

# The SNP Alliance



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

January 26, 2016

Submitted electronically via [chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)

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219 Dirksen Senate Office Building  
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The Honorable Ron Wyden  
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The Honorable Johnny Isakson  
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The Honorable Mark R. Warner  
United States Senator  
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Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

Thank you for the opportunity to submit comments to the Senate Finance Committee's Chronic Care Working Group on considerations contained in the Policy Options Document, December 2015.

## **SNP Alliance Profile**

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 31 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).

## **Strongly Support Bipartisan Chronic Care Working Group Strategy**

We strongly support the Committee's efforts to improve care for Medicare beneficiaries living with chronic illness. We especially support consideration given to a long-term extension or a permanent authorization of SNPs. We also appreciate the array of other options being considered to improve care coordination in the Medicare programs that result in better quality and cost outcome for chronically-ill persons. Many of the options identified are consistent with long standing interests of the SNP Alliance.

### Comments on Overall Policy Direction

We applaud the extensive examination and analysis done by the Chronic Care Working Group to arrive at the three main bipartisan goals as outlined in the Options document:

1. To increase care coordination across care settings and services to address the needs of individuals living with chronic conditions,
2. To streamline the payment systems to provide the right incentives for the appropriate level of care for beneficiaries living with chronic conditions, and
3. To facilitate the delivery of high quality care that will produce stronger patient outcomes, increase program efficiency, and reduce the growth in Medicare spending.

We first offer a few foundational comments on these goals:

- The nature of chronic illness requires us to take a more holistic, ongoing view of health policy.
- Most people with chronic illness also have other chronic illnesses that interrelate. As a result, we cannot isolate chronic illness care policy to individual disease states.
- Many people with chronic illness are also disabled, which requires policy to account for the relationship between disease and disability, and how that affects cost and quality outcomes.
- Many needs of chronically ill persons are not medical; and while Medicare was not designed to provide non-medical services, these non-medical factors affect healthcare costs and outcome.
- A variety of social factors influence as much as 80% of an individual's health status—where they live, their income, what social/family supports they have, their history, culture, habits, access to affordable housing, transportation and food—so that even if Medicare policy was designed to provide the right medical treatment, at the right time, in the right place, Medicare is not likely to achieve the kind of outcomes everyone hopes to achieve unless these social factors are taken into account.
- The characteristics of chronic illness require changes in healthcare practice as well as corresponding changes in HCC risk adjustment, program requirements, and evaluation metrics.

As in previous comment letters, we underscore the need to:

- 1) **Make SNPs permanent**- SNPs provide an ideal platform for advancing improvements in chronic illness care. Without permanent status, plans and states will not have the stability they need to invest in changes necessary for controlling costs and improving quality over time.
  - a. **We support providing general MA plans flexibility in benefit design as long as: a) consumers are provided a choice to access care from general MA plans or C-SNPs, b) SNPs are provided at least as much flexibility as general MA plans, and c) C-SNPs are enabled to advance additional improvements in care, given their ability to exclusively focus on a single chronic illness or related set of conditions.**
  - b. We support the Committee's interest in advancing dual integration ASAP, but structures must be in place that enable D-SNPs to integrate before a timeline is established.
- 2) **Improve MA risk adjustment** to more accurately account for costs of care for duals and others with complex chronic conditions.
- 3) **Remove barriers to Medicare and Medicaid integration**, which can improve care for millions of chronically ill beneficiaries and accrue financial benefits to both programs.
- 4) **More fully account for the influences of co-morbidity, disability, and social factors in quality measures**, particularly within the Star Ratings system.

In addition, we support the Committee's consideration for: a) expanding MA use of supplemental benefits, b) integrating behavioral health and medical care, c) providing MA enrollees with hospice, d) allowing ESRD beneficiaries to choose a MA plan, e) encouraging beneficiary use of chronic care management services, f) expanding MA use of telehealth, and g) increasing transparency at CMMI. Following are additional observations and recommendations regarding these considerations.

## COMMENTS ON SFC POLICY OPTIONS

### Framework for Policy Recommendations

**Policy options to address chronic illness care must take into account the effects of a person's *total life experience*.**

In our June 22 comments on the Committee's May 22 request for stakeholder input on their chronic care initiative, we provided the Committee with information on the importance of looking more closely at the presence of chronic illness among beneficiaries who are dually eligible for Medicare and Medicaid. We also provided the Committee with an outline of what we consider key principles for efficient and effective chronic illness care. While this information is equally relevant to this set of comments, we are not going to repeat any of that information here. Rather, we simply want to reiterate the core principle underlying this discussion. That is — effective chronic illness care requires moving beyond what occurs in a physician's office or provider setting, to accounting for how a person's chronic illness fits within the context of their total life experience. To optimize total quality and cost performance, chronic care policy option must take for factors into account, the following:

#### **1. The progression of chronic illness over time and the interdependence with other co-morbid illnesses.**

If we want to see better health care outcomes and lower costs over time, we must take into account the fact that most people with a chronic illness also have, and are being treated for, other chronic illnesses at the same time. The evidence from multiple studies shows that care or lack of care for one illness influences treatment for other related illnesses. While this information is not new to healthcare, Medicare payment methods, program requirement, and oversight metrics are still largely focused on accounting for costs, care methods, and health outcomes for specific diseases, provided by specific care providers, at specific points in time, without regard for their interdependence with other illnesses. They also generally ignore related care interventions that are provided at the same time or in sequence to one another, even though co-morbid illness — in fact multi-morbidity — is common for the overwhelming majority of Medicare beneficiaries.

#### **2. The interdependence between illness and function.**

Chronic illness affects and/or is affected by a person's functional abilities and/or disabilities. Whether one is treating a chronic illness for someone who is elderly and frail, or treating the illness of a younger adult with a physical, developmental, mental, or behavioral health disorder, the presence of his/her ability/disability profile changes the nature of the problem being addressed. Unfortunately, prevailing payment methods, regulatory structures, and performance metrics also do not fully account for the interdependence between disease and disability. Unless we take the interdependence of chronic illness with disability into account, we're not going to obtain the kind of quality and cost results that everyone wants.

#### **3. The affects of social factors on health and healthcare outcomes.**

A long history of scientific research tells us health and healthcare outcomes, for any person with a chronic illness, are also influenced by the presence of an array of social factors, such as dietary practices, monthly income, level of education, race, ethnicity, language, cultural practices, personal habits, the presence of family and social supports, and the nature of the workplace, home, and neighborhood environment where a person resides. While recognition of these relationships is relatively new to discussions of Medicare financing and performance evaluation, it's not new to scientific research. The SNP Alliance recognizes the Medicare

program was not intended to finance an array of social services that are also needed by many Medicare beneficiaries. However, Medicare will be unable to achieve the kind of cost savings and health outcomes everyone wants, unless Medicare takes into account a host of social factors that are interdependently related to any chronic illness being addressed by any plan or care provider.

