

The SNP Alliance



A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

SNP Alliance Comments on Request for Information

April 24, 2017

In the 2018 Rate Announcement and Call Letter CMS requested that stakeholders and the public share their ideas for changes to the program's regulations, sub-regulatory guidance, and practices and procedures. CMS indicated a commitment to maintaining benefit flexibility and efficiency throughout the MA and Part D programs by allowing for innovative approaches. CMS also indicated it wanted to continue this trend by using transparency, flexibility, program simplification and innovation to transform the MA and Part D programs for Medicare enrollees to have options that fit their individual health needs.

Ideas could include recommendations regarding benefit design, operational or network composition flexibility, supporting the doctor-patient relationship in care delivery, and facilitating individual preferences. They could also include recommendations regarding changes to the way plans are paid, monitored, and measured; when and how CMS issues regulations and policies ;and how CMS can simplify rules and policies for beneficiaries, providers and plans.

The SNP Alliance is a national leadership organization dedicated to improving total quality and cost performance through specialized managed care, and advancing integration of health care for individuals who are dually eligible for Medicare and Medicaid. Our membership includes representation from 27 health plan organizations and for the populations they serve. Our members offer more than 250 plans in 39 States and the District of Columbia and enroll over one million Medicare beneficiaries. SNP Alliance members serve over 50 percent of Special Needs Plans (SNPs) enrollees with representation from all SNP types, including those serving: (1) beneficiaries dually eligible for Medicare and Medicaid benefits (D-SNPs); (2) those diagnosed with a severe or disabling chronic condition (C-SNPs); and (3) those living in or eligible for nursing home care (I-SNPs). About three-quarters of the Alliance's members operate fully integrated, dual-eligible SNPs (FIDESNPs) or plans in the CMS Financial Alignment demonstration (MMPs).

We thank CMS for the opportunity to offer our ideas for maintaining benefit flexibility and efficiency, and allowing for innovative approaches in care of high-cost/high-need beneficiaries, particularly, but not exclusively, for those who are dually eligible for Medicare and Medicaid.

FOUNDATIONAL REMARKS

As background to our specific recommendations, we offer the following propositions to guide the re-engineering of Medicare financing, policy and oversight, with the goals of improving quality while containing the escalation of Medicare costs.

1. The vast majority of Medicare costs and care complexities are related to caring for persons who are poor, frail, disabled, and with late-stage and/or complex chronic conditions.
2. Most MA financing, policy, and oversight requirements do not adequately account for the multi-dimensional, interdependent, and ongoing nature of chronic disease and disability; OR a host of psycho-social and environmental factors affecting health and healthcare outcomes; OR the interdependence between Medicare and Medicaid in seeking to improve quality and cost performance in serving Medicare beneficiaries.
3. Improving Medicare quality and cost performance for these high-risk/high-need persons is dependent upon: a) taking into account the systemic nature of chronic disease and disability as noted above, b) improving the relationship among related care providers in serving these high-cost/high-need beneficiaries as their care needs evolve over time and across care settings, and c) improving the alignment of incentives, policy, and oversight requirements between Medicare and Medicaid for dually eligible beneficiaries.
4. SNPs and MMPs provide an ideal foundation for facilitating *the delivery of high-quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiencies, and advancing to an overall effort that will reduce the growth in Medicare spending over time.* (Current SNP law requires SNPs to go beyond the offering of traditional Medicare Advantage (MA) benefits and services to maintaining a model of care, network of providers, and team-based care management practices that are tailored to a defined population of high-risk/high-need beneficiaries. SNPs have an incentive to take into account a beneficiary's TOTAL array of care needs, re-order the balance of what is provided to them and the relationship among a full spectrum of related providers, and provide whatever combination of care that is most cost effective, in the aggregate. Over two million of the three million duals serviced by MA plans are served by SNPs.)
5. For SNPs and MMPs to be successful over time, SNP and MMP financing, policy and oversight must be more flexible, simpler, and more tailored to the unique needs of the poor, frail, disabled and chronically ill subgroups being targeted by SNPs and MMPs— consistent with their Congressional mandate for advancing specialized benefits and services for Medicare's most vulnerable, costly, fast-growing beneficiary groups.

Given these foundational propositions, we offer the following recommendations for improving the total quality and cost performance in serving high-need/high-cost Medicare beneficiaries. We pay particular attention to improving: 1) the alignment of Medicare and Medicaid and 2) improving performance measurement for high-cost/high-need persons.

RECOMMENDATIONS FOR BETTER ALIGNMENT OF MEDICARE AND MEDICAID

Since the creation of SNPs in 2003, the SNP Alliance has worked closely with Congress and CMS to shape SNP policy to improve services to dually eligible beneficiaries with special focus on advancing the integration of Medicare and Medicaid policy, operations and service delivery to improve the cost effectiveness, administrative efficiency and quality of services for this highly complex, costly and diverse group of beneficiaries. Dually eligible beneficiaries make up a disproportionate share of both Medicaid and Medicare costs. States, health care advocates, health plans, providers and CMS must all share a responsibility for improving care for this special needs population, with the proportion of

dually eligible enrollees in both programs expected to grow rapidly over the next ten years, driven in large part by the aging of baby boomers. Therefore, we are pleased to have this opportunity to provide innovative ideas and recommendations for changing regulatory or sub-regulatory policy related to better alignment of Medicare and Medicaid benefits and services.

While dually eligible beneficiaries technically have access to a broad array of Medicare and Medicaid services, they face a maze of complex and confusing financial, policy and operational conflicts between the two programs, resulting in inefficiencies, duplications, poorly coordinated service delivery and suboptimal outcomes. Further, these issues are not easily addressed without the cooperation of state Medicaid programs which provide long term services and supports (LTSS) and behavioral health services, along with additional medical care tailored to the needs of multiple subpopulations within varying state market environments. Though state Medicaid agencies are also at risk for increased LTSS and behavioral health expenditures resulting from poor coordination with primary and acute care occurring under Medicare, they are concerned that provision of MLTSS and other Medicaid services can result in Medicare savings (reduced hospitalizations for example) without an opportunity for states to recoup their Medicaid investments. Therefore, some states have been reluctant to embrace changes necessary for improving the alignment between these the two programs, even though such realignment is critical for improving total quality and cost performance for duals across the two programs.

Recognizing these problems, CMS approved the first state operated “legacy” dual demonstrations (MN, WI, and MA) in the late 1990s. Since then, states, health plans, providers and advocacy groups have worked steadily to design service delivery, care coordination and financing options to eliminate or reduce these conflicting fiscal incentives, and improve the quality of care and simplify these programs for beneficiaries. Over the past 12 years, through evolving D-SNP policies, the creation of the Medicare Medicaid Coordination Office and implementation of the MMP Financial Alignment Initiative and the MN D-SNP Administrative Alignment Demonstration, CMS has proved that these integrated programs are viable platforms for state and CMS innovation and collaboration for improvement of service delivery and fiscal policy. In particular, a recent ASPE study on the long standing integrated Medicare Medicaid program in Minnesota indicates significant improvements in outcomes for dually eligible beneficiaries enrolled in the integrated program compared to similar beneficiaries enrolled in a non-integrated Medicaid managed care program offered by the same plan sponsors. (See <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>) <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/09/BPC-Health-Dual-Eligible-Recommendations.pdf>)

These programs are rapidly reaching a pivotal crossroads, where additional policy decisions, guidance to Congressional leadership and operational issues must be addressed to sustain and increase the progress that has been made towards transformation of care for this high needs population. However, neither the D-SNP nor the MMP platforms are permanently authorized to continue to operate. In order for states and plans to make the long term investments and commitments needed to take integrated programs to their full potential, permanent program options which streamline duplicative administrative requirements and create aligned delivery system incentives must be secure, supported and clearly communicated. Through current and strengthened authority, such as that provided in the proposed bipartisan CHRONIC Care Act of 2017 (S 870), CMS can build on successful design features of both models to create permanent model options that fit the needs of most states and beneficiaries.

