

August 29, 2022

*Submitted via regulations.gov*

Ms. Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4203-NC  
P.O. Box 8013  
Baltimore, MD 21244-8013

Re: CMS-4203-NC

Dear Administrator Brooks-LaSure:

VNS Health appreciates the opportunity to provide recommendations for improvements in Medicare Advantage (MA). As one of the oldest and largest not-for-profit home-and community-based health care organizations in the U.S., VNS Health's services include skilled home health care, personal care services, hospice and palliative care, population health management, and behavioral health (BH) services. Health Plans from VNS Health offers MA, Dual Eligible Special Needs Plan (D-SNP), Fully Integrated D-SNP (FIDE SNP), and specialized Medicaid plans for individuals who require long-term supports and services (LTSS) and for individuals living with or at risk of HIV/AIDS.

We note that health equity implications are included throughout this letter, particularly given the population we serve. The vast majority of our patients are from ethnic and racial minority communities and qualify for Medicaid and other assistance programs. Aligned with VNS Health's commitment to serve the most vulnerable within our communities, we support CMS' efforts to advance health equity and reduce health disparities.

Below are our responses to select questions within the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI). Some recommendations overlap across responses given their applicability to several questions. We highlight notable innovations and opportunities for improvement from our perspective as both an MA plan and a provider of care in the home through MA contracts, specifically related to the following:

- **Advancing Integrated Care for Dually Eligible Beneficiaries**, including opportunities to leverage enrollment pathways, improve beneficiary, and expand the Medicare-Medicaid Coordination Office's (MMCO) role.
- **Enhancing Value-Based Insurance Design (VBID)**, including expanding caregiver support services, and ensuring palliative care benefit flexibility and maintaining the standalone hospice capitation payment during the MA VBID-Hospice Component demonstration period – while working with stakeholders towards future policy.
- **Supporting Value-Based Payment (VBP) Arrangements**, particularly by encouraging VBP arrangements between home health providers and MA plans and advancing Medicare-Medicaid integration to enable to more total cost of care arrangements within MA.

- **Improving MA Star Ratings**, by resolving issues with specific patient experience measures, exploring regional and MA-type stratification, and accounting for duals status.
- **Improving MA Payment and Risk Adjustment**, by allowing Highly Integrated D-SNPs (HIDE SNPs) to be eligible for frailty adjustments, incorporating a 5% social determinants of health (SDOH) adjustment for integrated D-SNPs, and incorporating functional status within the existing CMS- Hierarchical Condition Category (HCC) risk adjustment model.
- **Expanding Supplemental Benefits**, including by expanding the definition of “primarily health-related” to include healthy food and produce for both the member and household, incorporating a 5% SDOH adjustment for integrated D-SNPs, and expanding Special Supplemental Benefits for the Chronically Ill (SSBCI) to cover a larger population of MA members.
- **Improving Access to BH**, by expanding BH provider licensing.

## A. Advance Health Equity

### 1. What steps should CMS take to better ensure that all MA enrollees receive the care they need?

**Advance Integrated Care for Dually Eligible Beneficiaries.** We urge CMS to focus on the over 12 million people who are dually eligible for Medicare and Medicaid coverage. These individuals tend to be higher need than other Medicare enrollees, with more than half having three or more chronic conditions, requiring assistance with activities of daily living, or having a cognitive impairment or serious mental illness.<sup>1</sup> Dually eligible individuals are more likely than other Medicare beneficiaries to have their health outcomes impacted by social risk factors such as housing, food insecurity, or challenges with transportation and obtaining and seeking care.<sup>1,2</sup> Dually eligible individuals must navigate multiple health care systems across Medicare and Medicaid which are often uncoordinated, and their health and their SDOH needs are often unmet. These factors contribute to much higher utilization of both Medicare and Medicaid resources.<sup>3</sup> The 49% of dually eligible beneficiaries who require LTSS – both institutional and community-based – account for about three times higher Medicare and Medicaid spending than those who do not use LTSS services.<sup>4</sup>

For this category of MA enrollees (and dually eligible enrollees who have not enrolled in MA plans), it is critical that CMS focus policy proposals on advancing integrated care models, particularly for the subset of dually eligible beneficiaries with LTSS needs. An ongoing challenge is the lack of education and understanding regarding the benefits of integrated care. Policy solutions are needed to improve education and increase accessibility to integrated care programs. Specific steps could include:

- **Create a new special enrollment period (SEP) for beneficiaries to enroll into an integrated care product on a continuous (monthly) basis.** Limiting the SEP to new enrollments in integrated care products – either a D-SNP or Medicare-Medicaid Plan (MMP) - would allow more frequent opportunities for enrollment in integrated care on a monthly basis, supporting broad integration efforts. Once enrolled, beneficiaries cannot switch between D-SNP/MMP products outside of existing enrollment

<sup>1</sup> Center for Health Care Strategies. 2020. COVID-19 Effect on Dually Eligible Populations. Available here: <https://www.chcs.org/covid-19s-effect-on-dually-eligible-populations/>

<sup>2</sup> RAND Corporation. 2018. Types and Costs of Services for Dual Beneficiaries by Medicare Advantage Health Plans: An Environmental Scan. Available here: [https://www.rand.org/pubs/research\\_reports/RR2213.html](https://www.rand.org/pubs/research_reports/RR2213.html)

<sup>3</sup> MedPAC & MACPAC. 2022. Data book: Beneficiaries Dually Eligible for Medicare and Medicaid. Available here: [February 2022 MedPAC MACPAC Dually Eligible Data Book](#).

<sup>4</sup> Ibid.

timelines. Limiting the SEP to new enrollments in integrated care products helps to increase beneficiary choice, limit churn, and facilitate more consistent care management that would allow for integrated care to have a meaningful impact on beneficiaries.

- **Update Medicare Plan Finder (MPF)** and ensure functionality to identify integrated plans and their level of integration, and to provide easy-to-understand information on the benefits and advantages of integrated care products, including information on supplemental benefits.
- **Develop national and state-level tools to help beneficiaries navigate the integrated care market.** CMS, MMCO, and other stakeholders could develop educational materials on the benefits of integrated care to be used on the national level. The process of developing materials should include the opportunity for external stakeholder input.
- **Develop a database with Medicare data for all dually eligible beneficiaries that Medicaid managed long-term services and supports (MLTSS) plans can access for their members.** The database would include the beneficiaries' Medicare program enrollment and Medicare contract number (if applicable), and potentially their Medicare claims data in the future.