#### **4. A person's chronic care needs as they evolve over time and across care settings.**

By definition, the nature of chronic illness is ongoing. Many people with a chronic illness will need care for the rest of their lives. Any chronic care intervention is affected by a person's illness and clinical history, as well as the natural trajectory of a given condition or care regimen. Most health policy is focused primarily on what occurs at a specific point in time, without regard to a person's history or the accumulation of costs and clinical interventions over time. This is also true for conditions with an acute episode, such as a hip fracture or a stroke. Unless policy takes into account the accumulation of costs and trajectory of clinical outcomes over time, we will not achieve the kind of outcomes and cost savings that everyone wants and expects over time.

Within this context, the SNP Alliance offers the following observations and recommendations regarding the options outlined in the Committee's Policy Options Document disseminated December 2015. We have prioritized comments in relation to their relevance for SNPs. Options of major relevance to SNPs include:

1. Providing continued access to Medicare Advantage Special Needs Plans for Vulnerable Populations
2. Ensuring accurate payment for chronically-ill individuals
3. Accounting for social factors that adversely affect health and health outcome (only partially referenced among the options being considered)

## **Options of Major Relevance to SNPs**

### **Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations (page 10 of Options paper)**

We believe the time has come to make all SNP types a permanent part of the Medicare program, consistent with other types of MA plans. There are three primary reasons for this recommendation:

1. **SNPs are best able to address multiple, complex, and ongoing chronic care needs of frail, disabled, and chronically-ill persons — the most costly and fastest-growing segment of the Medicare population.** Improving quality and cost performance for high-risk/high-need persons requires a more sophisticated approach to care management than what is generally available in Medicare FFS or among general MA plans. It requires moving beyond use of specific chronic disease management interventions and monitoring quality and cost performance for individual care providers, to monitoring and managing chronic illness within the context of a person's total care needs. It requires an ability to identify and manage the complex interplay involved in care for persons with multiple chronic illnesses, as well as with complicating factors associated with various types of disability and the presence of various psycho-social and environmental factors — as previously identified. Consistent with the Committee's first goal to *increase care coordination among individual providers across care settings who are treating individuals living with chronic illness*, current SNP law requires SNPs to go beyond the offering of traditional MA benefits and services and maintain a model of care, provider networks, and

team-based care management practices that are tailored to the population of beneficiaries they enroll.

2. **The capitated financing structure of MA-SNPs allows Special Needs Plans to re-order traditional patterns of care to coincide more fully with the unique combination of care requirements of individual enrollees.** Under traditional Medicare, each care provider is incented to suboptimize quality and cost performance within their own span of responsibility, without regard to the cumulative effects on costs and quality, as a person's care needs evolve over time and across care settings. In contrast, SNPs have an incentive to look at a beneficiary's TOTAL array of care needs, re-order the balance of what is provided and the relationship among related providers, and provide whatever combination of care is most cost effective. This is not only true for persons with Medicare-only requirements, but for persons in need of an ongoing array of Medicaid services as well. This not only pays dividends for the Medicare beneficiaries they serve and for the Medicare program as a whole, but there is ancillary and synergistic benefit for the Medicaid program as well. While additional improvements to the MA risk adjustment model are needed for SNPs to optimize total quality and cost performance, permanent authorization of SNPs could help eliminate incentives for cost shifting between the Medicare and Medicaid programs, and among related care providers, and *incentivize the appropriate level of care for beneficiaries living with chronic disease*, consistent with the Committee's second goal.
  
3. **There is a national network of Special Needs Plans already in place for building the next generation of care for persons with multiple, complex and chronic-care requirements.** Currently, 550 Special Needs Plans provide specialty care arrangements to over 2.1 million persons. These include SNPs that specialize in care of persons with certain diseases, such as diabetes, ESRD, SPMI, and HIV-AIDS (C-SNPs); SNPs specializing in care of persons in need of nursing home and persons living in the community with similar needs (I-SNPs); and persons dually eligible for Medicare and Medicaid (D-SNPs). More than 85 percent of SNP enrollees are persons dually eligible for Medicare and Medicaid, many of which have disabilities and social factors that complicate clinical care. Many of those currently served by SNPs not only need an extensive amount of care right now, but they will need an expanded array of medical services for the rest of their lives, much of which is more complicated than what is seen by traditional Medicare and MA programs. SNPs provide a natural foundation for facilitating *the delivery of high-quality care, improve care transitions, produce stronger patient outcomes, increase program efficiencies, and contribute to an overall effort that will reduce the growth in Medicare spending over time...consistent with the Committee's third primary objective.*

Permanent SNP authority would:

1. Create stability for beneficiaries and their families by ensuring that the SNPs they chose will not sunset.
2. Enable Congress to build upon plans that are grounded in the principles of chronic illness care for high-risk/high-need persons
3. Give more certainty to States seeking to integrate Medicaid and Medicare for dual eligible beneficiaries. It would signal to states that they have a reliable option for advancing Medicare-Medicaid integration over the long term. In the current environment, some states are reluctant to invest in integration efforts if the D-SNP option could disappear through loss of authorization in the future.
4. Encourage States, plans, and providers to make long-term investments in new operating systems that are important to Medicare's and Medicaid's long-term financial viability.

### Comments on Request for Feedback Regarding C-SNP Modifications If General MA Plans Provided Benefit Flexibility.

The SNP Alliance recognizes that one of the Committee's considerations is giving general MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees, some of which are conditions being targeted by C-SNPs. As part of this consideration, the Committee has asked whether any modifications should be made to C-SNPs, if this consideration is advanced. The SNP Alliance believes:

#### **C-SNPs should be maintained with comparable flexibility provided.**

The SNP Alliance supports providing MA plans with increased flexibility to establish benefit structures based on the chronic condition of individual enrollees, as long as:

- Beneficiaries are provided the choice of enrolling in a C-SNP or an MA plan to receive specialized care they need and want;
- SNPs (including C-SNPs, D-SNPs, and I-SNPs) are afforded at least as much flexibility as provided to general MA plans for the population being targeted;
- C-SNPs, given their exclusive focus, are provided additional flexibility to advance new and improved methods for defined subgroups in need of specialized care systems. C-SNPs serving a high percentage of dually eligible beneficiaries, such as C-SNPs specializing in care of persons with HIV-AIDS or SPMI, are provided comparable abilities as D-SNPs in integrating Medicare and Medicaid for their dually eligible enrollees; and
- C-SNPs are afforded the same permanency status as what exists for general MA plans.

