SNP Alliance A National Nonprofit Leadership Organization

The National Voice for Special Needs and Medicare-Medicaid Plans

ATTACHMENT 1

SNP Alliance SNP Specific Network Workgroup Summary ***Revised 1-10-2018***

Issues and Ideas Summary Based on SNP Specific Network Workgroup Brainstorming Sessions and Discussion with CMS

Principles for Consideration of SNP Specific Network Requirements

- *Improve match of network requirements to population and subpopulation needs*
- *Consider efficiency of operational implementation and minimize additional administrative burden for both CMS and plans*
- *Yet recognize that there may need to be more complexity during interim steps to get to something workable, so refinement of criteria and operational implementation may occur over time*
- *Avoid penalizing or sanctioning plans for new processes during ramp up or phase in periods*
- *While reducing exceptions may be a goal, recognize need for appeals, exceptions and process for handling unanticipated issues*
- *Consider what has been learned in MMP and D-SNP demonstration*
- *Consider availability of NEMT, telehealth, mobile providers and in-home providers*
- *Consider developing delivery trends, impact and role of provider quality and value based purchasing strategies*

SNP Alliance Member In-put to CMS for SNP Specific Networks	***Suggestions for Possible Solutions***
1. ***Recognize Differences in Provider Delivery System for I SNPs***: • In most cases, the majority of ISNP members are dually eligible. • I-SNPs utilize large numbers of bedside providers (including specialists) who are not counted toward the HSD tables because networks are reviewed on a county basis and these providers do not serve the entire county population. • Instead ISNPs attempt to contract with SNF affiliated providers who are already serving residents so they build their networks around the SNFs. • Therefore ISNPs spend valuable resources contracting for providers that SNF members will never use.	• Develop and asses T&D and minimum number requirements on Medicare eligible individuals who meet nursing facility level of care (or if that data is not available, Medicare SNF/and Medicaid dually eligible SNF/NF members) (versus general population standards development and full county network assessment). This should result in modification of minimum number standards to reflect that these members do not use as many out of facility providers. • Allow bedside providers including primary care and specialists who focus on serving SNF and Assisted Living residents based on affiliations with SNFs (who may not serve the general population) to be counted

• ISNPs do not need many SNFs and certain other external providers in their networks as members live in a SNF and typically receive rehab in their "home".	and change provider directory requirements to reflect this. • Map population standards to location of SNFs versus whole county • Adjust time and distance standards for provider categories to reflect that most members do not need to travel to see providers • Change institutional provider requirements for ISNPs to recognize that most members receive rehab services in their SNF residences.
2. ***Recognize Differences in Needs and Provider Delivery System for Dual Eligibles in DSNPs**:* • Number of duals is much smaller than full Medicare population or may be distributed differently across the service area. • Number and type of providers needed may differ from larger Medicare population, including in general and as county urbanicity changes.	• Develop and calculate standards (including base metrics, 95th percentile) on population of eligible duals versus entire Medicare population (similar to MMPs). • Adjust D-SNP provider network requirements for distribution and utilization based on subpopulation of duals to be served such as FBDE, or over 65 or under 65 members.
3. ***Recognize and Take Into Account Alternative and Changing Service Delivery Patterns:*** • Dual eligibles often have transportation and access challenges not experienced by the broader Medicare population. These challenges are exacerbated in rural areas. Medicaid programs typically allow for telehealth, mobile, or in-home delivery to accommodate these vulnerabilities and enhance adequate access to care.	• Extend MMP additional exceptions process to DSNPs including embracing technological innovations such as mobile clinics, in home, e-visits and other telehealth modes to help address access issues such as shortages of behavioral health providers and other specialty types in rural areas, and to accommodate transportation limitations often experienced by duals.
4. ***Provider Refusal to Serve Dual Eligibles or Certain Complex Subpopulations:*** ISNPs and DSNPs report that providers often refuse to serve duals, individuals in SNFs, and individuals with complex disabilities. This leads to difficulty in contracting with these providers and/or or results in them refusing to provide access when contracted. **Exclusivity or Refusal of Provider to Contract:** ISNPs and DSNPs say that many providers will not contract with smaller plans or have exclusive relationships with certain plans despite favorable plan design providing full Medicare rates without cost sharing etc.	• Include refusal to serve dual population as an acceptable exception request. • CMS should adjust provider requirements to reflect that these providers are not available. For example, CMS could combine its physician supply data with state Medicaid provider data to identify providers who conceivably are willing to participate in both programs. • Develop a mechanism at the CMS level for dealing with plan and consumer reports of providers who refuse to serve duals • CMS should research underlying reasons for provider discrimination against these populations and should develop policies for addressing them with providers. These could range from regulatory requirements around discriminatory practices to providing incentives for providers such as recognition of issues around SDOH and other barriers to serving these individuals, or working with states to discourage exclusivity for