However, even under permanent authority, the success of these models rests on a myriad of technical administrative and operational issues that must be addressed to improve the efficiency of these programs and make them less complex and more workable for both states and plans. We understand that this requires a careful balance between creating increased flexibilities to accommodate varying

state Medicaid operational procedures while still preserving the interface with more centralized similar operational functions under Medicare.

Current MA statute and regulations already provide the vehicle for accommodating significant variabilities via the requirement that each D-SNP has a MIPPA contract with the state. But plans and states must be provided with greater incentives to fully utilize these contracts to integrate service delivery and operations and to help them overcome current inefficiencies, which are usually rooted in longstanding administrative and operational differences between Medicare and Medicaid.

True transformation would support the current MIPPA contracting process through creation of new authority (if needed) or identification of existing authority under MA for stable and predictable integrated model options (i.e. D-SNPs and/or MMPs or some new hybrid of both) to run on a separate administrative track within the overall MA structure. This authority would provide CMS more flexibility to separate or change current MA and/or Medicaid policy, administrative and operational processes where necessary to facilitate more efficient operations, reduce duplicative functions, and improve care management and delivery under integrated program options serving dually eligible beneficiaries.

To facilitate this transformation, CMS should undertake a review of integrated models, identifying the most effective and efficient operational and policy features and model options and make recommendations to Congress for any additional authority required for implementation.

Recommendations in Caring for Dually Eligible Beneficiaries

Following are more specific recommendations for improving operational efficiencies between Medicare and Medicaid in serving dually eligible beneficiaries:

- **Increase Flexibility, Incentives and Technical Assistance for States:** Transformation of care for dually eligible beneficiaries requires state cooperation and involvement to support MMP and D-SNP contracting, but both plans and states require more support and flexibility from Medicare to overcome technical and operational challenges to achieving efficient integrated systems of care.
 - Currently CMS uses Contract Management Teams (CMTs) to manage and coordinate three-way contracts for MMPs with states. Under the Minnesota D-SNP demonstration, which does not operate under a three-way contract, there is a modified CMT which coordinates policy and operational decisions, policy changes and communications with plans and resolves conflicts or problems. Both CMT models have been highly successful in improving three-way communications between CMS, plans and states, according to preliminary evaluations and feedback from states. CMS should extend the modified CMT to other states and plans that seek to advance improvements in their Medicaid programs through greater alignment of Medicare and Medicaid benefits and services for dually eligible beneficiaries.
 - CMS should also increase education and technical assistance, such as that provided through the Integrated Care Resource Center (ICRC) to states and D-SNPs, to improve understanding of MIPPA contract options, increase understanding of both Medicare and Medicaid requirements, clarify state role expectations for FIDE and HIDE SNP status, identify and address obstacles to operational integration, and create incentives for states and plans to strengthen integrated operational processes.
 - Many states indicate a lack of resources or lack of compelling reasons to pursue further integration of Medicare and Medicaid given other competing priorities. In particular, states complain that Medicare processes are complex and it is costly or too difficult for them to change their administrative and operational processes to match Medicare's. CMS could strengthen

- incentives for additional states to participate in integrated programs through reducing administrative burden such as eliminating requirements for overlapping Medicaid/Medicare reporting and oversight, offering additional supplemental benefit flexibility requested jointly by SNPs and states, such as currently available to MMPs, or by creating and offering new administrative flexibilities needed by plans and states, such as increased enrollment alignment options as outlined below, and expanding and further simplifying access to Medicare data for dual beneficiaries enrolled in FFS Medicare.
- In addition, CMS could provide an enhanced Medicaid match, additional shared savings or grant opportunities.
 - CMS should also increase resources to support states in their effort to reduce costs and improve quality for dually eligible beneficiaries. We believe that an additional investment of time and resources in support of states can pay great dividends for Medicare and Medicaid alike in addressing the large and growing cost of serving a rapidly growing dually eligible population.
- **Strengthen Joint Enrollment Processes and Enrollment Alignment Strategies:** Without aligned enrollment in plans that offer coordinated options to participate in both programs, many of the potential efficiencies of integrated care are not viable (i.e. single enrollment cards, integrated assessments and care coordination systems, and integrated member materials). CMS should promote consistent passive enrollment, seamless conversions and auto assignment opportunities to enable aligned enrollment into integrated plans specializing in serving dually eligible beneficiaries. This effort should include the following:
 - Options for states and plans to passively enroll dually eligible members of Medicaid Managed Long Term Services and Supports plans (MLTSS) into corresponding Medicare D-SNPs offered by the same plan sponsor,
 - Ongoing passive enrollment for new Medicaid eligibles already on Medicare into a corresponding integrated Medicare D-SNP offered by the same plan sponsor on a monthly or quarterly basis,
 - Exempting integrated D-SNPs from the seamless enrollment moratorium for Medicaid members who become Medicare eligible,
 - Streamlining Medicaid's current bi-directional plan assignment methods,
 - Facilitating deeming periods for temporary loss of Medicaid eligibility due to lags in processing redetermination forms, and
 - Matching Medicare to Medicaid MLTSS plan lock-ins.
 - **Strengthen Co-Marketing Strategies:** CMS should work with states as well as MMPs and D-SNPs to clarify and strengthen marketing strategies for integrated plans to assure that beneficiaries are provided with clear and streamlined information about the features and benefits of integrated programs including:
 - A CMS outline of options for states and plans for co-branding of corresponding Medicare and Medicaid products for dually eligible beneficiaries,
 - CMS and states should actively promote and educate potential enrollees about the benefits of integrated programs, including state mailings to potential enrollees (which have been effective in some states), and
 - CMS should address conflicts between Medicaid and Medicare broker systems. Where there is competition from non-integrated MA plans using brokers, CMS should assure equitable treatment by allowing MMPs to utilize trained staff sales persons.
 - **Advance SNP Specific Networks and Exceptions Processes:** The SNP Alliance welcomes CMS' announcement of plans to move toward SNP specific networks. We also support CMS' current movement toward a using a more supply-based approach to network requirements. We believe

these efforts are an important first step in seeking to re-engineer care delivery to be more in keeping with the unique care needs of high-cost/high-need beneficiaries.

We especially appreciate improvements made in the network development and review process under the MMP and MN D-SNP demonstrations. We understand that this process includes additional flexibility in the network exceptions process and that states can be consulted in that process to verify local market situations for ongoing exceptions. CMS has also modified requirements in order to consider the number of dually eligible enrollees in the service area (versus all Medicaid beneficiaries) as well as the types of services needed and utilized by dual eligible beneficiaries. Some MN plans report a 50% reduction in the number of exceptions that must be submitted. CMS should look to lessons learned in this process and extend these principles and features to other FIDE SNPs, D-SNPs and SNPs as part of the new SNP specific network process.

However, we note below continued problems with the Medicare.gov sources, exceptions processes, and HSD table methodologies that CMS uses for identification of available providers. These problems must be addressed to ensure that the current MMP and D-SNP network review process continues to work and so that any new SNP specific network approaches can be successfully and efficiently implemented for all parties.