#### **SNPs should be given at least as much flexibility as the Committee is considering giving to MA plans.**

While C-SNPs are authorized to exclusively serve certain Medicare subgroup, they are *required* to follow the *same* payment and program requirements of *general MA plans*, including rules regarding uniformity of benefits, restrictions on supplemental benefits, payment bids, marketing, contracting, audits, and compliance. Some of the features being considered for general MA plans have never been made available to C-SNPs. For example, currently, C-SNPs are not allowed to provide additional supplemental benefits that are not presently allowed by general MA plans. SNPs are not allowed to reduce cost sharing for items/services. They also are not allowed to adjust provider network requirements beyond what is permitted by other MA plans.

#### **An exclusive plan focus can provide added dividends for consumers and government.**

General MA plans could clearly benefit from increased flexibility to tailor benefits and services for persons with certain chronic conditions. However, the healthcare profession is replete with evidence of how allowing an organization to devote all their energies to resolving a particularly problem results in an accelerated advancements in care methods beyond what is otherwise possible. C-SNPs are simply an extension of this specialty care concept where Congress authorized managed care companies to establish plans that specialize in care of persons with certain types of *severe and disabling chronic conditions*. Congress should require/enable CMS to change payment, policy, and performance metrics for C-SNPs (as well as other SNPs) in ways that not only allows but empowers C-SNPs to move beyond what is possible for general MA plans that must address the full spectrum of Medicare needs. CMS should *enable* C-SNPs to establish new and improved methods of operation more in keeping with the needs and interests of people with certain conditions designed by Congress.

**Consumer choice enables the option that works best for those who need them to prevail.**

Over time some specialty care options currently provided through C-SNPs may prove to be more cost effective, as well as preferred by Medicare beneficiaries, under the jurisdiction of a general MA plan. However, there is already a system in place for advancing more extensive innovation in specialty care for persons of importance to the future of the Medicare program. If C-SNPs were authorized to go beyond the norms of general MA plans in establishing benefits and services for certain high-risk/high-need subgroups, a variety of new and improved options could evolve with accrued benefits for consumers and government alike.

**The MA Value-Based Insurance Design (VBID) demonstration can provide guidance if SNPs are given comparable flexibility.**

In advancing increased flexibility for MA plans to provide special benefit and care arrangements for persons with certain target conditions, we think it's important to highlight the similarity of this provision with considerations being given by the Center for Medicare-Medicaid Innovation (CMMI) in implementing and testing the VBID Model. If the Committee decides to advance this provision sooner rather than later, we believe it would be useful to conduct an ongoing evaluation of models being advanced, with CMS given the authority for participating plans to implement best practices as soon as a particular intervention or set of interventions is seen as improving care outcomes. This is similar to how the private sector uses flagship operations to design, test, and implement new innovation. If the Committee decides to use the existing demonstration as a precursor to advancing a broader policy for MA plans, we believe CMS should provide C-SNPs with a comparable set of flexibilities afforded to plans participating in the VBID demonstration and/or be allowed to participate in the demonstration itself.

**Comments on Request for Feedback Regarding Time for States and D-SNPs to Successfully Integrate all Medicare and Medicaid Services**

In consideration for a long-term extension or permanent authorization of SNPs, the Committee also asked for *feedback on how much time is needed for states and D-SNPs to successfully integrate all Medicare and Medicaid services.*

**The SNP Alliance strongly supports the Committee's interests in full integration.**

In addressing this question, we want to be clear the SNP Alliance fully supports the Committee's interest *for states and D-SNPs to successfully integrate all Medicare and Medicaid services.* Our nation can no longer afford to maintain duplicative and conflicting administrative, financing, and delivery structures in serving some of our nation's most vulnerable and costly beneficiaries, where payment methods and related regulatory structures incent cost shifting, engender waste, and ignore the financial interdependencies between Medicare and Medicaid in seeking to improve total quality and cost performance.

**In 2003, Congress established D-SNPs as a foundation for advancing integration.**

In 2003, Congress laid an important foundation for advancing dual integration by establishing Dually Eligible SNPs (D-SNPs), building on a prior history of national demonstration. It later added a set of requirements for D-SNPs to contract with State Medicaid agencies for the coordination of Medicare and Medicaid benefits and services and establish an important model of care and care management capabilities. In 2010, Congress took another step toward advancing integration by requiring CMS to establish the Medicare-Medicaid Coordination Office (MMCO) to more effectively integrate benefits, and improve the coordination between the Federal Government and states. The goal was to ensure access to quality services for individuals who are enrolled in both programs. In 2011, CMS made additional strides for addressing Congressional integration interests by launching

the Medicare-Medicaid Financial Alignment Demonstration to test, in partnership with states, new program integration models.

**Today, there is a national network of integrated plans on which to build.**

Today, over two million dually eligible beneficiaries are served through various federal/state partnership programs focused on improving the overall experience of dually eligible beneficiaries. More than 1.7 million beneficiaries are served by D-SNPs, which offer an array of specialized benefits and services and coordinated care arrangements for duals. Over 110,000 beneficiaries are served by Fully-Integrated, Dually-Eligible Special Needs Plans (FIDE SNPs) that offer the full array of Medicare and Medicaid benefits. Another 350,000 beneficiaries are served by Medicare-Medicaid Plans (MMPs) under the Financial Alignment Demonstration, many of which are administered by the same MCOs that administered D-SNPs and FIDE-SNPs under general MA requirements.

The SNP Alliance believes the time has come for Congress to take another step in its quest to improve health outcomes and contain the growth of costs for our nation's 10 million dually eligible beneficiaries. Our nation simply cannot achieve the kind of outcomes and cost savings it wants to achieve without a more proactive effort to manage over \$350 billion a year in services for dual eligibles, (comprising roughly 40 percent of Medicaid and over 30 percent of Medicare spending).

**SNPs cannot fully integrate Medicare and Medicaid until CMS and states integrate Medicare and Medicaid financing, policy, and oversight requirements for dual plans.**

While the SNP Alliance shares the Committee's interest and concern for expediting the process for full integration, we find it difficult to establish a *timeline for integrating all Medicare and Medicaid services* until CMS and States establish the infrastructure of policy and oversight that allows plans to accomplish this goal. It is simply not possible for D-SNPs to *fully integrate Medicare and Medicaid services for their enrollees*, in accordance with the Committee's interests, unless states have the infrastructure to develop and manage a fully integrated program. D-SNPs cannot operate or become FIDE SNPs without state approval and involvement. Yet, states and D-SNPs continue to face a number of challenges that require resources and changes at the state level in order to move forward with integration. These include lack of state Medicare expertise and resources, differences between Medicare and Medicaid enrollment processes and processing systems, enrollee notice and benefit determination requirements, network review requirements, procurement processes and timelines, data sharing requirements, variations among states in authority to meet FIDE SNP requirements for D-SNP provisions of nursing home and long-term services and supports, and differences in quality assurance and performance metrics. Each of these issues requires resolution of a host of intricate regulatory, sub-regulatory, and administrative requirements at both state and federal levels.