**2a. What are examples of specific policies, programs, and innovations that can advance health equity within MA? How can CMS support the development/expansion of these efforts?**

**Supporting and Advancing Integrated Care Models.** We urge CMS to work with states to develop strategies for providing integrated care for their dually eligible beneficiaries. Specific policies and strategies to expand integrated care include:

- **Encourage enrollment by expanding default enrollment.** More flexible default enrollment criteria is necessary to allow a greater number of beneficiaries to enroll in the most integrated care options. CMS indicates that default enrollment “is only permissible in circumstances where the member continues to receive comprehensive Medicaid coverage from the Medicaid managed care organization (MCO) after attainment of Medicare eligibility”.<sup>5</sup> This currently prohibits New York State’s (NYS) partially capitated MLTC program from participating and creates a missed opportunity to better address the needs of the most vulnerable newly dually eligible beneficiaries who require LTSS. CMS should consider allowing Medicaid MCOs that offer “comprehensive LTSS” to qualify for default enrollment, with reasonable state-specified service exclusions and carve-outs.
- **Streamline enrollment pathways.** Processes and dates for enrollment and disenrollment should be aligned across Medicaid and MA with one entity administering both processes. This will ensure the process is streamlined and eliminate any gaps in coverage for members that may occur with mismatched enrollment/disenrollment dates. Minnesota has implemented such a change for their Minnesota Senior Health Options (MSHO) program that could serve as a model for widespread implementation, in which State staff serve as third-party administrators for MSHO plans to access enrollment files for both Medicare and Medicaid and achieve simultaneous beneficiary enrollment.
- **Implement Medicaid continuous eligibility.** Medicaid recipients are at risk of losing Medicaid coverage if they fail to submit renewal paperwork on time or if their income level or assets change. People of color make up a higher proportion of duals than Medicare-only beneficiaries, and non-white dually

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<sup>5</sup> Medicare-Medicaid Coordination Office. Default Enrollment FAQs. February 2019. Available here: <https://www.integratedcareresourcecenter.com/resource/default-enrollment-faqs>

eligible beneficiaries are more likely than their white counterparts to lose Medicaid eligibility.<sup>6, 7</sup> For dually eligible beneficiaries, losing Medicaid eligibility also means losing access to their integrated care benefits and services. The recertification process is administratively burdensome for both members and plans, as more often than not, the beneficiary is still eligible yet required to go through the time-consuming process of resubmitting paperwork and proof of eligibility. We support legislation that would guarantee Medicaid eligibility for a continuous 12-month period following approval or renewal of Medicaid status.<sup>8</sup>

- **Encourage provider engagement and participation through enhanced rates.** Provide incentives for providers to promote and educate patients on integrated care (via rate enhancements, incentives, and other measures). Require or incentivize providers participating with Medicare and Medicaid programs to become contracted participants of all integrated care plans operating within the catchment area of their practices/facilities. This would remove the Out-of-Network (OON) provider restrictions that beneficiaries are faced with when weighing the benefits of opting for integrated care versus losing accessibility to providers they trust. This is particularly a concern for dually eligible beneficiaries who require qualified providers in their neighborhoods. CMS could consider enhanced rates based on counties or zip codes where there are “provider deserts”.

## **2b. What data could better inform this work?**

As mentioned in *Section A, Question 1*, developing a database with Medicare data could support MLTSS plans in better serving dually eligible beneficiaries. The database would include the beneficiaries’ Medicare program enrollment and Medicare contract number (if applicable), and potentially their Medicare claims data in the future. MLTSS plans would only download data for their members for whom they can verify enrollment in their plan using key identifiers (e.g., plan has a beneficiary’s date of birth and Social Security Number or Medicare Beneficiary Identifier). While MLTSS plans and providers gain valuable insights into dually eligible individuals’ health care needs and quality of life through LTSS interventions, fundamental system constraints limit their access to primary care provider and other medical utilization data. Improving MLTSS plans’ access to Medicare data will allow them to better respond to and coordinate medical and non-medical needs of members.

Additional data to support identifying communities with “provider deserts” that should be addressed, include health disparities on clinical outcomes (e.g., readmissions, Emergency Department use) and out-of-network use by county or zip code.

## **8a. How are SNPs (including D-SNPs) tailoring care for enrollees?**

**FIDE SNP Efforts to Tailor Care.** MA plays an important role in delivering integrated care for dually eligible beneficiaries through D-SNPs. D-SNPs offer enhanced care management and coordination with Medicaid to address the needs of dually eligible beneficiaries. FIDE SNPs, in particular, also provide Medicaid benefits, including LTSS and/or BH. This coverage and relationships with LTSS and/or BH providers allow FIDE SNPs to tailor efforts. For example, for members in VNS Health’s FIDE SNP with the most complex needs, often with

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<sup>6</sup> CMS Medicare-Medicaid Coordination Office, “Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019,” 2020.

<sup>7</sup> MACPAC, “An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP,” 2021.

<sup>8</sup> [H.R. 1738](#) | [S. 646](#), *Stabilize Medicaid and CHIP Act of 2021*.

multiple (7+) chronic conditions, we offer enhanced proactive care management to prevent hospitalizations and minimize the burden of complex illness. This involves:

- 24/7 access to care: Clinicians available around the clock to help support and triage patient concerns after hours
- Nurse Practitioner (NP) escalation and comprehensive visit: NP acute urgent visits or annual wellness visits, including the ability to deploy community paramedicine
- Interdisciplinary care team (IDT): IDT includes nurses, pharmacists, social workers, therapists, NPs, health coaches, dieticians, etc.
- Technology assets: Remote monitoring services/telemedicine to receive biometrics daily, interactive voice response and alert management technology to manage performance and real-time alert interventions

**Tailored Supplemental Benefits.** For our products for dually eligible beneficiaries, Medicare benefits are primary. It is important to understand what benefits Medicaid already covers in order to determine what MA supplemental benefits to include or expand. In addition to standard supplemental benefits like dental, hearing, vision, fitness, and over the counter (OTC) benefits, we offer certain benefits given the specific needs of our membership, including the following (not exhaustive):

- *Grocery with Food Delivery:* We've found this to be valuable for our FIDE SNP members who are typically home-bound given disabilities and/or LTSS needs.
- *Enhanced dental:* For our D-SNP and FIDE SNP members, this benefit augments existing Medicaid benefits.
- *Acupuncture:* We offer acupuncture for our D-SNP population given their needs, and also given that we have a high percentage of Chinese populations enrolled who traditionally use acupuncture.

**VBID Hospice-specific benefits:** Through our participation in the VBID-Hospice component demonstration, our participating MA plans (including D-SNP and FIDE SNP) can offer hospice-specific supplemental benefits that are tailored to the individual's care needs. For CY2023, VNS Health will be offering a \$500 allowance upon hospice election with an in-network provider to help keep members comfortable in the home – a valuable benefit for the population enrolled in the demonstration. These allocated funds are intended to help with expenses associated with in-home hospice stays such as home and bathroom safety devices, housekeeping services, meal preparation and delivery, and other services that provide comfort in the home and contribute to a positive quality of life.

#### **8b. How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care?**

**Recommendations to Strengthen Integrated Care.** CMS has taken important policy actions to recognize and promote integrated care over the past few years particularly through the Bipartisan Budget Act implementation and most recent finalized CY23 MA and Part D Final Rule (CMS-4192-F). Notably, recently introduced bipartisan legislation signals Congressional focus on developing and enhancing integrated care programs in partnership with States.<sup>9</sup>

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<sup>9</sup> [S. 4264](#), *Advancing Integration in Medicare and Medicaid (AIM) Act*; [S. 4273](#), *Supporting States in Integrating Care Act of 2022*; [S. 4635](#), *Comprehensive Care for Dual Eligible Individuals Act of 2022*.