- *Exceptions Requests and Correction of CMS Provider Sources:* It appears to be extremely difficult both for plans as well as internally within CMS to clear up obvious Medicare.gov provider discrepancies such as cases where providers have moved, were only in a location on a temporary basis or are permanently roving between locations, etc. Providers appear to have few incentives to update their information. The burden of proof is then on the plan which has to invest hours of staff time to document proof that such providers do not exist (sometimes over and over for the same provider.) CMS should categorize such exceptions requests so that those due to geography or death of providers, or other permanent situations do not have to be resubmitted each year. CMS must address this obstacle to assure that the new SNP specific network approach can work.
- *Reflecting Actual Patterns of Care:* In addition, there are many important providers (podiatrists, SNFists, dental specialists, therapists, geriatric specialists, behavioral health clinicians, and others) who do not maintain clinics and/or provide in-home or in-facility, telehealth or mobile van services, where current sources used as a basis for HSD table requirements do not seem to be able to account for them adequately. I-SNPs in particular tell of situations where they use these providers but they are not counted on the HSD tables, so they still have to maintain contracts with additional network providers who are rarely if ever used, just to comply with HSD table requirements. With increasing shortages of many providers, along with changing technologies and the need for more efficient modes of delivery, CMS must find a way to allow SNPs to account for these providers in their networks.
- *Time and Distance Mapping:* SNPs also report continuing problems with the mapping methodologies CMS utilizes which may include a “crow flies” method for time and distance standards, sometimes ignoring geographic boundaries. In one case, for example, the nearest provider (40 miles) required was across Lake Superior in a neighboring state, requiring a nearly 9 hour drive around the lake for access. Such clearly permanent geographic obstacles should not require hours of phone calls with CMS for resolution. CMS should consider how to amend time and distance “crow flies” standards when applied to such geographic barriers and should maintain documentation so that these cases do not have to be dealt with over and over again. In order to resolve such issues more quickly, CMS could create and staff for quick turnaround, a mailbox specific to application network questions e.g., similar to the DMAO Mailbox used to respond to other types of application questions.

- *Refusals to Serve Dually Eligible Beneficiaries:* We also remain concerned that CMS network requirements do not address problems with Medicare providers who refuse to serve dually eligible beneficiaries. While plans that sponsor both larger MA products and SNPs can tie participation in the larger products to serving dually eligible members, smaller stand-alone SNPs may lack the leverage to obtain such provider cooperation. We ask that CMS consider and address this issue by allowing for an exception that this occurs as the new SNP specific requirements are developed. We also suggest that CMS should notify plans both well in advance and with enough specificity to allow plans enough time to appeal adverse CMS network adequacy decisions.
 - *New Medicaid Network Requirements:* We continue to be concerned about potential conflicts between new Medicaid network requirements and CMS Medicare requirements. On the one hand, state Medicaid networks often allow for telemedicine and transportation options that Medicare should also allow. On the other hand, as states develop new network requirements, CMS should make sure that where plans provide integrated programs, alignment with Medicare is considered in the new state Medicaid requirements.
 - We appreciate that CMS has noted that it intends to work on network adequacy requirements fitting SNPs and are interested in working with CMS on these policy enhancement efforts, not only for dually eligible beneficiaries but also for all other SNP types serving defined high-cost/high-need subgroups of Medicare beneficiaries.
- **Increase Coordination of Model of Care (MOC) and Health Risk Assessments with Medicaid MLTSS:**

The heart of the opportunity for improved health outcomes, management of costs and efficient service delivery for dually eligible beneficiaries in integrated Medicare and Medicaid programs lies with their care coordination systems. Unlike general MA plans, SNPs must develop a MOC specific to the population of beneficiaries served. In addition, since D-SNPs enroll dually eligible beneficiaries who often require extensive LTSS and behavioral health services provided through Medicaid, coordination with states and Medicaid benefits is an essential additional requirement. State MLTSS programs are bound by separate Home and Community Based Waivers and Medicaid State Plan parameters that must contain both state and federal regulatory and statutory requirements, thus further complicating coordination of care management strategies. Some FIDE SNPs have been able to attain a high degree of integration in their MOCs and MLTSS care coordination systems, largely within the bounds of current Medicare and Medicaid requirements, through their existing MIPPA contracts. MMPs have been able to maximize integrated MOCs through three-way contract arrangements and overarching CMS-State Memorandums of Understanding (MOUs). However, many other D-SNPs and states face numerous administrative and operational challenges when they try to implement and “retrofit” integrated programs after they are already established under separate products.

First of all, such integration requires aligned enrollment, and dually eligible members may be enrolled in different plan sponsors for Medicare and Medicaid; and, as a result, the enrollee may be subject to two different care coordination systems with possibly conflicting and cost-shifting incentives. In addition, in many situations, state MLTSS assessment requirements and forms may not coordinate well with Medicare HRA requirements and timelines. Staffing levels, qualification requirements and scope of work for individual care coordinators may differ, even within states, depending on which population and which MLTSS waiver services are included. Care Plan requirements and requirements for Interdisciplinary Care Teams may also differ. Differences in performance measurement requirements, including measures, data collection, methodologies, survey tools and priorities, are yet another issue. Some requirements are in state law, posing challenges for plans that operate products in multiple states and need to maintain a certain standard across states.

While there is nearly unlimited potential for improving the efficiency of care coordination models under an integrated Medicare Medicaid platform for both states and plans, investment in administrative and operational changes needed to ensure that MOC functions are efficient and complementary rather than duplicative or conflicting are hampered by the lack of permanent platforms and clarity about the future direction for these models. This is also hampered by conflicts in oversight and measurement priorities and frequent changes and perceived lack of flexibility in administrative processes and details. Under the exact right circumstances, including extraordinary state interest and coordination, it is potentially feasible to achieve a reasonably efficient integrated care coordination system outside of demonstration status, but only a few plans have done so. The current MMP and D-SNP demonstrations have had additional advantages that have addressed some of those barriers. For example, these states received grant funding to assist in development of integrated models of care including MLTSS. MMPs are able to fully align enrollment into both plans through use of passive enrollment and are required to have an overall MOC for both Medicare and Medicaid. D-SNPs in the MN D-SNP Demo initially built their MOCs on state MLTSS requirements and the state was then allowed to add and review key MLTSS features within the MOC documents.

New CMS requirements for MOCs to be constructed at the contract level could make it more difficult to continue to reflect D-SNP features specific to state MLTSS populations and subpopulations, creating new administrative complexities in integrating care coordination functions. CMS should continue to provide additional instruction about how MOCs can reflect state and subpopulation differences (including well-coordinated or aligned MLTSS requirements) at the contract level similar to the current MOCs for the MMPs and D-SNP demonstrations. If integrated plan options are to grow, longer term, CMS should consider requiring that MOCs for integrated plans match population and care models enrolled at the Plan Benefit Package (PBP) level and/or modification of the H number assignment policy for D-SNPs to create options for “clean contract numbers” without forcing D-SNPs into current H numbers with other plan products.

CMS should also provide additional flexibility to allow plans and states to align, coordinate or merge administration of assessments and assessment tools where it makes sense to do so, allow flexibility on annual assessment deadlines to avoid duplication and enrollee burden and make other adjustments to more efficiently incorporate MLTSS requirements. Flexibilities could include allowing states to add MLTSS requirements to the MOC and to review and provide feedback on those sections to facilitate ongoing integration, and CMS assurance that CMS audits will take into consideration MOC variations related to such state requirements in order to avoid conflict upon audit.