Even SNPs and MMPs that have been able to develop more fully integrated dual programs cannot put in place an integrated administrative and delivery structure necessary to achieve the kind of cost and quality outcomes everyone hopes to achieve as long as they are required to maintain separate administrative and delivery structures with duplicative and conflicting rules and regulations.

**FIDE SNPs provide a template for advancing full integration..**

Currently, Fully Integrated, Dually-Eligible Special Needs Plans (FIDE SNPs) are concentrated in seven states (AZ, CA, ID, MA, MN, NY, and WI). Fully capitated programs, known as Medicare-Medicaid Plans (MMPs), are concentrated in 10 states (CA, IL, MA, MI, NY, OH, RI, SC, TX, VA). Another half dozen or so states are advancing more fully integrated programs through other means,



including: NJ, TN, OK, PA, etc. That leaves approximately 50 percent of the states with little capability to develop and advance dual integration programs, even though D-SNPs were authorized in 2003.

**We may have reached a tipping point in CMS and with States for advancing integration.**

There clearly is growing momentum among State Medicaid Agencies for more integration, with the National Association of Medicaid Directors supporting permanency for integrated plans and for building on the D-SNP platform. In particular, the growth of state managed long-term supports and services programs (MLTSS) are driving increased interest among states in improving coordination with Medicare. There also are newfound capabilities within CMS and among states for advancing full integration. The time is ripe for an aggressive push for dual integration.

**In spite of recent developments, we still have a long way to go.**

Everyone involved in dual integration efforts is still faced with the daunting task of trying to align Medicare and Medicaid structures and procedures amidst a system that defies alignment, and lacks arbiters with authority to make operational decisions to support integration at sub-regulatory levels. Current payment methods, program policies, and oversight requirements for serving dually eligible beneficiaries are deeply rooted in structures, methods, and a culture that reinforce use of separate and often misaligned program requirements and incentives. Authority to enroll duals for both Medicare and Medicaid into matching plans under one plan sponsor is a critical first step toward successful integration, but it is only a first step. SNPs and MMPs cannot successfully integrate all Medicare and Medicaid unless states have the capacity to manage a fully integrated program. And, states actively engaged in advancing a fully integrated program cannot be successful in their efforts without the kind of federal-state partnership necessary for eliminating the pervasive duplication and conflicts involved in Medicare and Medicaid payment methods, program policy, and oversight.

**Rather than focus on a D-SNP timetable, Congress should outline a pathway for the next generation of integration to evolve.**

Successful integration of all Medicare and Medicaid services — a laudable Committee goal — requires that Congress take the next step toward full integration by creating a *pathway for integration* designed to eliminate the pervasive array of duplications and conflicts in Medicare and Medicaid financing, administration, and oversight for dually eligible beneficiaries. This pathway should include enabling states to develop the capacity for managing a more fully integrated program, and creating a more stable federal-state infrastructure for collaboration on dual integration issues.

**Recommendations for an incremental, bipartisan, low-cost approach**

If there is to be full alignment of Medicare and Medicaid for duals, changes must be made in one or both programs. It is our belief that much progress can be made by the Working Group to increase federal/state capabilities for administering a dual integration program and that builds on the D-SNP platform, with incentives for advancing FIDE SNPs and/or transitioning MMPs where deemed successful. More specifically, we recommend that Congress:

- **Empower the CMS MMCO to serve as a coordinator/arbitrator of interests in efforts to further align payment methods, program policies, and oversight for SNPs and MMPs.** The MMCO has made important advances in bringing together the various federal/state interests involved in dual integration. It has also made important progress in further aligning key program elements. However, there continue to be significant regulatory, sub-regulatory, and operational disconnects and interpretations that neither CMS Medicare nor states have the authority to resolve on their own. What they need is an arbiter to align

differences. For example, unless D-SNPs are allowed to operate differently than a typical MA plan, they will never be able to “*successfully integrate all Medicare and Medicaid services.*” To enable next-stage efforts critical for advancing full integration over time, Congress should give the MMCO authority to:

- **Propose a master plan for achieving integration**, working in collaboration with state Medicaid agencies and other key stakeholders for alignment of Medicare and Medicaid payment methods, program policies, and oversight structures with particular regard for improving total quality and cost performance in care of poor, frail, disabled, and chronically ill persons — Medicare’s most costly, fastest-growing and vulnerable subgroups.
- **Establish and maintain an internal federal-state structure for communication on dual integration issues**, including coordinated federal/state review of D-SNP Medicaid contracts and coordinating Medicare and Medicaid policy guidance for integrated programs.
- **Establish and monitor use of aligned and administratively efficient Medicare and Medicaid program requirements** for D-SNPs and FIDE SNPs, including enrollment policies, marketing and member materials, rate setting, Medicaid benefits and model of care policies, performance measurement and methods, and appeals and grievances, including arbitration of Medicaid-Medicare differences in policies and procedures.
- **Align policies and procedures for MMPs and SNPs**, within the context of existing waiver and program authority, including extending MMP and dual demonstration operational policies to D-SNPs (such as the dual specific network review and member materials and review process) with added incentives for advancing FIDE SNPs.
- **Develop a grant or enhanced financial match program** to help build increased state capabilities for establishing and managing dual integration programs.

### Ensuring Accurate Payment for Chronically Ill Individuals (page 19 of Options paper)

#### **We strongly support Committee leadership to improve CMS-HCC risk adjustment.**

The SNP Alliance has been a long-standing advocate of CMS efforts to adjust payment based on a beneficiary’s health conditions. Studies show, however, that plans seeking to specialize in care of high-cost subgroups are adversely affected by the CMS-HCC’s inability to fully account for the medical costs involved in serving them. The CMS-HCC model under predicts costs for high-risk conditions and for dual eligible beneficiaries as a group. Payment accuracy for every chronic condition is not always necessary or possible under the MA risk model, as most under- or overpayment for conditions within the model are generally averaged out for plans serving a relative normal distribution of Medicare beneficiaries. However, the accuracy of payment becomes problematic whenever a plan seeks to specialize in care of a subpopulation, where an underpayment cannot be offset by an overpayment in care for another population segment.

In making comments on this issue, we also want to clarify that we understand the HCC model is based on costs associated with care of beneficiaries served through the traditional Medicare program, and that in certain cases, fee-for-services costs do not fully reflect costs of care of a given person, e.g. the medical costs of homeless persons are frequently underestimated in a fee-for-service environment. We also recognize that CMS is moving toward more extensive use of encounter data, and that other factors, such as normalization factors and adjustments for MA coding pattern differences also affect payment for care of any given enrollee.