We've been able to operate high-quality, high-touch integrated care programs for our dually eligible beneficiaries and want to ensure more of our seniors and individuals with disabilities who are eligible have access to the same comprehensive set of benefits and support.

We encourage CMS to provide support to states in developing robust integrated care strategies, including by incentivizing and enhancing FIDE SNPs to meet the needs of the subset of dually eligible beneficiaries that require LTSS. To adequately manage the cost and quality of care, CMS should support the recommendations noted in *Section A, Question 1*, and the following (aligned with The National MLTSS Health Plan Association recommendations<sup>10</sup>):

- **Expand MMCO authority over all integrated care products.** This would provide MMCO greater oversight and ability to modify integrated care programs based on their expertise, removing the current administrative burden required of CMS to meet with MMCO, plans, and states regularly for monitoring and decision-making.
- **Provide funding and technical assistance from MMCO to support states.** MMCO should have funding and authority to create a planning grant program for states that are pursuing integrated care. States would apply for a one-time planning grant to support a specific set of activities related to implementing or improving integrated care, and would be required to provide training on dually eligible beneficiaries and integrated care to state employees. MMCO should also be required to lead on providing states with technical assistance in the development, implementation, and administration of integrated care programs, with CMS continuing to provide support where appropriate.
- **Enhanced Federal Medical Assistance Percentage (FMAP) to support dually eligible beneficiaries.** Congress could also provide states with an increased FMAP to support operational activities related to integrated care programs. The increase would be calculated based on the population of dually eligible beneficiaries enrolled in the state's integrated care programs.

In addition, CMS may want to consider setting Model of Care (MOC) standards to differentiate intensity between D-SNPs, HIDE SNPs, and FIDE SNPs. This differentiation could better tailor and coordinate care for the specific populations enrolled in each and strengthen oversight. MOC standards already differentiate between the different types of Special Needs Plans (i.e., D-SNP, Chronic Condition SNP, and Institutional SNP), so distinguishing between the D-SNP designations would be a natural progression.

**9. How have MA plans/providers used algorithms to identify enrollees that need additional supports or services? Describe prediction targets used to achieve this, whether such algorithms have been tested for different kinds of differential treatments/inequities including racial bias, and if bias is identified, any steps taken to mitigate unjustified differential outcomes.**

VNS Health makes significant investments to engage in complex statistical analyses, examine drivers of clinical outcomes and analyze opportunities for clinical interventions and for managing risk-based populations. Below are examples of models we use, but note that our experience may differ from other organizations:

***Advanced Illness Management (AIM) Model***, which employs a predictive risk model to identify and stratify home health patients who are at increased risk of dying within the next 6 months. Those stratified as hospice eligible but do not elect hospice are referred to palliative care for outreach and engagement.

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<sup>10</sup> National MLTSS Health Plan Association. Policy Proposals to Advance Integrated Care. Available here: [4f0f40\\_e8383fbf618f4b40a95bfd3ce5c6f5da.pdf \(usrfiles.com\)](https://www.usrfiles.com/4f0f40_e8383fbf618f4b40a95bfd3ce5c6f5da.pdf).

***Predictive Risk Model for Hospitalization***, which predicts hospitalization risk for home health patients within 60 days of starting or resuming care using OASIS assessment information. The predicted risk of 60-day hospitalization is then used to generate risk-informed plans of care and target risk-mitigating clinical interventions.

***Predictive Modeling for 6- and 12-Month Mortality for VBID-Hospice Component Demonstration***, which identifies members who may have palliative care needs, as well as those members who are eligible for hospice (approaching the end of life up to six months) but do not elect to enter hospice. The model also predicts mortality risk within the next 12 months. Eligibility for the Palliative Care program is primarily based upon the results of our predictive mortality risk stratification model called the *Palliative Care Application tool*. The tool also determines touchpoint frequency by the Palliative Care Manager and/or the need for additional virtual or in-home nurse practitioner (NP) visits, in addition to any outreach needs related to changes in health status or post-hospitalization needs. The tool relies on information from the following sources or categories: claims history up to 24 months (e.g., inpatient stays, emergency room visits), diagnosis categories, drug categories, need for assistance with activities of daily living (ADLs), status of chronic conditions, and presence/efficacy of caregiver and other support networks.

We are working on continuously improving the tool's accuracy. We recently improved the tool's eligibility confidence to 75%, by combining the risk stratification model with mortality information from claims data. Case Managers contact members and their families to discuss palliative care needs and referral to hospice when appropriate.

Traditionally, machine learning models are built only focusing on direct model performance metrics. We deploy best practices in assessing racial bias as an additional criterion when selecting a "final" model. This allows us to minimize (if any) racial bias that could exist for our members and patients. We also have model architectures that utilize face-to-face clinical assessments versus claims driven models; biases that are known to exist in how members interact with the healthcare system can be complemented by risk models that use face-to-face assessment data. In addition, our standard for deploying predictive models includes local interpretation to complement the prediction. This allows for a greater level of clinician engagement and judgement to interpret and inform predictive model results, determinations of risk, and the workflow.

***Predictive analytics to support risk stratification and care management***, to identify members with chronic conditions who often need additional social services and supports beyond clinical/medical care. VNS Health also uses an SDOH screening script which is adapted from the Accountable Health Communities Health-Related Social Needs Screening Tool<sup>11</sup> to screen our patients and members. We aim to develop additional algorithms that build in factors like zip code and ethnicity to more accurately identify patients with SDOH needs that puts them at higher health risk and in greater need of services or higher levels of care.

***SDOH Future Strategies:*** As part of an enterprise-wide effort across VNS Health, we are examining data collected across different electronic health record systems (EHR) and health assessment tools to identify potential information gaps within our data warehouse; assess health, care, and social needs of our patients and members; and support strategic planning and continuous quality improvement efforts aiming to decrease health

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<sup>11</sup> This screening tool was developed for CMMI's [Accountable Health Communities Model](https://innovation.cms.gov/innovation-models/ahcm), which tests the impact of systematically identifying and addressing health-related social needs among Medicare and Medicaid beneficiaries. More information found here: <https://innovation.cms.gov/innovation-models/ahcm>

disparities and improve equity. Thus far, we have found the following to be essential to facilitate the implementation of culturally appropriate care:

- Data quality improvement, including by greater consistency collecting data on race, ethnicity, preferred language, and literacy levels;
- Strategies and incentives for greater use of z-codes by providers;
- Improvement of interoperability across EHR systems so members/patients do not have to repeatedly answer the same SDOH questions; and
- Better communications within and across care teams and providers.

We are also working on multivariate analyses that examine whether differential health outcomes are associated with gaps in service provision (e.g., risks of hospitalization related to missed service delivery) and to identify opportunities for operational improvement and outcomes.

