggestions:
- Consider incentives for beneficiaries to respond that also promote health, for example, a digital BP cuff, a voucher for fresh produce, or a DVD on mindful meditation or an exercise.
- Consider people who do not have access to wifi/broadband or digital technology. Is this unequal treatment? Perhaps CMS would consider providing a digital device or otherwise facilitating access?
- Considering the methods and accommodation of special populations is important for SNP enrollees who are more likely low-income, and have high social risk issues. People enrolling in SNPs are more likely to have cognitive disabilities or limitations, be of diverse ethnic, racial, and cultural groups. We must also consider those speaking a primary language other than English, Spanish, Chinese. This has been an important issue and barrier in the administration of the Health Outcomes Survey—which is limited in language access. We should not compound the issue in a new digital format.

We have just commented on some of the issues we see with the CAHPS instrument (see above) which also are important in considering response rates.

The meaningfulness of the questions and the comprehension of the respondent (health literacy, culture understanding and health beliefs, familiarity with the U.S. health system—all are factors). These characteristics of the instrument also impact willingness to respond. People with varying ethnic, cultural and language backgrounds may not read or interpret the questions the same way that a White, English-speaking, American-born person would. Some questions can be confusing on how to answer (e.g., rate "all of healthcare").

A final recommendation is for CMS to test the differences in CAHPS responses based on mode of administration. We have read several studies providing evidence that the mode of administration effects responses given. For example, respondents will generally be more positive in their evaluations/answers to telephone surveys than to a written or electronic survey. Differences arising from mode of administration should be considered in aggregating and tabulating results and especially in making comparisons.

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—primarily those with complex needs. We are happy to answer any follow-up questions or provide additional information, should that be helpful.

Please contact Deborah Paone, DrPH, Performance Evaluation Lead and subject matter contact for quality measurement at dpaone@snpalliance.org, or myself at cphillips@snpalliance.org

Respectfully,

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