**We applaud Senators’ Hatch and Wyden for their bipartisan letter of support for CMS’s recent proposal to apply the risk model to six separate community segments.** This is without question the most important adjustment to be made to the HCC model for improving the accuracy of payment for persons dually eligible for Medicare and Medicaid. We wholeheartedly concur with the Senators’ comments that this proposal *“will lead to two significant improvements. Duals will have more robust options to receive coordinated care, and MA plans will be properly incentivized to offer high quality care to the dual population.”* While there are other important considerations for improving the HCC’s payment accuracy, there is perhaps no other option more important for *incentivizing the appropriate level of care for beneficiaries living with chronic diseases* — the second overall objective of the Committee. The CMS proposal: (1) improves payment equity between MA and Fee-for-Service (FFS); (2) eliminates perverse financial incentives in Medicare Advantage; and (3) enables specialized MA plans to survive, particularly those specializing in care of duals — Medicare’s subpopulation with the most costly and medically complex chronic conditions.

**We also recommend other refinements to the CMS-HCC model.**

The SNP Alliance recognizes it is not possible in any capitated payment structure to accurately predict costs associated with small subgroups without reverting to a concurrent FFS payment. However, the SNP Alliance continues to support additional refinements to the CMS-HCC model that would complement the proposed establishment of separate community segments for the six populations identified. We will not repeat these recommendations here, as they are outlined in our June 22<sup>nd</sup> comment letter.

**We support use of multiple conditions to enhance the HCC payment method.**

There are a variety of methods that CMS could use to calculate the number of conditions. Depending on which method is used, it could affect the level of improvement in payment accuracy and level of associated payment. However, we believe adjusting payment, based on the number of chronic conditions, will strengthen the predictive accuracy of Medicare costs in serving persons with multiple chronic conditions. We would encourage the Committee to identify options for calculating multiple conditions and related implications before finalizing its policy directive.

**Developing Quality Measures for Chronic Conditions (page 22 of Options paper)**

**The Committee should include provisions in the Chronic Care Working Group package that require CMS to more fully account for social factors that influence health and healthcare outcomes in the Star Rating system.** We firmly believe that adjustments to the Star Rating system are needed to more accurately define bonus payments and public reporting so that beneficiaries with more complex needs are not disadvantaged or misled by the Star Ratings system. Our recommendation is based on the following:

- 1. The evidence that social factors influence health and healthcare outcomes is strong.** Research has demonstrated the role of social determinants of health, such as income, education, occupation, and social supports as significant contributors to health outcomes.<sup>1</sup> The 2002 Institute of Medicine report titled, *“The Future of the Public’s Health in the 21st Century,”* observed “research has increasingly demonstrated the important contributions to health of factors beyond the physical environment, medical care, and health behaviors, e.g., socioeconomic position, race and ethnicity, social networks and social support, and work

<sup>1</sup> Booske, B., Athens, J., Kindig, D., Park, H., Remington, P. Different perspectives for assigning weights to determinants of health, County Health Rankings Working Paper, University of Wisconsin Population Health Institute, February 2010.

conditions, as well as economic inequality and social capital.”<sup>2</sup> A large meta-analysis seeking to assign weights to determinants of health found that, on average, access and quality of clinical care contribute about 20 percent to health outcomes, while social and economic factors such as education, income and family/social supports contribute 40 percent. Health behaviors such as alcohol and drug abuse contribute 30 percent to health outcomes.<sup>3</sup>

- 2. Risk adjusting Star metrics would not mask disparities or lower quality.** The SNP Alliance has no interest in masking true differences in quality or lowering expectations for those most in need of quality care. Our position is quite the opposite. We believe that the existing Star Ratings system actually masks the well-documented burden that people with poverty and low socioeconomic circumstances have in achieving levels of health and health care outcomes, especially when compared with people of average or greater resources.

Moreover, CMS already adjusts Plan All-Cause Readmission rates for known differences in healthcare outcomes for age, gender, and chronic conditions. These adjustments are also based on research that shows a strong correlation (not causal relationship) between age, gender, and chronic conditions and health outcomes. There is no evidence that these adjustments conceal disparities or lower quality for these population segments. There is also evidence that if social factors influencing health and healthcare outcomes were properly accounted for in the Star Ratings system, some plans serving a high percentage of people with low socio-economic status may actually have, on average, a higher rate of performance than plans that do not.

- 3. CMS’s own analysis shows current Star ratings systematically mask disparities in Star performance ratings among dual eligible (DE) enrollees and enrollees who receive a low-income subsidy (LIS).** In September 2015, CMS released findings from a RAND study that provides scientific evidence that a beneficiary’s dual-eligible status significantly lowers outcomes on 12 of 16 Star Rating measures examined, while disability status significantly lowers outcomes on 11 of 16 Star Rating measures. A study by Inovalon, Inc. found similar results — characteristics of dual-eligible enrollees accounted for 30 percent of worse outcomes for dual eligibles on average on 5 of 8 Star ratings measures examined. For example, the results showed dual-eligible status lowers performance on the plan ‘all cause hospital readmission’ measure, the only Star rating measure that is already adjusted for age, gender, and co-morbidity. Research also demonstrates that adjusting for dual/LIS/disabled status will not close the disparity gap found in Star Measures that are the result of socioeconomic status.<sup>4</sup> It is therefore incumbent on CMS as stewards and consumers of performance measures to reflect this evidence in quality measurement.
- 4. Uncertainties about long-term solutions should not prevent progress.** We recognize the difficulty in crafting a long-term solution to this problem; and we appreciate the Committee’s reluctance to address this issue more fully in their Policy Options Document. However, CMS and Congress should not wait for the perfect solution. Congress should

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<sup>2</sup> The Future of the Public’s Health in the 21st Century, Institute of Medicine, 2002.

<sup>3</sup> County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute. Accessed at <http://www.countyhealthrankings.org/our-approach> on October 10, 2014.

<sup>4</sup> An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures, Inovalon White Paper, March 2015.

require that CMS take interim steps to mitigate negative consequences of the Star Rating system until a long-term solution is developed.