VNS Health is home to the independent Center for Home Care Policy & Research (CHCPR),<sup>12</sup> which has conducted extensive research on disparities in home health and hospice patients. The Center is currently conducting a study to investigate whether use of judgement language in clinician visit notes are associated with patient race/ethnicity and differential outcomes. The study will support efforts to assess and address possible implicit racial bias.

## B. Expand Access: Coverage and Care

### **1. What tools do beneficiaries generally, and beneficiaries within one or more undeserved communities, need to effectively choose between different options for Medicare coverage, and among different MA plans? How can CMS ensure access to these tools?**

***Update Medicare Plan Finder to Include Information on Integrated Care Products.*** Medicare Plan Finder (MPF) supports beneficiaries in making informed decisions about enrolling in MA plans, but only includes information on Medicare-covered services. This results in limited information displayed, when considering options for dually eligible beneficiaries. Incorporating the Medicaid-covered services in the design would provide more comprehensive information about FIDE SNP. Specifically, we recommend CMS update MPF to include new functionality and information on integrated care products. CMS could identify MA plans that would be considered “integrated” (D-SNPs, HIDE SNPs, and FIDE SNPs), and use beneficiary-friendly language to note level of integration (some coordination with Medicaid, alignment and coordination with Medicaid, and full alignment and coordination with Medicaid). It would also be helpful to provide high-level general information on the benefits and advantages of integrated care products. More generally, it would also be helpful to add information on supplemental benefits for all plans to arm beneficiaries with more comprehensive information. MPF could also benefit from more advanced features like a recommendation engine that would help beneficiaries view MA enrollment options based on geography and income/needs. The engine could include a better predictive model/eligibility calculator that opens a menu of integrated options first, before listing MA FFS or general MA-

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<sup>12</sup> Center for Home Care Policy and Research advances the national knowledge base underpinning Home and Community-Based Services (HCBS) by conducting objective and scientifically rigorous research and supporting informed decision-making by providers, policymakers, and consumers. More information here: <https://www.vnshealth.org/professionals/research-center/about-the-research-center/>



PD plans. Input from consumer advocates and stakeholders through focused conversations on enhancements to MPF would be valuable.

More comprehensive outreach and consumer education are needed, in particular, regarding supplemental benefits. MA plans offer extensive caregiver support, housing assistance, utility payments, and other services that reduce social isolation and promote healthy living (e.g., grocery benefits and fitness/wellness). However, beneficiaries are not always fully informed of the value of supplemental benefits offered and what the differences are across plan options. The MPF also does not always provide plain, clear, and complete explanations as to how each benefit functions. If beneficiaries understand the array of supplemental care they would get in an integrated care plan, it will lead to a better understanding of different options for Medicare coverage and more successful enrollment in integrated care.

***Consumer-Facing Materials to Help Navigate the Market.*** We recommend CMS also develop national and state-level tools for beneficiaries and other stakeholders to help beneficiaries navigate the integrated care market. CMS, MMCO, and other stakeholders could develop educational materials on the benefits of integrated care to be used on the national level. The process of developing materials should include the opportunity for external stakeholder input.

***Consumer Ombudsman.*** On a national level, CMS could create a consumer ombudsman. This entity would act primarily as an advocate on behalf of Medicare beneficiaries and their caregivers. It would take cases triaged from more localized groups, such as community-based organizations and state-based State Health Insurance Assistance Programs (SHIPs). The ombudsman should include specific resources that cater to dually eligible beneficiaries with information on available integrated care options.

#### **4a. How are MA plans providing access to behavioral health services, as compared to physical health services?**

***Targeted BH outreach.*** VNS Health provides access to BH services by targeting BH outreach. Once a triggering event is identified (recent use of BH service, whether substance use-related or mental health), VNS Health conducts outbound calls. Using service use as a triggering event is timelier than analyzing Healthcare Effectiveness Data and Information Set (HEDIS) scores which are often delayed. This level of outreach is valuable given the time sensitive nature of BH needs, particularly for those with chronic conditions who have additional needs. A list of in-network providers is given to these identified patients, and support is provided to navigate and access services.

#### **4b. What steps should CMS take to ensure enrollees have access to the covered BH services they need?**

***Expand BH Provider Licensing.*** Medicare coverage for certain mental health services may not be as comprehensive as Medicaid. For example, only certain provider types are currently eligible for reimbursement, such as psychiatrists, psychologists, and licensed clinical social workers. However, these types of providers are not always available at crisis stabilization facilities, despite the availability of crisis psychotherapy codes in Medicare. Medicare restricts Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (MFTs) from being eligible for reimbursement in Medicare. This impacts access to BH in Medicare by

limiting the pool of accessible providers. As noted by a March 2022 GAO report, this limitation exacerbates current capacity issues and created waiting lists in the thousands.<sup>13</sup>

We recommend that CMS expand licensing to include additional BH provider types and adopt the CY2023 Physician Fee Schedule (PFS) proposed rule to allow LPCs and MFTs to provide BH services while being under general supervision rather than direct supervision.

**7a. What factors do plans consider when determining which supplemental benefits to offer, including offerings under SSBCIs and VBID?**

**Medicaid coverage and requirements.** For our products for dually eligible beneficiaries, Medicare benefits are primary. It is important to understand what benefits Medicaid already covers in order to determine what MA supplemental benefits to include or expand. In addition to standard supplemental benefits like dental, hearing, vision, fitness, and OTC benefits, we offer certain benefits given the specific needs of our membership. Moreover, we consider State requirements for D-SNPs. In NYS, Medicaid has required D-SNP contractors to use at least 10% of the rebate amount for covering Medicaid benefits through MA. We offered enhanced dental through our D-SNP and FIDE SNPs as Medicare supplemental benefits that augment the existing Medicaid benefits.

**Flexibilities to tailor benefits, informed by care management.** As we select our supplemental benefits, we consider flexibilities we have, such as under the VBID demonstration and through Special Supplemental Benefits for the Chronically Ill (SSBCI). These flexibilities have allowed us to tailor supplemental benefits to address the SDOH needs of members. Through strong care management relationships, knowing the population we serve is a key factor in determining the most beneficial benefits to support members.

**Market and competitive landscape.** It is important to assess the trends and needs within the market. Supplemental benefits have grown in 2021 and MA plans had lower premiums and cost sharing, focusing on SDOH and telehealth initiatives. Competitor analysis for each type of MA product is extremely helpful in finding which supplemental benefits are of interest.

**Financial impact, dependent on rebate dollars.** Supplemental benefits are financed through the use of rebate dollars. Higher-quality plans receive a larger percentage of the difference between the bid and FFS county benchmark rates. So, we must look at what our collective MA operating margin is each year and assess available rebate funds for supplemental benefits accordingly.