In summary, to bring the care coordination required under integrated programs to its most effective and efficient potential there are prerequisite design features that must be in place to support that goal. At minimum, any current and future platform must address the following elements:

- Permanent D-SNP/MMP platforms with some clarity and stability in related requirements under both Medicare and Medicaid,
- Clarity in roles and expectations for states along with some opportunities to benefit from the arrangement,
- More aggressive passive enrollment or related provisions to support fully aligned enrollment.
- Flexibilities to coordinate, integrate or align Medicare HRA and MOC requirements with MLTSS assessment processes, care plans and care coordination requirements to reduce duplication and improve the efficiency of the care coordination process,

- Ability for D-SNPs to create MOCs tailored to state specific MLTSS requirements and to clearly reflect multiple subpopulations and PBPs within contract level MOC templates,
 - Alignment of performance measurement expectations and oversight requirements (as has been done to some extent under the MMPs) with collection and reporting of meaningful data reflecting the population served (if multiple products under one contract it must be reported at the PBP level), and
 - Integration of Medicare acute care financial risk and Medicaid MLTSS financial risk at the plan/PBP level to encourage long-range incentives.
- **Improve Beneficiary Communications through Simplification of Member Materials and Review Process:** We greatly appreciate the strides CMS has made to improve member materials under both the MMP and D-SNP demonstrations. We congratulate CMS for working to bring some of those improvements (such as the new Summary of Benefits model) to D-SNPs outside of the demonstrations and encourage CMS to continue to expand those options for other D-SNPs. We recommend that CMS continue this work through additional improvements including the following:
 - Beneficiaries enrolled in FIDE SNPs and some highly integrated D-SNPs should be allowed to benefit from use of the MMP Member Handbook model instead of the more complex and difficult to read ANOC/EOC. We request that CMS make this option available as soon as possible to FIDE SNPs and integrated D-SNPs requesting to use the Handbook. CMS recently requested comments on these documents through the Paper Work Reduction Act (PRA) Request for Comment process. Please see the SNP Alliance comments submitted March 16, 2017 as part of that process. While we understand that many CMS divisions rely on EOC provisions for legal reasons, we encourage CMS to work to find plain language accommodations for those requirements.
 - We encourage CMS to improve and simplify beneficiary materials by continuing to add flexibility in language blocks and translation requirements to meet local needs, working with states and FIDE SNPs and integrated D-SNPs to reduce or consolidate duplicative notices, including support for legislation to modify integrated denial notice (IDN) requirements, and reducing the language levels used in CMS required documents (states often limit it to 5th or 7th grade reading levels, while CMS documents Flesch at grade 12 levels).
 - We also recommend that CMS extend the joint materials review process provided under the MMP and D-SNP demonstrations to other states and FIDE SNPs and assess whether the process could be used by other D-SNPs as well. This process should be designed to provide plans and states opportunities to consolidate or un-duplicate certain notices to reduce paperwork burdens for beneficiaries as well as for better coordination of timelines and reductions in conflicts between states and CMS in handling updates and other language changes needed for both programs.
 - **Collection of Performance and Financial Data at the PBP Level:** We recommend that where there are multiple D-SNP products for dually eligible beneficiaries included under one contract number, CMS move toward collecting performance, model of care and financial data at the PBP level versus the contract level. Sample sizes for performance information collected at the contract level such as for HOS and CAHPS surveys are not large enough to capture the wide variations in dually eligible sub-populations enrolled under many SNPs. As a result, data collected at the contract level does not reflect actual SNP performance for this important and complex population, hampering the evaluation of the many special MOC and other care management initiatives employed by SNPs to address complex needs of their enrollees.

Further, states report that contract level data is not useful to states for evaluating SNP performance under MIPPA contracts because it is not specific to the dually eligible population enrolled. States then must duplicate oversight and data collection in order to fully evaluate performance for the

actual enrolled population that then increases administrative burden for both plans and states. Collection of data at the PBP level would increase the usefulness of Medicare required data for states, and could reduce duplicative oversight for both parties, by allowing states to rely on Medicare's data instead of duplicating collection.

In moving toward collection of data at the PBP level it is critical that the more refined data collection effort fully account for the impacts of social determinants of health (SDOH) on health care outcomes for dually eligible beneficiaries in order to facilitate a fair accounting of the differences between dually eligible beneficiaries and the general Medicare population. It is also critical that CMS do everything possible to minimize data burden on plans involved. If properly done, we believe CMS, states and plans will be able to more fully craft and assess the cost benefit of caring for one of the most vulnerable, costly, and complex care segment of the Medicare program. This kind of approach is also going to be necessary to pursue as CMS crafts policy for plans participating in the VBPD demonstration where product differentiation for certain segments of a plan's overall enrollment is being contemplated.

- **Improved Coordination of Procurements:** CMS should create options for further alignment of state/federal procurement mechanisms for integrated D-SNPs and Medicaid managed care plans to address off schedule and unforeseen situations such as plans leaving the market or to address the need to increase plan options through Service Area Expansions. While CMS does not directly procure for participation in MA, using an application process instead, states are generally required to follow formal procurement requirements in Medicaid. These procurements may also be driven by broader population considerations while impacting dually eligible enrollees who are a smaller subset of the Medicaid. It is not possible to predict all legitimate situations in which local market changes or financial or performance problems can disrupt ongoing access to integrated plan options for dually eligible beneficiaries due to procurement requirements. However, alignment of current Medicaid and Medicare procurement or application cycles requires a minimum of 18 months and often it is not possible to align even within that timeframe. CMS, states and plans need an additional window for resolution in situations where beneficiaries could face unneeded disruption and/or loss of benefits. CMS should define those situations. As part of a more permanent set of options for states and integrated plans recommended above, CMS could look to the PACE program where states and providers are provided additional flexibility for program initiation and readiness review timeframes mutually agreeable to all parties.
- **Improved Supplemental Benefit Flexibility:** The SNP Alliance appreciates the additional flexibility provided to allow D-SNPs that meet a "high standard of integration and specified performance and quality-based standards" as outlined in Chapter 16b of the Medicare Managed Care manual (sometimes referred to as Highly Integrated Dual Eligible SNPs) to provide the expanded list of supplemental benefits to members not otherwise eligible for them under Medicaid as outlined in CMS' January 8, 2016 memo. However, we point out that the list of supplemental benefits allowed beyond that of regular MA is still limited and has not been all that useful to D-SNPs. Many of the additional benefits listed are more expensive services that cannot be accommodated within bid limitations (i.e. personal care and adult day care) or are already covered by Medicaid so are not useful to the large array of members receiving Medicaid MLTSS services.

Further, because the expanded list of allowed services for HIDE SNPs focuses on more costly and often open ended services, it is also difficult to model or design management parameters predictive of the financial impact of these services to assure they can be successfully accommodated under bids. There also appears to be some confusion about the parameters of these benefits. While Instrumental Activities of Daily Living (IADLs) are discussed as part of the basis of need for the

current list of services, requests for affordable and useful supplemental services that directly address IADL needs have been rejected by CMS. SNPs may also have to prioritize inclusion of more traditional services such as hearing, eye and dental care to meet state expectations and to match local competition with general MA plans. Further, little information about the HIDE SNP approval process has been available so it is not clear whether the lack of participation in this feature is due to plans not meeting the quality standards or to problems with the benefits.