## **A framework for advancing policy to address influences of social factors on health**

As a framework for advancing the effects of non-medical factors on health, the SNP Alliance recommends the Committee:

1. **Give SNPs serving a high percentage of low-income beneficiaries more flexibility in benefit design, model of care and care management requirements, and use of supplemental benefits to address social and environmental factors that affect a person's health and healthcare outcomes in the treatment of chronic diseases.** We believe the starting point for addressing the influence of social factors on health is with the plans and providers responsible for the care of persons where these issues are most important. SNPs are already crafting and implementing care management practices to address social factors that adversely affect the health and health outcomes of various chronic illness interventions. It's important to recognize the added responsibility already accepted by plans in advancing specialty care arrangements for dually eligible beneficiaries and provide them with the flexibility needed to fulfill their specialty care mandate.
2. **Require CMS to expand the socio-demographic factors included in risk adjustment models.** In advancing proposals to address performance measurement of plans serving poor and disabled Medicare beneficiaries it is important to recognize the full array of factors that influence health and health outcomes beyond those influenced by the health system. These include neighborhood characteristics, such as rates of poverty, crime, pollution, and access to nutritious food; social factors, such as widowhood, levels of education, and types of employment; real income disparities that go beyond simple calculation of Medicaid eligibility; and the higher prevalence of certain chronic conditions among the poor to include conditions such as dementia, co-morbid illnesses, and later-stage illnesses that involve higher and more complex levels of self-care and professional support.
3. **Require CMS to risk adjust quality measures in the Star Ratings system for beneficiaries' socio-demographic characteristics beginning in 2018.** The science and methodology is already there to begin adjusting quality measures for these social factors. We believe the starting point should be measures where there is solid evidence for significant disparities in Star ratings for DE, LIS, and/or disability. A leading candidate for risk adjustment, sooner rather than later, is the Plan All-Cause Readmission measure. Research finds there are statistically significant within-plan disparities between dual and non-duals on this measure, even though the measure is already adjusted for age, gender, and conditions. This measure is also of broad concern to other industry segments specializing in care of poor beneficiaries. Other measures could and should be added to a targeted set of measures to receive priority for adjustment in 2018, based on existing evidence of within-plan performance disparities for DE, LIS, and/or disabled Medicare beneficiaries.
4. **Require CMS to implement an interim solution to account for social factors affecting quality measures in 2017.** We believe it is imperative that CMS implement an interim solution in 2017. By 2017, benchmark rates will have been tied to quality ratings for five years without any consideration for SES of the beneficiaries served by MA plans. Although we have concerns about specifics of the options presented by CMS, we believe they represent a step in the right direction toward a long-term solution. We believe it is possible to come to a reasonable interim solution in the final 2017 Rate Notice and Call Letter.

We are particularly interested in having an interim solution that accounts for the full adverse effects of significant DE, LIS, and/or disability enrollment under the existing Star Ratings system. One factor that is critical to achieving this outcome is measure selection. Another is the specification of the regression to estimate the full impact of SES factors.

We strongly recommend that CMS err on the side of *maximizing* rather than *minimizing* the number of measures selected, as well as expanding the range of socio-demographic factors used for adjustment. At a minimum, all of the 12 measures CMS found to show a negative performance gap for dual eligible members, as well as consideration of neighborhood poverty and physician shortage factors, should be included in the adjustment. Otherwise, the effect of the adjustment on a plan's overall rating is not likely to meaningfully reflect the influence of SES on quality measures.

- 5. Provide short-term financial relief in 2016 for D-SNPs compromised by a variety of social and environmental factors that affects the plan's ability to receive bonus payments and other bonus rewards under current Star Ratings methods.** The SNP Alliance supports the short-term proposal put forth by Senators Portman and Casey. However, we would also be supportive of other proposals that provide similar short-term relief for plans adversely affected by the existing Star Ratings system.

### The need for new metrics to address the system nature of chronic illness

The SNP Alliance shares the Committee's concerns that current performance measures do not adequately address the needs of persons with multiple chronic conditions. Current performance measurement is still too component-based and illness oriented. It focuses on monitoring symptoms and interventions by specific providers without regard to the pervasive presence of co-morbid illnesses and circumstances and conditions associated with the nature of chronic illness, such as the simultaneous presence of disability and social factors that influence health and healthcare outcomes. There are virtually no metrics for measuring "total quality and cost performance" as a person's care needs evolve over time and across care settings, and for measuring issues of "alignment" among providers who serve the same person, at the same time, or in sequence to one another.

In serving persons with complex care needs, some of the issues that we think need special attention include: interdisciplinary care (not just in assessment and care planning but in actual delivery of care); aligning Medicare and Medicaid benefits and services; ensuring continuity of care among people serving the same person at the same time, particularly where there are multiple prescribers and dispensers of medication involved; ensuring safe and effective care transitions; enabling flexibility in use of benefits and services so what is provided can be tailored to the unique needs and interests of persons served; secondary and tertiary prevention strategies (not just primary prevention); family and informal caregiver involvement; and the influences of social determinants of health, etc. There also is strong evidence that the level of patient activation is associated with ability to achieve positive health outcomes concomitant with recommended standards of care.

C-SNPs specializing in care of a defined population segment should also have their performance metrics tailored to address issues of primary importance for their area of specialization. For example, currently there are no measures in the Star Ratings system addressing issues of primary importance in serving persons with HIV-AIDS; making it is difficult for a C-SNPs specializing in care of persons with HIV-AIDS to demonstrate, and get credit for, their specialization.

**We support, with caution, the GAO conducting a report on community-level measures.**

We support the concept of the GAO conducting a report on community-level measures, as they relate to chronic care management; however, we believe it would be helpful to give greater attention to the systemic nature of chronic illness care, particularly those relating to caring for people with multiple, complex and ongoing care requirements. There are also a variety of other measurement development efforts being undertaken on care management that should be taken into account.

We recognize this kind of analysis and measurement development takes time. As a result, we would caution the Committee from moving too quickly in holding providers accountable to community-level measures and linking them to payment. In some cases, it may not be possible to implement a fully tested set of new measures for 5-10 years. However, we believe it is important for Congress to provide leadership in advancing a new generation of performance measurement more in keeping with the systemic nature of the ongoing management of chronic illness for poor, frail, disabled with various types of chronic illnesses, many of which involve managing co-morbidity, and in many cases multi-morbidity. This is critical to the Committee's ability to be successful in its effort *to improve outcomes for vulnerable Medicare beneficiaries living with multiple chronic health conditions*.

## Other Options of Importance to SNPs

Following are comments of other options being considered that affect the delivery of specialized chronic illness care by Special Needs Plans but are not specifically directed toward SNPs.

1. **Giving MA plans benefit flexibility in serving persons with chronic conditions (page 13 of Options paper)**

We support giving MA plans the flexibility to establish a benefit structure that varies based on conditions of individual enrollees. As previously indicated, our primary concern is that SNPs currently are not provided the flexibility of being considered general MA plans. We believe whatever considerations are given to allowing general MA plans the ability to tailor benefits to improve the care and/or prevent the progression of chronic conditions should be granted to SNPs right now. This includes:

- Providing supplemental benefits beyond what is currently allowed.
- Reducing cost sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease.
- Making adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic conditions or prevent the progression of the chronic disease.
- Adding care improvements and/or wellness programs specifically tailored for the chronic condition.
- Allowing for plans serving a high proportion of dually eligible beneficiaries and providing a comprehensive array of Medicare and Medicaid benefits and services to align enrollment processes, including passive enrollment policies, marketing and member materials, contracting and network requirements, Medicaid benefits and model of care policies, performance measurement and methods, financial management requirements, and appeals and grievances processes.