**8a. How are enrollees made aware of supplemental benefits for which they qualify?**

**Education and Marketing.** Member materials (e.g., Evidence of Coverage, Statement of Benefits, and newsletters) and advertising (e.g., marketing materials and flyers) help provide details on supplemental benefits and how to access them. Brokers and providers can help members be more aware of available supplemental benefits, but there continues to be a need for education here. Members often are aware of dental, vision, hearing, and OTC benefits at the time of enrollment, but can be unaware of these and other benefits that would

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<sup>13</sup> Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts: Report to the Chairman, Committee on Finance, U.S. Senate. Washington, DC: United States Government Accountability Office, 2022. Available at: <https://www.gao.gov/assets/gao-22-104597.pdf>

address unmet needs. Care managers and other member-facing staff, such as in our Call Center, also help enrollees become aware of supplemental benefits for which they qualify.

#### **8b. How do enrollees access supplemental benefits, what barriers exist for full use of benefits, and how could access be improved?**

##### **Barriers:**

- **Beneficiary awareness of supplemental benefits.** It is important that enrollees are made aware of their supplemental benefits, as noted above. A disconnect still exists between member and benefits, making it easy to overlook what benefits are being offered and going unused despite needs. Dental coverage is one major example of a driver of membership but not readily used due to lack of awareness.
- **Maximum benefit coverage may not meet full needs of membership.** Certain supplemental benefits may be offered but may not be enough to cover needed procedures. For example, though we try to offer as much as we can for the dental benefit, there are certain procedures (e.g., extraction, root canal) for which the maximum supplemental benefit only covers half the cost. Plans may not have the financial flexibility from a bid perspective to provide additional coverage, which leaves the beneficiaries with significant out-of-pocket costs. For our lower-income members, this is a barrier to access.

##### **Recommendations to improve access:**

- **SDOH Adjustment.** We support the Association for Community Affiliated Plans' (ACAP) proposal for CMS to incorporate a 5% SDOH adjustment for integrated D-SNPs.<sup>14</sup> Plans would be required to use this funding adjustment to offer supplemental benefits targeting the social determinants of health that impact duals the most including food and nutrition programs, increased transportation, programs to combat social isolation, and housing support.
- **Expand Supplemental Benefits.** We believe CMS should support an expansion of SSBCI to cover a larger population of MA members so all beneficiaries are able to receive targeted care. SSBCI are currently only offered to beneficiaries with chronic illness or comorbidities, so many MA members do not receive the same level of targeted care and support.

#### **10a. How do MA plans use utilization management techniques, such as prior authorization?**

**MA Plan Experience.** Utilization management (UM) is critical to ensuring members access care at the right time and place. As part of the UM review, prior authorizations are used to ensure and explain to members the benefits of using in-network providers and the costs associated with using out-of-network (OON) providers, should they choose. Prior authorizations are also used to make sure that members utilize the appropriate care or therapeutics, and it provides an opportunity to prevent member harm (e.g., wrong or duplicate medications, less expensive alternatives). Moreover, it provides an opportunity to care manage and to ensure appropriate follow-up care (e.g., physical therapy, cardiac physical therapy). For example, a newly diagnosed hypertensive or diabetic member would need to follow up with the appropriate specialists, lab testing, and receive member education about their new diagnosis and management.

**Home Health Considerations.** Effectively managing care in the home is a critical tool in serving hard-to-serve populations, a growing preference for consumers, and a key driver of improved outcomes and lower overall health care costs. By design, care in the home lowers the cultural and racial barriers to care. It meets people

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<sup>14</sup> Association for Community Affiliated Plans. 2022. ACAP Pathway to Improve Health Equity. Available here: <https://www.communityplans.net/wp-content/uploads/2022/06/ACAP-Pathway-to-Health-Equity.pdf>

where they are – in their homes and communities. That remains as true today as it did when VNS Health nurses on the Lower East Side of Manhattan went rooftop to rooftop to bring needed care to marginalized minority populations shut out of traditional health care institutions.

Typically, in a managed care environment, home health care is seen as an ancillary service subject to standard utilization management approaches. We believe this results in a major missed opportunity for MA plans, Medicare enrollees, CMS, and taxpayers. Medicare enrollees (including MA) are getting older and sicker, and their needs are becoming more complex and costly. Growing numbers of enrollees want to remain in their homes as much as possible. They prefer being cared for in their home to being in a nursing home, and they want to avoid hospitals unless it is entirely necessary. Investing in home health and home-based care management services that can effectively direct home health resources can play a major role in reducing overall costs while improving outcomes.

**10c. What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?**

***Continued oversight of denials and appeals.*** We support CMS' continued oversight and audits of MA compliance, including coverage determinations, appeals, and grievances. CMS could also calculate the rate of inappropriate denials and report for outliers.

***Provide greater oversight of post-acute care utilization management.*** One of the byproducts of the undervaluation of home health has been the increased use of post-acute care utilization management. There is nothing inherently inappropriate with an MA plan contracting out for expertise in certain areas, including home health and post-acute care. Indeed, VNS Health's care management organization provides this kind of expertise, but with incentives that align with and support the MA plans' broader care management objectives. However, MA plans incentivize vendors and conveners to reduce home health and other post-acute utilization without consideration for the impact on overall cost and care outcomes (particularly in hospital readmissions). Thus, there is a devaluation of home health care and a missed opportunity to improve outcomes and reduce overall costs.

## C. Drive Innovation to Promote Person-Centered Care

**1a. What factors inform decisions by plans and providers to participate (or not) in value-based contracting within MA?**

***Medicaid value-based payment (VBP) policies.*** State Medicaid Agency initiatives to require and implement VBP arrangements state-wide were critical to pushing Medicaid providers and MCOs to participate in VBP. Many of these providers and MCOs also participate in MA, particularly in integrated plans such as FIDE SNPs. In NYS, the VBP Roadmap initiative spurred several efforts for providers – including Primary Care Providers (PCPs), Independent Physician Associations (IPAs), home health agencies, skilled nursing facilities, and personal care agencies – as well as fully integrated plans to engage in VBP.

***Scale and member attribution.*** With low scale or attributable members with providers, providers can be reluctant to take on risk for a low panel size since just one hospital admission could have negative financial consequences on their day-to-day operations. For example, we have a provider with a panel size of 11 members. In the first seven months of the year, this provider had a 60% Medical Loss Ratio (MLR), but in the month of August, one member got long-term hospitalized, and the average MLR for the provider's panel for August rose

to over 380%. As a result, now the provider's overall MLR would be around 100%. For saturated plan and provider markets, many providers can have small panel sizes. And because of this vulnerability, they are not willing to accept downside risk in VBP arrangements. Likewise, having a substantial attributed membership with a provider is the triggering event for deeper full-risk VBP arrangements in some of our contracts.

**Plan and provider infrastructure and capabilities.** To enter into VBP arrangements, both plans and providers need data analysis and sharing capabilities and resources and financial viability. More mature and larger providers typically have the ability to collect, report, and track data, and have had experience with other carriers. Certain smaller independent practices don't have the infrastructure to enter into VBP.