- We recommend that CMS work with D-SNPs and states to revise the list of additional supplemental benefits available to HIDE SNPs to provide additional flexibility, focusing on affordable supplemental benefits that can address SDOH and IADL needs.
 - We also recommend that CMS revisit the quality criteria used to define HIDE SNPs and improve transparency around the application and approval process to clarify whether the criteria are providing unrealistic barriers to provision of the expanded supplemental benefits.
 - Under the FAI, states and MMPs have more flexibility to jointly agree upon and offer supplemental benefits more specifically tailored to dually eligible beneficiaries and populations enrolled. We recommend that CMS extend similar flexibility to integrated D- SNPs.
 - In addition, we also recommend that CMS extend the opportunity to provide additional supplemental benefits to other SNP types, such as I-SNPs, IE- SNPs and specialty C-SNPs enrolling large numbers of dually eligible members (such as plans that specialize in serving beneficiaries with HIV and Behavioral Health diagnoses). These plans would also be able to better serve their members if provided added flexibility in their supplemental benefits. CMS could require that plans demonstrate how the additional benefits are of unique importance for improving health and healthcare outcomes for the particular subgroup being targeted.
- **Improved Methodology for Access to the Frailty Adjustor:** Congress provided authority for FIDE SNPs with similar average frailty scores to PACE to receive an additional frailty adjustor payment to recognize costs of caring for a high concentration of dually eligible members. However very few FIDE SNPs qualify for this payment, largely because of state Medicaid enrollment requirements. PACE only enrolls members age 55 and over who are already eligible for MLTSS. But most states do not limit enrollment under their MIPPA contracts to dually eligible beneficiaries who meet MLTSS criteria; instead many require that FIDE SNPs also enroll duals who do not meet those criteria so the FIDE SNP population mix is not comparable and average frailty scores are lower than PACE.

There is nothing to prevent states and FIDE-SNPs from utilizing similar enrollment criteria as PACE, thereby enabling many more FIDE-SNPs to meet similar average frailty scores. In fact, a few states do facilitate this by splitting their programs into two and limiting their MLTSS enrollment to those who already qualify for MLTSS services while enrolling the non-MLTSS and therefore less frail beneficiaries into a separate managed care program. They may then also have separate MIPPA contracts that can coordinate with each product. However, more typically, state Medicaid managed care programs require that FIDE-SNPs enroll all elderly dually eligible members, regardless of frailty status, or may require that they enroll all dually eligible beneficiaries, regardless of age. States make these choices based on legitimate policy decisions but these decisions are entirely outside of the control of D-SNPs. Some states argue that enrolling the entire population creates stronger incentives for long-range investment in prevention of and care management for chronic conditions and provides opportunities for quicker interventions to address members' status changes. They also believe it reduces administrative burdens for members who would otherwise have to re-enroll in a separate Medicaid plan and D-SNP when their status changes.

The result is that even though FIDE-SNPs may enroll all of the available MLTSS enrollees in their service area, enrollment of the less frail non-MLTSS enrollees will reduce their frailty scores and make it difficult for the SNP to reach the PACE average frailty score. This also deprives dually

eligible frail MLTSS members of potential supplemental benefits that may have been made possible through the frailty payments. We question whether Congress anticipated or intended this result.

We believe that the methodology CMS uses for comparing average levels of frailty between PACE and FIDE-SNPs should be based on an appropriate comparison between members with similar frailty status. CMS could encourage D-SNPs to become more integrated by developing a new methodology for comparing frailty status based on actual identification of eligible MLTSS members enrolled in both programs. For FIDE SNP members this could be accomplished through use of home and community based service (HCBS) data for those members assessed to be eligible for state MLTSS services programs. This data is already collected and monitored by states through CMS HCBS waiver programs. CMS could then equitably compare average frailty scores for that group of FIDE SNP enrollees with the PACE population. As discussed above, CMS already allows D-SNPs and states to split dually eligible plans and members so splitting the membership into MLTSS and non-MLTSS groups is already consistent with current CMS policy. However, the new methodology would better preserve long term incentives for care management and reduce administrative burden for managing enrollment changes related to MLTSS status for both beneficiaries and plans.

At the same time, CMS should use a different instrument for determining the frailty score. As discussed in previous comments submitted in response to the Call Letter, HOS is a poor instrument for determining frailty due to small sample sizes and other problems.

A further issue with the frailty adjustor relates to the timing of CMS notification to plans of their qualification for receipt of the additional funds. Notification to qualified plans is usually provided 7 to 8 months after bids are submitted. Such late notice interferes with the plan's ability to incorporate those funds into activities that most benefit the members and could even trigger an unexpected Medical Loss Ratio rebate requirement.

Finally, we wish to point out that IE-SNPs also serve populations similar to those enrolled in PACE, and we recommend that they should also be able to access the frailty adjustor.

Integrated Grievance and Appeals: Few issues are as complex and vexing as the problems dually eligible beneficiaries encounter due to conflicting, duplicative and overlapping requirements for grievance and appeals under the Medicaid and Medicare programs. We recognize that CMS has tried to address some of these issues through alignment of certain requirements under the FAI and D-SNP demonstrations and changes in the new Medicaid managed care regulation that align Medicaid timelines with Medicare and require that appeals be exhausted at the plan level prior to second level reviews. However, we are aware that some states have additional statutory requirements and/or consumer and advocacy expectations that may be difficult to reconcile and thus may have objections to the new requirements so we are concerned about whether these portions of the new rule will be fully implemented and we encourage CMS to work with states to resolve these issues while continuing to align timelines and processes.

In addition, there are a number of remaining obstacles to integrating Grievance and Appeals processes including policy and/or statutory differences between Medicare and Medicaid around the following issues:

- Requirements for duplicative integrated denial notices (IDN) under Medicare even when services are covered by Medicaid (recently addressed by CMS but not fully resolved due to statutory interpretations),
- Auto-forwarding of appeals to separate entities and separate hearing rights including federal rights to Medicaid hearings,

- Medicare amounts in controversy levels (Medicaid usually does not have such requirements),
- Requirements for aid pending appeal (not allowed in Medicare),
- Possible time frame differences depending on implementation of the new Medicaid rules, and
- Handling of provider level appeals.

Much can also be learned about increasing coordination of the two processes from the experiences in the FAI and the D-SNP demonstration. Many of these issues could be resolved by utilizing an approach based on these demonstrations where appeals and grievance timelines and processes are coordinated and agreed upon and coupled with a plan level integrated benefit determination process that triages the items to the appropriate Medicare or Medicaid second level entity for further action. Such integrated determinations can reduce duplication and thus the volume of items that need to be forwarded to second level reviews while preserving rights under both authorities and can be used as a model for resolving some of the remaining conflicts. These issues are highly technical and must be informed by expert advice.

- We recommend that the MMCO be provided with authority to waive federal Coverage Determinations, and Appeals requirements for dual eligible beneficiaries who are entitled to services pursuant to a contract between Medicare Advantage and the State Medicaid agency, with guidance provided from stakeholders, including D-SNPs and consumer advocates.
- **Coordinate State and CMS Audits and Oversight:** It is highly inefficient and costly for both SNPs and their regulators to sustain multiple and duplicative state and federal financial and performance audit and oversight processes for dually eligible beneficiaries enrolled under both programs. CMS has mitigated this somewhat as part of the design of the FAI demonstrations, but FIDE SNPs and other D-SNPs are still subject to the full array of all oversight provisions applicable to both Medicare and Medicaid. One D-SNP recently reported that they were subject to five different audits from both programs at nearly the same time. As part of the plan for future design options for integrated programs for dually eligible beneficiaries discussed above, and building from lessons learned from states and MMPs under the current FAI demonstration, CMS should create a coordinated Medicare and Medicaid oversight process that reconciles duplicative and often conflicting data collection, auditing protocols, and timelines and streamlines, integrates and coordinates those processes to reduce administrative burden for all parties.
- **Value Based Purchasing (VBP) Arrangements under Integrated Programs:** D-SNPs and MMPs provide an excellent platform for implementation of value based purchasing initiatives since they are uniquely able to merge Medicare and Medicaid financing at the plan level creating new efficient payment models and improved incentives for care management that can benefit beneficiaries at both plan and provider levels. A number of D-SNPs across the country are working to integrate care delivery systems for primary care and behavioral health and/or primary care and MLTSS services through various provider level performance payment mechanisms ranging from sub-capitations that integrate care coordination functions to inclusion of dually eligible beneficiaries in accountable communities for health or sharing risk and gains through performance pools.