We also suggest:

- Giving MA flexibility in benefits design to the same set of conditions currently authorized for C-SNP enrollment, using the same definitions and condition-verification process.
- Requiring plans to follow the same model of care and reporting requirements that are mandatory of C-SNPs for those conditions selected for plan flexibility.
- Giving C-SNPs greater benefit flexibility, as currently being envisioned, and conduct a study to evaluate which of the flexibility provisions have the greatest effect on improving health outcomes before transferring those provisions to general MA plans.

2. **Expanding supplemental benefits to meet the needs of chronically ill MA enrollees (page 15 of Options paper)**

The SNP Alliance supports allowing MA plans the ability to offer a wider array of supplemental benefits than what can be offered now. Similar arrangements also have been proposed by CMMI in advancing specialty care arrangements through implementation and testing the VBID Model. However, with the exception of FIDESNPs, Special Needs Plans currently are not provided any additional flexibility in use of supplemental benefits. This has been an issue of concern to the SNP Alliance for years.

CMS indicated in 2013, when FIDESNPs were given greater flexibility in use of supplemental benefits option, the purpose was to foster integration of Medicare and Medicaid benefits and help keep people out of nursing homes and in the community. While this flexibility has been beneficial to FIDESNPs, we have two principal concerns with CMS limiting the ability to offer certain supplemental benefits under §422.102(e) to certain dual eligible special needs plans. First, we believe there is no policy justification for making this delineation. The value of offering these additional benefits in terms of enhancing the health of its members clearly accrues to all SNPs, not just dual SNPs that meet the additional integration requirements specified by CMS. Further, CMS' decision to allow FIDESNPs to offer these specified supplemental benefits reflects implicitly a decision by CMS that these benefits are "health" benefits. Otherwise, CMS would lack the authority to allow them to be offered. The MA regulations give all MA plans the right to offer supplemental "health" benefits that are not Medicare covered benefits. We believe that CMS' decision not to allow other MA plans the opportunity to offer these benefits is in conflict with the MA regulations. The fact that CMS is continuing to allow MA plans to use supplemental benefits to cover telehealth benefits further supports our position.

In response to the Committees feedback on this consideration, we:

- Support allowing additional supplemental benefits to include medical services or other non-medical and social services that improve the overall health of individuals with chronic diseases.
- Suggest similar flexibility should be given to plans to address social factors that adversely affect health and healthcare outcomes of poor Medicare beneficiaries.
- Recommend the plan should demonstrate how the additional benefits are of unique importance for improving health and healthcare outcomes for the subgroup being targeted.

It might also be useful for Congress to clarify the flexibility that CMS already has to enable SNPs and other MA plans to advance specialty care arrangements for targeted subgroups, and expand that authority, where Congress understands their existing authority is too limiting.

3. **Integrating behavioral health and medical care in MA and FFE (page 12 of Options paper)**

We agree and endorse the efforts of the Chronic Care Working Group to recognize the importance of supporting integration and coordination between behavioral health and primary care/medical



care providers. We have noted the significant efforts of SAMHSA and HRSA to support the progress of providers and systems to integrate these services, settings, and providers. The challenges are great, but it is clear that mental health and behavioral health issues greatly impact or influence the ability of beneficiaries and practitioners to achieve progress on medical condition goals.

In crafting provisions to advance integration of behavioral health and chronic illness care, it is important to keep in mind:

- **Integration of behavioral health and medical care also requires a better alignment of related financing, program policy, and oversight structures.** Current payment methods contain incentives for excessive and inappropriate use of institutional services. Specific program component requirements often impede aligning clinical interventions among related care providers. Performance metrics do not fully account for the coexisting nature of chronic illness, mental health, and/or interdependencies in caring for persons with these coexisting conditions. Structural barriers include restrictions on information sharing under patient health information privacy protection requirements, the non-integrated medical record and information systems, the differing quality metrics/measures, the disparate service eligibility and payment models/methods, and the lack of capacity within each setting to align workflows, patient outreach, care management methods, and treatment plans/goals.
- **Removing barriers to integration is as or more important than adding new plan or program requirements.** Healthcare plans and related care providers are already highly regulated. Many physicians are already feeling overburdened with requirements, even where the requirement is seen as well-intended. For example, many physicians see the chronic care management fee as overregulated to the point it is almost unusable. The same is true for the medical home fees.
- **Integration of medical care and behavioral health is still a relatively new concept.** “Medical care” needs more input/connection/integration with behavioral health care, while behavioral health needs more input/connection/integration with medical care. And patients need both. Some plans have found it more important to establish an entirely new clinical practice model that is organized, paid, managed, and staffed differently with primary care and psychiatric providers. There are trials/pilots of integrated models being tested through other venues as well. Congress, CMS, plans and providers should all build on this accrued learning.
- **Caring for a person with medical and behavioral health requirements is complicated and time consuming.** Introducing too many changes too fast can have unintended consequences. It often takes 3-5 years to change practice styles and more time for the changes to be effective. Giving care providers more flexibility and support in addressing their complex circumstances may be more effective than adding a whole new set of additional requirements. New programs are often over-thought by regulators such that few providers engage change/innovation early out of either fear of regulatory requirements or insufficient payment. Starting simply and then adjusting payment and regulation as practices work their way through the implementation may be a better way to encourage engagement and more practical effective care results.
- **Mental health parity is still an emerging reality.** Effective integration of medical care and behavioral health is in part dependent upon full implementation of mental health parity. Integration may be an effective tool for advancing this much-needed change in health policy and practice.
- **Capitated financing can enable a fuller realignment of medical care and behavioral health.** Incentives offered under properly constructed managed care enables plans to provide whatever covered (or non-covered such as social/family interventions) combination of care is most cost effective to achieve the covered clinical aim. Capitated financing incentives also can enable a reengineering of relationships and balance among behavioral health services and other medical care benefits and services. Striking the right balance among providers and services is highly local in health care and rarely can be standardized in detail across the country.