### **1b. How do plans work with providers to engage in value-based care?**

As an MA plan, we often work with providers to align VBP with quality goals and incentives. As mentioned earlier, NYS Medicaid's VBP Roadmap initiative spurred plan-provider engagement on VBP in pay-for-performance incentive structures, upside with limited downside risk, and full risk arrangements. The State had provided VBP performance funds which supported providers in entering into VBP. Though Medicaid-focused, the State initiative included fully integrated plans like FIDE SNPs. Over time our risk arrangements with IPAs have evolved to be full upside/downside risk arrangements that go into effect once a certain membership threshold is met. The arrangements also include a strong quality component with bonus incentives based on certain measures identified in the MA Star Ratings program as priorities for the plan and able to be impacted by the provider.

### **1d. To what extent do MA plans align the features of their value-based arrangements with other MA plans, Medicare Shared Savings Program, CMMI models, commercial payers, or Medicaid, and why?**

**Quality Alignment.** As an MA plan, we've aligned quality components of our VBP arrangements with MA Star Ratings, which overall supports provider arrangements with other MA payers. Likewise, as a Medicaid plan, our VBP arrangements with LTC providers align with NYS' MLTC Quality Incentive Program which also supports provider arrangements with other MLTC payers.

**Alignment with Medicaid.** For MA plans that operate as D-SNPs or FIDE SNPs, VBP arrangements may include features that align with Medicaid. As mentioned above, through NYS Medicaid's VBP Roadmap we developed VBP arrangements for Medicaid providers (personal care agencies, home health, and skilled nursing facilities) in our Medicaid managed long-term care (MLTC) plan and carried over similar arrangements in our FIDE SNP which also contracted with these providers for LTC.

### **2a. What are the experiences of providers and MA plans in value-based contracting?**

**MA Plan Experience.** For VNS Health, though we've entered into these arrangements with providers, we need to ensure there is sufficient attributable membership before risk is shared. Given NYS' saturated plan and provider market, this continues to be a challenge as providers haven't been able to truly engage in VBP.

**Home Health Provider Experience.** Fully two-thirds of VNS Health Medicare home health services are in Medicare Advantage. We have significant capabilities in care management and predictive modeling that provide more tailored and effective interventions to patients who are at risk. These capabilities are at the heart of our shared risk value-based arrangements with MA and other managed care plans.

VNS Health’s value-based contracts typically involve episodic payments that cover the period the patient is under our care and a period of time after the patient is discharged from home health services. Services include traditional home health services (e.g., skilled nursing, therapy, social work, and aide services), as well as virtual visits and remote patient monitoring (which is not considered utilization in the traditional home health benefit). Service utilization and authorization is managed through VNS Health’s evidence-based care management program. VNS Health receives either a bonus or penalty that is tied to our performance on key metrics, most notably hospital readmissions. Most recent data demonstrates that VNS Health has reduced 90-day readmissions by more than 10%.

Value-based arrangements help health plans reduce readmissions and total cost of care while improving quality and HEDIS scores. They can help hospitals lower Medicare readmission penalties and manage bed capacity. They provide our home health agency with greater flexibility and authority to deploy resources (including virtual) than in traditional fee-for-service arrangements (which often include additional administrative burden and associated costs).

Despite our experience, value-based arrangements with MA plans are still the exception and not the rule. There are several reasons for this.

- In many regions of the country there are numerous providers each holding small shares of the market. These providers tend not to have the technological infrastructure, analytical capabilities, or patient volume to take on risk.
- There is a general lack of understanding and recognition of the impact of post-acute care, particularly home health care, on patient outcomes and total cost of care. The result is that home health is seen primarily as a health care service whose utilization needs to be managed, not as a critical component of overall care and cost management.
- Contracting with MA plans is challenging. There are often separate agreements for different plans (e.g., MA, commercial, Medicaid). Value-based contracts may be agreed to by an MA plan at the regional level, but can be rejected at the corporate (national) level.
- Unlike with hospitals and large health systems, MA plan reimbursement for home health services is usually less than Original Medicare. Without adequate reimbursement, home health agencies cannot recruit and retain sufficient staff to provide care (see below).
- It is often challenging for MA plans to attribute impact to any one service, making reconciliation in risk-based arrangements more challenging. For example, a reduction in readmissions may have been the result of successful home health visits, a PCP spotting a risk in bloodwork, or behavioral health counseling, all three, or another factor.

**Workforce and Network Adequacy.** The potential of home health to make significant contributions to the MA value proposition is further undermined by increasing demand for home health services, rising labor costs, and a shrinking home health workforce. The impact is much greater in “home care deserts” – communities and populations already suffering from disparate levels of care.

State Medicaid Agencies have begun to acknowledge these challenges through investments in the direct home care workforce, particularly through funding made available from the American Rescue Plan Act. Commensurate investments need to be made by Original Medicare *and* MA plans through appropriate reimbursement rates and incentives that enable home health agencies to take on and effectively staff cases. These increases are needed to address the dire workforce crisis, but Medicare-reimbursed providers cannot be left behind.

### **3a. What steps could CMS take to support more value-based contracting in the MA market?**

**Increase payments in “home health deserts”.** MA plans should analyze geographic areas (at the zip code or more granular level) and provide supplemental funding to ensure home health agencies can provide adequate staff in these communities. Generally, network adequacy is done on a county level. That may be appropriate in less populated counties, but more specificity is needed in densely populated counties with large socioeconomic differences.

**Encourage VBP arrangements between providers and MA plans serving specific or high-need populations.** To improve quality and advance health equity, CMS could encourage plans and providers to specifically enter into VBP arrangements to better serve members and from agreed-upon communities of need with identified SDOH needs and facing health disparities. This should be informed by and through contractual arrangements with providers and community-based organizations serving these beneficiaries, with outcomes that improve key metrics – including potentially avoidable hospitalizations and readmissions.

**Invest in Home Health information exchange.** Home health agencies can capture important data from in-home assessments and patient monitoring that can help MA plans improve on key HEDIS measures (e.g., medication reconciliation). But investment in IT infrastructure has been lacking, preventing the efficient and timely exchange of critical health information between home health agencies and plans. Plans should provide home health agencies with ready access to their health information exchange (HIE) systems and incentivize home health agencies through “pay for reporting” of health information.

**Advance Medicare-Medicaid integration.** The existing fragmentation across Medicare and Medicaid for dually eligible beneficiaries is not only problematic from a beneficiary experience, care management, and health equity perspective, but also from a VBP perspective. For duals with long-term care needs, an even more complex subset of the population, Medicaid spending on long-term services and supports - particularly effective home-based long-term care - has the potential to reduce avoidable hospitalizations and other costly interventions that are paid for by Medicare. However, there is little to no ability to develop meaningful risk arrangements to impact the total cost of care without a truly integrated framework and funding stream. CMS could advance policies that enhance fully integrated plans and encourage enrollment to the extent possible (see response to Section A. Health Equity, Question 8b.)