Other SNPs focusing on specific populations (I-SNPs, IE SNPs and C-SNPs) are also working with providers to design unique and innovative payment and intervention models specific to complex populations served. Yet, SNPs have not been included in CMS VBP demonstration opportunities such as the Value Based Insurance Design demonstration (VBID) that provides additional flexibility to tailor benefits and innovations in provider payments to meet the needs of identified subpopulations.

- The SNP Alliance recommends that all SNPs be given comparable flexibility to other MA plans participating in VBID arrangements or be allowed to participate in VBID, allowing them to design additional supplemental benefits and consumer incentives to enhance care for their population subsets, including opportunities to address social determinants of health and additional non-medical services that improve the overall health of individuals with chronic diseases.
- CMS should also seek to include Part D benefits in member incentives. CMS allows Part-D member incentives for plans that participate in VBID demonstrations but not for SNPs. The benefits from the demonstration are yet to be fully determined but seem promising as they are based on commercial consumer driven models. From a value-based perspective, all plans could benefit from having such flexibility. Moreover, SNP members have cost sharing requirements that may act as barriers toward adherence to medications and or the SNP's ability to help steer their members' decisions toward value-based drugs. Adding this feature may improve utilization patterns and help reduce costs.
- **Alignment of FIDE SNP and MMP Requirements:** FIDE SNPs and MMPs are both advanced forms of integration and serve similar population segments, yet they operate under slightly different payment methods and administrative structures. The SNP Alliance recommends viewing MMPs and the SNPs demonstration program in Minnesota as an ongoing testing ground for improving the performance of program integration through redesign of administrative, oversight, and program policy. Where a particular change in approach has been showed to simplify operation, improve efficiencies, and/or improve care outcomes, the change in policy and/or oversight practice should be immediately applied to FIDE SNP operations. CMS should also explore options for merging best practices from these two programs into a new, next-generation program for advancing dual integration over the long term. The SNP Alliance would welcome the opportunity to work with CMS in exploring these options as the SNP Alliance membership contains broad representation from the full spectrum of MMP and FIDE SNP programs, with those involved having decades of experience at the plan and state levels in advancing integrated care for duals.
- **Continued Promotion and Support for Data Sharing:** We appreciate steps CMS has taken to make additional Medicare data available to states and MMPs as part of the FAI. We recommend that CMS facilitate sharing of "blind spot" encounter or claims information with SNPs who are serving dually eligible members who are in FFS or other Medicare arrangements. For example, a March 3, 2017 CMS study prepared by FEi Systems *MMDI Use Case: Leveraging Integrated Medicare & Medicaid Data to Examine Dual Eligibles' Prevalence of Behavioral Health Conditions and Differences in Cost and Service Use*, indicates that without utilizing both Medicare and Medicaid data, behavioral health conditions will be significantly under reported and access to both data sets is necessary to understand the full range of related diagnoses of dually eligible beneficiaries. In addition we recommend that CMS facilitate and develop solutions to continued confusion and conflicts between within network providers, SNPs and states around sharing of data for behavioral health/substance abuse needs and care planning.
- **Improvement in Risk Adjustment Model:** The SNP Alliance is very appreciative of the 6-segment adjustment that CMS made to the community segment of the HCC model to more fully and fairly account for the cost of serving full benefit duals. This has been particularly important for plans seeking to advance care innovation through exclusive targeting of certain high-risk/high-need subgroups. In the spirit of advancing further innovation in care of special needs populations, we want to call your attention to several provisions contained in the 21st Century Cures Act. These are:
 1. Taking into account the total number of diseases or conditions of an individual enrolled in an MA plan.

2. Using at least 2 years of diagnostic data in calculating payment.
3. Evaluating the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model.
4. Evaluating the impact of including the severity of chronic kidney disease in the risk adjustment model and whether other factors should be taking into consideration.

These are scheduled to be phase-in over three years beginning in 2019.

We also want to highlight Cures Act provisions that require MedPAC to study: 1) how to most accurately measure the functional status of enrollees in Medicare Advantage plans, 2) whether the use of such functional status would improve the accuracy of risk adjusted payments under the Medicare Advantage program; and 3) what the challenges are in collecting and reporting functional status information for Medicare Advantage plans.

The SNP Alliance would welcome the opportunity to work with CMS on these efforts as they are critical to the ability of plans to specialize in care of Medicare's most vulnerable, costly and fast-growing service groups.

IMPROVING PERFORMANCE MEASUREMENT FOR HIGH-COST/HIGH-NEED PERSONS

The SNP Alliance has a number of short-term recommendations for improving the existing quality measurement system and a longer-term recommendation for transforming the current system so that it better supports meaningful quality improvement.

The SNP Alliance offers the following additional *guidelines* when refining the existing quality measurement system to promote fairness, equity, attention to health disparities, and health equity, and attention to meaningful measurement—balancing administrative burdens with value added information that can drive quality improvement.

Measurement System Guidelines

1. Measures should reflect the population needs and characteristics to be meaningful and relevant for quality improvement efforts.
2. Every beneficiary should be able to participate equally in the quality measurement process.¹
3. Social determinants of health risk factors are fully considered--minimum standards are set for measure developers and stewards for testing and adjustment.
4. Analysis of results supports relevant comparisons so that like populations are compared with each other consistently and so that relevant quality improvement efforts can be designed and tested.
5. Fairness and attention to administrative burden is demonstrated.
6. There is a balance of process and outcome measures, with greater focus on outcomes that plans and their provider networks can impact.
7. There is an ongoing effort to increase effectiveness and consistency for quality measurement that is based in science, through aligning metrics across states, where possible, recognizing state's authority.

¹ Currently those who do not speak English, Spanish, or Chinese, and/or who have: low health literacy/limited education, transient residences, lack of reliable phone communication, little/no access to the Internet, cognitive impairment, or other limiting conditions and social risk factors—experience significant barriers to participation.