With these principles in mind, the SNP Alliance recommends the following:

1. **A GAO study on the current status of integrating behavioral health and primary care, as considered by the Committee.** This can provide the foundation for advancing new legislative provisions, with a better sense of what is most efficient and effective.
2. **Extend the analysis to include SNPs.** In part, SNPs were established to advance a realignment of benefits and services for complex beneficiaries, including those with co-existing medical care and mental health and behavioral health requirements. D-SNPs, I-SNPs, and C-SNPs all have a greater preponderance of enrollees with medical care/behavioral health needs than general MA plans, as well as many ACOs. Some SNPs also have advanced important new practice interventions specifically designed to better integrate medical care and mental health and behavioral health services. The GAO analysis should include an analysis of these models as well as options for organizing care around various behavioral health diagnoses such as depression, bipolar disorders, schizophrenia, developmental disability, chemical dependency/addiction, and Alzheimer's disease and dementia. GAO should also analyze the role of medical and behavioral health medications in treating CD and opiate addiction, psychotropic medications that are usually managed by mental health providers even though they often have medical side effects, while primary care physicians or specialists manage the coexisting diabetes and cardiovascular drugs.
3. **Need for financial training and education of healthcare practitioners on behavioral health and related integration opportunities.** Behavior health care and concepts related to their integration with medical care must be better understood. New behaviors need to be established. Plans, providers, and beneficiaries all need more knowledge, skills, and commitment in this area for the silos of care fragmentation to be softened up and broken down.
4. **Require CMS to remove barriers to integration, and advance alignment of incentives and program requirements among related care providers.** This includes reassessing interaction terms in the HCC payment method; removing barriers for integration among component program providers and between Medicare and Medicaid; encouraging care teams to be more inclusive of members with behavioral health expertise; monitoring influences of behavioral health medications with the coexisting medical condition, such as diabetes; increasing the use of telemedicine; accounting for differences between urban and rural providers; aligning informatics and redefining performance metrics to more fully account for related condition and provider interdependencies.

#### 4. Providing MA enrollees with hospice (page 8 of Options paper)

The SNP Alliance is supportive of requiring general MA plans to offer the hospice benefits provided under traditional Medicare. This is all consistent with efforts to enable more of a person-centered approach to care, which is especially important when issues of medical, non-medical, and personal well-being come together during the end of life for patients and their families. Adopting this policy should enable plans to offer a full arc of care from prevention to end of life as well as to address the array of interdependencies that exists in serving persons with complex chronic conditions. This should also encourage further development of, and alignment with, palliative approaches that are important in earlier stages of the trajectory of life-limiting illnesses. Since life-limiting illnesses do not always fit the hospice criteria, this could *enable a plan to give more attention to palliative care related elements, such as more comprehensive advance directives, and goals of care, etc. — all important aspects of a person-centered approach to care.* This is particularly important to SNPs in that many SNPs are responsible for helping manage the complexities of care for a large number of enrollees with life-limiting illnesses, and enabling them and their families and related care

providers to address the totality of a person's care needs, including those that give meaning to life and their families in times of crisis.

In advancing this proposal, we believe it is important to ensure that plans:

- Identify and connect the appropriate patients for the hospice service;
- Maintain consumer protection features that have been identified in the current Hospice program; and
- Enable continuity of care in transitioning to this new arrangement.

We also believe it is important that CMS:

- Not be overly aggressive in cost saving expectations;
- Focus primarily on care quality; and
- Appropriately account for hospice costs in the plan's capitated payment.

#### **5. Allowing ESRD beneficiaries to choose a MA plan (page 9 of Options paper)**

The SNP Alliance supports allowing end-state renal disease beneficiaries to choose a MA plan. We believe beneficiaries should be allowed to seek and receive ESRD services through a general MA plan or through a Special Needs Plans that exclusively serves persons with end stage renal disease.

#### **6. Encouraging beneficiary use of chronic care management services (page 23 of Options paper)**

The SNP Alliance supports the Committee's consideration of establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule outside of a face-to-face encounter. However, the SNP Alliance suggests:

- If this is added to FFS provider payments, CMS also makes adjustments to SNP payment based on percentage of enrolled beneficiaries (all duals) with specific HCCs.
- The following diseases/conditions also be considered: CHF; CKD; chronic lung failure/COPD; physical disabilities; HIV-AIDS; substance abuse disorders; homelessness; serious and persistent mental illnesses; and diagnosed dementia/Alzheimer's disease.

#### **7. Expanding convenience for MA beneficiaries through Telehealth (page 16 of Options paper)**

Telehealth has the ability to empower patients and caregivers, while improving the lives of Medicare beneficiaries. The use of telehealth technology provides patients with real-time access to physicians who are able to consult and provide quality care without needing to visit an urgent care center or other more costly care setting.

Our members find that telehealth and remote monitoring techniques can facilitate patient engagement and coordination of services across multiple settings. It can enable SNPs to collect daily weight and/or BMI data that triggers an almost immediate telehealth visit if concerns are identified. Remote monitoring can also assist in care coordination and monitoring for individuals identified at high risk for readmissions. Those with diabetes can transmit blood sugar levels and their weight, while blood oxygen levels and blood pressure of patients with congestive heart failure can also be monitored. In 2014, UPMC (a SNP Alliance member) found only 12.9% of remotely monitored patients with congestive heart failure were readmitted to a hospital within 30 days of their initial hospitalization, compared with 20% of patients with the condition who did not participate. These meaningful, real-world reductions in hospitalizations, readmissions, and costs, along with improved outcomes, demonstrate that telehealth strategies can genuinely impact the delivery and financing of healthcare, especially for those individuals with multiple chronic conditions.

Currently, the Medicare program recognizes and pays for only certain Part B telehealth services while beneficiaries are only eligible for these services if they are provided at a medical facility in a

rural area. Further, any use of telehealth services beyond the narrowly defined original Medicare telehealth benefit must be a supplemental benefit in the MA program. As a supplemental benefit, a SNP must use a portion of its rebate dollars or charge the enrollee an additional premium to provide the service. These circumstances often disincentivize the offering of telehealth services.

The SNP Alliance urges the Senate Finance Committee to pursue a policy option that:

- Allows Medicare providers—including FFS, MA plans, and ACOs—to assess which of their patients would benefit most from telehealth services and to, in turn, be able to use and be reimbursed for such providing services;
- Enables telehealth services to be included in an MA plan bid; and
- Allows the “home” to serve as an originating site, assuming the member is home-bound and, of course, assuming the connectivity is available.

#### **8. Increase transparency at CMMI (page 28 of Options paper)**

We support CMMI in testing various payment and service delivery models that aim to improve outcomes and reduce costs. CMMI has provided important leadership in advancing a variety of initiatives of importance to the SNP Alliance. However, members report they are often tasked with responding to Requests for Information (RFI) or other notices from CMMI—that frequently contain limited information—in a short period of time. Requiring CMMI to adopt a more formal rulemaking process, particularly for initiatives that impact a significant amount of Medicare spending, providers, beneficiaries, or plans would enable all stakeholders to take on a more active role in helping shape these models. This would, in turn, allow CMMI an opportunity to incorporate valuable feedback to help ensure that models are successful. However, we understand rulemaking to be a protracted process. As a result, we encourage CMMI to craft rulemaking processes that enable stakeholders to meaningfully engage in model development without stifling innovation and quickly adopting beneficial practices.

### **Closing**

We would like to affirm the direction that the Chronic Care Working Group has taken along with your three key goals. We believe your efforts will achieve better care and cost outcomes for some of our nation’s most vulnerable Medicare beneficiaries and uphold the tenants of this program for beneficiaries who depend on it.

Thank you for the opportunity to comment on this important and significant work.