### **4. How are providers and plans incorporating and measuring outcomes for the provision of behavioral health services in value-based arrangements?**

As a provider of BH services, when we enter into VBP contracts with plans, we establish agreed-upon outcome metrics that will be monitored throughout the provision of services. Typical parameters of outcome measurement include a control cohort, admission and discharge criteria, baseline data, and identification of screening tools that will be utilized at the start and end of care to monitor progress. These outcomes are incorporated into the contract and measurement intervals are established prior to delivering services. Expectations for each party regarding data exchange are also outlined in the contract. Plans often lean toward selecting measures that contribute toward improving HEDIS and Star Ratings, and these metrics often dovetail with provider priorities such as ensuring individuals can meet their health goals while remaining in their home and community setting. At VNS Health, we address unmet BH needs for the MA population in an integrated manner with our general medical care management teams. Intervening in BH conditions and ensuring connection to consistent outpatient BH care has a significant impact on adherence to medical treatment, thus greatly impacting outcomes beyond just BH and driving down overall cost of care.

### 8a. How do beneficiaries use the MA star ratings?

Generally, beneficiaries may use MA Star Ratings to compare plans through MPF by sorting for MA plans with 4 stars or above or narrowing down available options. However, typically MA Star Ratings may not even be known by beneficiaries. The greatest visible differentiators across plans for beneficiaries are often differences in network and available supplemental benefits.

### 8b/c. Do MA star ratings quality measures accurately reflect the quality of care that enrollees receive? If not, how could CMS improve the measure set to accurately reflect care and outcomes?

We generally support CMS' approach to MA Star Ratings as a reflection of the quality of care that enrollees receive. However, we note a couple areas that we believe require additional consideration.

- **Patient Experience.** Though we agree on the importance of patient experience, the increased weighting of Consumer Assessment of Healthcare Providers and Systems (CAHPS) and patient experience measures reduce the weight on clinical quality. This implies that if the member is happy with their experience, the member is receiving high-quality care – which may not always be the case. We caution the need to maintain a balance and ensure clinical quality is not undermined.

One issue in particular involves Measure C27 – Complaints about the Health Plan which is described as the “Percent of members filing complaints with Medicare about the health plan”. However, the rate of complaints about the health plan is calculated using complaints logged into the Complaints Tracking Module (CTM), which monitors complaints beneficiaries and providers report to CMS about a health plan. Provider complaints may include those from non-participating providers or driven by provider payment issues and skew the measurement data away from the focus on member complaints. We note that plans should still address provider complaints by following CMS' Standard Operational Procedures (SOP). We support CMS' continued expectation for plans to provide the same level of research and quality service as they would for a Medicare beneficiary or other program stakeholder, but strongly recommend that provider complaints are removed from the CTM data for Star Rating purposes.

- **Regional and MA-Type Stratification.** As an MA plan operating in both urban and rural areas, our experience has been that urban areas tend to have lower satisfaction scores. Regional stratification could level the playing field for MA plans and provide a more accurate reflection of scores when comparing plans. In the 2022 CAHPS Survey, we see an average of 0.3% higher performance across NYS plans vs. New York City (NYC) plans.

Moreover, stratification between D-SNP and MA plans would also be welcome. Based on the same CAHPS Survey results, we see an average of 1.4% higher performance for all NYS plans vs. just NYS D-SNP plans.

- **Duals Status.** As noted in earlier sections, duals status is the most powerful predictor of poor outcomes of all social risk factors. Though recent CMS policy has supported addressing this, we are supportive of CMS' exploration of stratifying Star Ratings measures by dual eligible status, LIS, and disability status, and the public reporting of this data and would recommend that CMS require MA plans to separately report Star Ratings for D-SNPs. We understand that the intent of this policy is to improve integration, rather than to address the impact of dual status on plans' Star Ratings. However, as CMS continues to evaluate the impact of D-SNPs having separate contracts, we encourage CMS to explore whether it is feasible to require plans to report Star Ratings measures at the Plan Benefit Package (PBP) level. We also recommend that CMS modify the Star Ratings to adjust for between-contract differences between D-



SNPs and non-SNP MA plans that are due to underlying population differences rather than actual differences in the quality of care provided by plans. Adjustment for between-contract differences is a way for CMS to address sustainability and access.

**9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?**

**Consider a Home Health Value-based Insurance Design (VBID).** The CMMI Home Health Value-Based Purchasing (HHVBP) model clearly demonstrated the value that home health agencies can provide on patient care and reducing overall Medicare spending (particularly on readmissions). HHVBP is being rolled out nationwide in 2023 and CMS is projecting \$3.4B in savings from its implementation over the next five years. While home health agencies may be involved as ancillary providers in current VBID models, CMMI could explore a demonstration specifically designed to test and incentivize appropriate use of home health to improve outcomes on key quality measures and reduce overall spending. Models should enable maximum flexibility and include, at a minimum, an upside/downside risk component. Advanced arrangements may involve delegating responsibility for total cost of care.

**10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID model that would test how to address SDOH and health equity?**

**Expanded Healthy Food and Produce:** Though food and produce are available as home-delivered meals through SSBCI, the MA population more broadly in certain areas and those from certain communities may also require health food options. For example, seniors facing food insecurity or individuals with physical impairments that impact food preparation, as well as members from areas with limited healthy food options and grocery stores (i.e., food deserts), could benefit from home-delivered meals. Moreover, members may be impacted by food that is prepared by caregivers or other members of the household. Expanding the benefit to address the needs of caregivers and family living with the member would support the health of members as well.<sup>15</sup>

We recommend that CMS further expand the definition of primarily health-related to include healthy food and produce as supplemental benefits to address SDOH needs for MA members more broadly, and consider flexibility to expand the benefit to cover food for the member's household.

**Expanded Caregiver Support:** As a participant in the MA VBID-Hospice component, we recognize the critical role that caregivers play in caring for members. Additional flexibility to specifically address the needs of caregivers of hospice patients with expanded benefits would be welcome. For example, respite care, call-in support line, caregiver training and resources greatly support caregivers and prevent unnecessary hospitalizations of members. However, though benefit flexibility is already available to provider caregiver support, benefits like respite care are limited to 5 days. Limitations on these benefits negatively impact those who are already facing health disparities.

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<sup>15</sup> Geisinger Health's Fresh Food Farmacy program (FFF) prescribes enough fresh food for two meals per day, five days per week, for *everyone* in the patient's household. The program improved outcomes (average 2-point drop in HbA1c levels and lower weight, blood pressure, triglycerides, and cholesterol), and led to a collective \$1.5 million in health care savings for patients who participated in the program. Moreover, the intervention has the potential to change the trajectory of disease burden and future costs. More information found here: <https://wwwf.w.geisinger.org/freshfoodfarmacy>

Other caregiver supports to test that would benefit caregivers, and ultimately beneficiaries, include care management social services (e.g., virtual administration/finance/legal support, live navigator); and free caregiver videos with best practices on delivering culturally competent care in home-settings for different demographics and cultural communities (e.g., dementia patients, African American, Puerto Rican, etc.).

Lastly, standardized caregiver burden assessments could be developed and used by the caregiver's physician to assess stress-levels of family caregivers and ensure caregivers are then connected to appropriate caregiver support services. The assessments could also give insight into the family's system of care more broadly.