8. CMS reporting comparisons ensure match of like to like in terms of plans and populations enrolled.

In adopting a population-based focus on quality measurement and improvement, CMS signals its recognition that population characteristics affect individuals' health and care delivery. We strongly recommend that CMS attend to the dully eligible population as a preferred starting point for advancing a population-based approach to performance measurement. Dual and non-dual Medicare beneficiaries exhibit significantly different characteristics. Therefore, the quality measurement system that is focused on populations of general MA plans should not be applied across plans with very different enrollee populations. CMS should also create an environment where quality is compared for similar populations. In addition, in keeping with the Assistant Secretary for Planning and Evaluation (ASPE) and National Academy of Sciences, Engineering and Medicine (NAM) recommendations and analyses on accounting for social risk factors in Medicare quality and value-based payment, the SNP Alliance also strongly urges a more robust approach to adjust for social risk factors, and stratifying analysis and reporting.^{2 3}

Current QMS - Recommendations for Modifications

With this context as a background, we offer the following recommendations for modifying the Medicare Quality Measurement System (QMS) program under current CMS authority:

1. **Allow SNPs to substitute the four SNP-specific Star measures for four other related measures**—The SNP specific measures are important to maintain. While difficult to address and complex in terms of specification, these four measures provide important information to special needs plans and their providers for quality improvement. The effort expended should be supported by some flexibility and relief—allowing SNPs to use these measures in lieu of 4 others, with CMS accepting and incorporating these in measures in the Star rating and QBP system. This would signal CMS' recognition of: the unique challenges of addressing multiplicity of needs among the dually eligible, the additional administrative burden which has only been applied to SNPs, and the need to continue to tailor measurement in order for it to be meaningful and useful for quality improvement.
2. **Authorize additional exclusions and exceptions to specific preventive measures for beneficiaries with specific conditions at later stages**, e.g., ALS, MS, Parkinson's disease, severe or late stage Alzheimer's disease, HIV/AIDs in a late stage, etc., such as is being proposed for I-SNP populations that have similar characteristics where the measures are not clinically meaningful and/or where opportunity for harm/distress outweighs opportunity for benefit to the individual.
3. **Stratify at the beneficiary level** – CMS should provide guidance to plans and providers on what relevant beneficiary groups should be stratified, and how, using consistent data definitions, variables, and methods. Such stratification (grouping) would take into account social risk factors and function/care complexity, and also use designated variables known to affect health outcomes independent of provider or plan actions—where data is available or can be made available by CMS. Beneficiary groups should be defined using both Medicare and Medicaid matched data samples.

² *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. December, 2016.

³ *Accounting for Social Risk Factors in Medicare Payment*. Washington, DC: National Academy of Sciences, Engineering and Medicine, Board on Population Health and Public Health Practice, Committee on Accounting for Socioeconomic Status in Medicare Payment Programs. January, 2017.

4. **Stratify Plans by proportion of Duals served** –Stratifying health plans into either high Dual and low Dual groups or into quintiles (based on percent of Duals in enrollment) for purposes of analysis and reporting allows for more relevant comparisons within these groups of Medicare Advantage Organizations (MAOs). With such stratification, we can begin to tease out opportunity for quality improvement (QI) and move toward better construction of a tailored QMS around populations. This also enhances the accuracy, reporting, and utility of Star Ratings.
5. **Either eliminate use of the Health Outcomes Survey (HOS) instrument due to serious methodological and design challenges when applied to a language and ethnically diverse population, OR require revalidation and retesting of the HOS survey instrument** using a random sample of diverse, low-income, dually eligible, and non-English speaking populations as the relevant population group as compared to a White general Medicare-only population. Currently, unless individuals speak English, Spanish, or Chinese, and have stable cognitive function for two years, their participation in the QMS is severely constrained and/or their responses have a strong potential for bias (in any direction) and therefore the accuracy of the HOS sample results and contribution to Stars is under serious question. As background, The HOS survey is used to assess beneficiary experience. The same instrument is used for the general Medicare Advantage population (non-dually eligible) as for dually eligible beneficiaries in managed care/SNPs. The instruments are only available in three translations: English, Spanish, and Chinese. Beneficiaries who do not speak or read in these languages may receive the survey instrument in the mail or receive a telephone call asking the person to participate, however explanatory material is not in their language. Proxy survey responses are allowed, however the surveys are lengthy (more than 50 items) and the family member translating the survey would need to tolerate a three-way listen, interpret, and parrot response, which would extend the time to complete. Unfortunately, Medicare does not allow for any translation of the survey by health plan interpreters and does not provide the survey in other languages. This effectively shuts out participation by many non-English speaking individuals and those with limited English proficiency.
6. **Ensure transparency of HOS Results by Population Subgroup.** In addition to attending to the design, instrument and methodological challenges with HOS, CMS should report HOS results by beneficiary subgroups (as defined/stratified above), to support the goal of transparency and utility, and report findings of HOS re-testing including attention to at least the following: face validity, validity and reliability of items by population subgroups, level of understanding of the HOS questions/items among surveyed individuals, response to the methodology and methods by the surveyed individuals, and reliability of responses as measured across two testing periods or using two similar items.
7. **Require measure developers to re-test their measures using subgroups of dually eligible beneficiaries** who are language/ethnically diverse, non-English speaking, and live in poor neighborhoods.. Compare measurement testing in these diverse, low-income groups to those in the White general Medicare population, and report findings.
8. **Make further additions and modifications to the Categorical Adjustment Index (CAI)** for more robust impact that would yield a more substantive effect toward its intended purpose. This would include: applying additional variables, including dual status, disability, LIS, living in a poor neighborhood (including a smaller-neighborhood level geographic unit of analysis at the 9-digit zip code), limited English proficiency, and other social risk factors endorsed by the NAM, and ASPE committees—for adjustment to current Stars measures. Stratify results, report, and disseminate.
9. **Conduct various analyses using alternate methods for re-calculating Star quality bonus payments and adjusting overall Star ratings.,** One method, for example, would base quality

bonus payment (QBP) calculations on two peer grouping of plans such as the High Dual/Low Dual grouping. Alternatively, the method might be based on applying additional risk adjustment factors at the beneficiary level. Note that meaningful measurement and reporting is at the PBP level vs. the contract level. We recognize that small enrollments may yield small samples, yet the SNPs and the beneficiaries enrolled in these special plans need and deserve information around quality that pertains to that plan type, with relevant provider network, model of care, and care management structures and processes. Special Needs Plans' quality improvement efforts for special needs population subgroups require this additional stratified level of analysis. Even if QBP changes are not made, it is critical to stratify and report.

Future PE Focus – “Big Idea Pilot”

In moving toward a future where value-based payment has a bigger role in performance measurement and improvement and in financial health of organizations participating in Medicare and Medicaid, the future QMS must become more robust—simultaneously providing accurate, relevant, and meaningful data/information on specific subgroups in a rapid-cycle improvement approach for defined plan and provider types, AND offering a population based view at national level with relevant peer groups that support comparisons, performance evaluation, and fair and equitable resource distribution towards achieving targets.

We believe that the definition and focus of quality measurement and improvement should start with the person and with relevant population subgroups of individuals who have similar needs and characteristics. This provides the foundation for further required analysis, testing, and investment towards quality improvement.

What we are proposing as a “big idea” would be considered a major restructuring of the current system. In moving toward a transformed performance measurement and quality improvement system, we believe that a re-structured approach should begin with design and pilot testing on dually eligible subgroups. The reasons are many.

As an overall population group dually eligible beneficiaries are the most costly group to both the Medicare and Medicaid programs. The services, care, support and attention they need require sustained and significant effort over time and across disciplines and settings. Dually eligible beneficiaries have many socioeconomic issues and social determinant of health risk factors. Many of those with non-majority language, race, ethnic, and health belief characteristics are dually eligible.

In fact, we know that dually eligible beneficiaries, while often discussed as one population, are a heterogeneous population. There are distinct subgroups that are clinically and functionally relevant—where characteristics drive care models, care management, cross-continuum efforts toward improved outcomes as defined by the beneficiary and within the parameters of what “improvement” means for a person with those needs and characteristics. For example, an individual with late-stage ALS may define quality of care/life differently than a person with HIV/AIDs which is controlled. The services and systems of care that support each of these individuals may likewise be tailored and organized differently (e.g. from a focus on comfort care to the person and family vs. a focus on virus/infection control, prescription drug regimen management, and support for living independently).

When we more closely examine the characteristics of people who are dually eligible, there are distinct subgroups that emerge. In addition, when we look at the SNP enrolled populations—specializing in care of the duals and of vulnerable persons with high cost conditions, we find that dually eligible beneficiaries with additional special needs enrolled in SNPs can be grouped based on age, social risk, language, functional status/frailty, behavioral health/substance dependency, chronic condition, and

stage of condition characteristics. For example, groupings that would be useful for purposes of quality measurement and improvement could include the following (based on SNP member discussions about key characteristics that drive care management and provider services):

- (1) Younger persons with physical disabilities and mental/behavioral health issues where the behavioral health and substance dependency issues drive condition management;
- (2) Frail elderly with multiple chronic conditions, advanced functional limitations, and often cognitive impairment (and who are usually deemed at a nursing home certifiable level of care), where functional and cognitive status drive or greatly influence condition management;
- (3) Younger disabled persons with a severe/life limiting chronic disease that represents the principle diagnosis/condition, and where managing this condition is a principle goal of health and social services care/support around which other care must be organized (e.g., HIV/AIDs); and
- (4) Dually eligible persons of any age with multiple chronic conditions and social risk factors, particularly those who are foreign born, have very limited understanding of the healthcare system, cannot speak/read/write English and need an interpreter. The social risk characteristics for this group greatly influence all clinical, social services, and other services and care management that can be provided and how these services and care can be managed.

These groupings are illustrative, to highlight how characteristics influence care and the care approach—and thus the definition of “quality” and a quality measurement and improvement approach.

In a restructured approach to quality measurement and improvement for people dually eligible for Medicare and Medicaid, the care management efforts and quality targets that would be set –would be across settings, services, and disciplines for these subgroups of populations. Such an aligned approach would *define both population subgroup and systems performance measures*, so that the many entities (providers/services/plans/stakeholders) involved in care and accountable to the beneficiary subgroup--would be working in tandem rather than with disparate measures, goals, and sometimes counter-productive objectives. The measurement set would draw from current health plan Stars measures and would also include measures that providers would select to meet their MIPS/APM requirements. Given that providers are likely to be in multiple health plan provider networks in a given area—we anticipate that a consensus process for providers key to serving dually eligible population subgroups, and the health plans that are held accountable with the providers—would be necessary for development of a core measurement set. This consensus core set across settings (medical/clinical, behavioral health, and long-term services and supports), with a focus on dually eligible beneficiaries, would be crafted based on criteria (e.g., measure has utility for quality improvement efforts, effective interventions and best practices for impacting measure exist, measure is meaningful to support cross-setting, cross-discipline practice standards and patient/client goals, etc.). We would not want a further proliferation of measure silos that increasingly represent burden across settings, do not align, even though the various providers and plan are attending to the same beneficiary, and may not provide sufficient or useful information for accountability or quality improvement for these dually eligible subgroups.

We hope that results from such a dually eligible subgroup pilot by CMS would greatly advance an aligned and population-based approach to quality measurement and analysis that could translate even further—in order to support quality improvement efforts across the system. Such a pilot could include the following components (illustrative):

- Define the dually eligible population subgroups for the pilot;
- Establish the parameters of a voluntary pilot;
- Offer Plans with the high proportion of dually eligible enrollees the opportunity to participate in the pilot;
- Establish selection criteria, the parameters of the CMS and independent panel review, and other required elements of participation by plans;
- Waive plan participants from the existing CMS QMS Stars Rating for the 3 year pilot period;
- Separate these plans by plan type;
- Separate these plans' beneficiaries by:
 - Subgroups as defined, and
 - Beneficiaries who have been continuously enrolled for at least one year from those who are transient/recently enrolled (no history);
- Identify an alternate set of quality measures –selecting a core set arranged and/or designed around dually eligible beneficiaries from a family of measures—which could include some of the Star measures but may also include other endorsed measures. Measures selected would have face validity with providers and plans, have evidence of scientific validity and reliability, be have been tested with a dually-eligible, diverse group of beneficiaries, and have been piloted for use in the field. There would be preference for measures that had been endorsed by the National Quality Forum (NQF).
- Organize measures into a set of domains (for example: safety and standards of care, continuity/follow-up, communication, person/family involvement and education, care management effectiveness, preventive/proactive, supportive of goals and preferences... etc.);
- Match the alternate measurement set to the defined subgroups – allow for tailoring of the measurement set at the plan level -- based on the characteristics of their enrolled subgroup population, e.g., with specified # of measures set for each domain, but some flexibility—measures would each be weighted the same (e.g., 1);
- Plans utilize these core measures in lieu of participating in the existing QMS with 47 Star measures;
- CMS provides stability in QBP/VBP during the years of pilot testing. Plans participating would be “held harmless” – QBPs are carried forward for 3 years;
- Data time period for collection, analysis, review isshortened—that is, the revised set of measures would use data that is more recent (e.g., last year’s data for these beneficiaries);
- CMS provides support for data review, analysis and integration—claims, encounter, EHR, and also provides technical support and analysis to each plan ;
- CMS provides data set at the neighborhood level for geographic area/enrollment area for each health plan, which provides additional SES/SDOH risk factor information;
- The plan and CMS set minimum, expected, and “reach” targets for each measure in the selected measurement set, corresponding to the enrollment population characteristics;
- CMS determines quality measurement and improvement results for these enrolled dually eligible individuals within these plans for the defined period--based on the set minimum, expected, and “reach” targets--and as compared to baseline for that plan/sub-group;
- Results are grouped/stratified at PBP level and at dually eligible subgroup level;
- CMS provides reports on outcomes by specific subgroup segments of the Dual population and in plan peer groups--comparing like plans to like plans.CMS provides subgroup analysis to offer Dual-specific data for benchmarking and quality improvement among participating plans. Successful improvement results are shared around specific subgroups and quality measures.

And also, for comparison purposes in analyzing this pilot compared to the current QMS, we would propose that CMS simultaneously improve stratified analysis such as:

- Among all MAOs - **Stratify population subgroups among all MAOs based on previous year's enrollment with additional set variables** such as: LIS/Dual, Disability, and selected SDOH characteristics (such as nativity, neighborhood poverty, education, and ESL/Language), as well as age, number of selected high cost conditions (including behavioral health, substance dependency, dementia/cognitive impairment, among the conditions) segmenting variables. Thus the population characteristics across MAOs and across SNP types would be better understood for meaningful comparisons and quality improvement efforts
- **Customize measure sets & reporting.** Select key quality measures to allow consumers to simultaneously compare (1) plan type, (2) enrollment characteristics, and (3) quality measure results – providing better information to the consumer when making comparisons.
- **Test rapid cycle approaches for quality improvement in lieu of existing 2-3 year look-back quality measure reporting.** Allow for some flexibility and customization related to population characteristics among all MAOs serving a high proportion of dually eligible beneficiaries and special need populations. Reporting on QI success efforts with matched comparison groups could be voluntary or mandatory or offer opportunity for additional QBP. This would offer the advantage of disseminating effective practice more quickly.

We again thank CMS for the opportunity to submit a set of SNP Alliance ideas for regulatory, sub-regulatory, policy practice and procedural changes to transform the MA and Part D programs for Medicare enrollees to have options that fit their individual health needs. This opportunity is particularly important for plans seeking to craft innovations in care of poor, frail, disabled and chronically ill beneficiaries—Medicare's most vulnerable, costly and complex care subgroups. We look forward to working with you in maintaining benefit flexibility and efficiency throughout the MA and Part D program using transparency, flexibility, program simplification and innovation. Please let us know if you have any questions about our ideas.