***Payment for In-Home Support Services.*** Though in-home support services have increasingly been offered as MA supplemental benefits under the expanded definition of "primarily health related", certain markets may not see the same uptake due to existing Medicaid coverage for members, robust state Medicaid benefits, and a greater concentration of smaller regional plans that may not have the resources to offer supplemental benefits beyond standards supplemental benefits (e.g., dental, vision). These same regional plans typically serve members who are at-risk of becoming Medicaid eligible and could benefit from in-home support services. CMS could test payment for in-home support services within VBID.

#### **11a. What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID model?**

***Ensuring palliative care flexibility, though definition needed in the long run.*** In the current state, the definitions and use of palliative care is set up to be flexible for MA plans to explore different models. We believe it is important to maintain that flexibility during the demonstration period to foster innovation.

However, though VBID-participants may add palliative care as a supplemental benefit (as VNS Health does), palliative care services are undefined and beneficiaries may not receive the full array of palliative care services, depending on the MA plan's specific definition. In the long-term, without the delineation of "core" palliative services, beneficiaries may face discrepancies in interpretations of comprehensive palliative care services. This definition is of particular importance given that CMS recently expanded MA supplemental benefits to include non-health related benefits, including palliative care for beneficiaries with more than 6 months to live.

Moreover, CMS could also work with VBID model participants and hospice providers to more clearly define when and how patients are or should be transitioned from palliative care to hospice.

***Continue Transitional Concurrent Care (TCC).*** We are supportive of TCC as an important innovation but note that is difficult to test TCC in the demonstration given limited understanding and awareness from beneficiaries, practitioners, and providers of the benefit. For many of our members, when they've come to terms with accepting that hospice is right for them, it can be an emotional decision. It can be difficult to then consider the option to continue treatment. TCC can also be hard to understand given potentially differing decisions between members and their families. We focus on having open and honest discussions with members and family members to ensure that they are aware of all available options at each stage of the process.

Though not a specific recommendation, we want to convey our support for TCC and our continued efforts to educate providers and beneficiaries of TCC. With more physicians aware of TCC, we would expect that beneficiaries have increased access to continue curative treatments, increased satisfaction, and earlier election of hospice. However, as TCC utilization increases, it may increase hospice revocation risk in the short-term for those patients receiving TCC as that model continues to be refined by MA plans and hospice providers.

**11b. What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?**

We support receiving the hospice capitation payment as a standalone payment, rather than as part of the bid for covering Parts A and B benefits. As both a hospice provider and health plan participating in the VBID-Hospice component demonstration since its inception, a major goal of ours has been to increase hospice access and utilization – particularly given that NYS has consistently been one of the states with the lowest hospice utilization in the country. If the hospice capitation payment was folded in as part of the bid, we would expect that MA plans would be constrained by the bid, competing needs, and conduct utilization management through reductions in hospice utilization.

We are committed to maintaining the integrity of the hospice benefit. We feel it is imperative that the comprehensive hospice benefit remains intact to ensure hospice-related outcomes. By moving to the bid, MA plans may “unbundle” the hospice benefit, which would not serve hospice patients well, and also put hospice providers in an untenable position given financial instability. Moreover, during this demonstration period, it is imperative that the payment be separate from the bid to fully evaluate the impact of the model.

VBID should encourage MA plans to increase hospice access for their patients to improve end-of-life care. As hospice access increases, the VBID hospice-specific payments to MA plans will increase per capita. With any evaluation of program success, the whole picture needs to be evaluated to include Parts A/B payments as well as the VBID hospice payment to evaluate the potential for total cost of care reductions.

VNS Health remains committed to participating in the demonstration to inform model improvements and future policy in the long run.

#### D. Support Affordability and Sustainability

**1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?**

***Allowing HIDE SNPs to be Eligible for the Frailty Adjuster.*** To support the sustainability of HIDE SNPs and to promote expanded access to integrated care, we support ACAP’s proposal for CMS to expand the applicability of frailty adjustments, which is currently available for FIDE SNPs, to also allow HIDE SNPs. FIDE SNPs and HIDE SNPs often enroll populations with no underlying differences in enrollee demographics, dual eligible status, or levels of frailty, and thus payment accuracy should be a consistent principle across these integrated care plans.

***SDOH Adjustment.*** We support ACAP’s proposal for CMS to incorporate a 5% SDOH adjustment for integrated D-SNPs.<sup>16</sup> Plans would be required to use this funding adjustment to offer supplemental benefits targeting the social determinants of health that impact duals the most including food and nutrition programs, increased transportation, programs to combat social isolation, and housing support.

**2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?**

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<sup>16</sup> Association for Community Affiliated Plans. 2022. ACAP Pathway to Improve Health Equity. Available here: <https://www.communityplans.net/wp-content/uploads/2022/06/ACAP-Pathway-to-Health-Equity.pdf>

**Incorporate functional status.** CMS could incorporate functional status within the existing CMS-HCC risk adjustment model. The current model's focus on disease-state acuity calculations precludes the type of whole person functional perspective taken by LTSS care management approaches. As stated in a 2018 GAO report, the MA risk adjustment model underestimates spending on individuals' functional status and their ability to perform daily activities such as bathing or dressing.<sup>17</sup> Though a plethora of assessment tools are used to collect the functional status data needed to inform the inclusion of such functional information in the risk adjustment process, this serves as the basis for a vast portion of eligibility and service delivery determinations in the LTSS environment. More importantly, despite these challenges, state Medicaid agencies, including New York, are already performing rate-setting actions for MLTSS plans using functional status through encounter-level data reported by Medicaid managed care organizations.<sup>18</sup> This experience can serve as an important reference point for changes to the existing MA risk adjustment model.

**Incorporate social risk factors.** CMS could consider incorporating social factors that place individuals at higher risk. A key challenge with this risk adjustment approach is obtaining data regarding social risk factors. Historically, data on social risk determinants have not been collected consistently or systematically in a manner similar to how medical diagnosis data is recorded. The limitation can be addressed by using census survey data as a proxy for individuals' own social factors, and repurposing existing administrative and claims data pertaining to social risk factors. Acquiring, linking, and analyzing this data is uniquely difficult mainly because of the disjointed way in which data is collected and the lack of standardization.

## Conclusion

Thank you for the opportunity to comment. We look forward to continuing to partner with CMS to advance health equity goals, encourage VBP, and strengthen the MA program for the beneficiaries we serve.

Sincerely,



Dan Savitt  
President & Chief Executive Officer  
VNS Health

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<sup>17</sup> Benefits and Challenges of Payment Adjustments on Beneficiaries' Ability to Perform Daily Tasks. GAO Publication No. 18-588

<sup>18</sup> Center for Health Care Strategies, Inc. Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations. January 2016. Available at: [https://www.chcs.org/media/MLTSS-Rate-Setting\\_Final1.pdf](https://www.chcs.org/media/MLTSS-Rate-Setting_Final1.pdf).