	Medicaid contracts through methods such as rate floors and ceilings (e.g., using rate floors to encourage participation and ceilings to discourage out of network care). This approach likely would influence Medicare contracting practices in the state as well.

5. Contract Level vs PBP Level Reviews
• Many SNPs are part of larger contracts and thus subject to contract level reviews
• How to balance additional burden with potential benefit of additional PBP submissions
	• Allow contract level option in provider types where no significant differences for subpopulation exist (establish threshold parameters for "significant " differences)
	• Where methodology shows needs exceed contract level, conduct those provider type reviews at PBP level along with exceptions that expand access as in MMP process
	• Other options/variations include:
	    o Single MAO network submission that CMS assesses twice (once against broader population (standard) and once against SNP population and standards); MAOs would receive two sets of results
	    o If certain providers are only contracted for certain products, potential to add columns to the HSD tables that address the PBP a provider should be mapped to (MAOs still have single submission with CMS/Quest writing code that pulls and maps the appropriate provider); two sets of results back to plans
	    o Off cycle reviews to minimize burden (coupled with PBP level submission and review) -- e.g., alternate review years
	• Involve states in exceptions review for DSNPs.

6. **Reduce Confusion for Beneficiaries in PBP Level or SNF Specific Directories:** • When the ISNP is using their contract level network, providers must be listed who are not available to SNF residents, making provider directories confusing. • Providers who are exclusively serving SNF residents are also listed in directories although they are not available to the community residents.	• SNP specific network could eliminate this problem if network review is done at the PBP level • Or if network review is at contract level, allow difference in member materials

7. ***IE SNPs and Assisted Living****:* Some IE SNPs have had trouble with network reviews related to Assisted Living, which are not a covered service under Medicare so they don't appear on plan previous network or Medicare supply tables and cannot be contracted until after the application/contract is approved but CMS is requiring they be contracted prior to the approval.	• Adjust review process guidelines or provide training for reviewers to consider that IE SNPs cannot contract with Assisted Living until contract is approved.

8. ***Recognize New Service Delivery Best Practices and Role of Quality in Providers, vs Quantity****:*
• Some provider care systems have been developed with special expertise and focus for chronic conditions, geriatrics, end of life care, integration of primary and behavioral health, disease specialties, etc.
• Beneficiaries may benefit more from improved care under value based provider contracting arrangements with these types of providers than by having access to poor providers. This would reflect CMS efforts to shift to alternative payment models across Medicare more broadly.
• However, to meet current requirements plans must use valuable administrative resources on obtaining contracts with providers on the supply files, rather than focusing on providers that are interested in serving dual groups and who also provide more value.
• Supply based approaches may also be driving unnecessary utilization and costs.
	• Consider impact of growing role of value/quality based contracting approaches in network development
	• Work toward recognizing quality vs quantity (supply) based best practice approaches to network development
	    o Clarify or strengthen process for reporting of and reducing use of poor quality providers in network development, for example allowing an exception for these providers when they are the nearest available to beneficiaries
	    o Possible Approaches:
	        − Pass a network in instances where it fails network access but exceeds quality thresholds (would need to create guardrails around how much of a fail is permitted; perhaps, pass networks at 75% coverage (rather than 90%) if providers meet some quality threshold)
	        − Remove providers from supply file in instances where at least two MAOs in a county have signaled poor quality of that providers
	        − Develop an overall scoring algorithm that measures both "quantity" and quality, such that MAOs can pass solely on quantity (i.e., status quo) or can get "bonus points" of some sort based on the quality of their network (similar to number 1 above)
	• Consider improving definitions of what constitutes supply, perhaps based on FFS or encounter data (eventually) patterns of care for subpopulation groups such as dually eligible benes.
	    o As encounter/utilization data improves, move toward a service access approach instead of a provider type availability approach
	    o Consider expertise and relationships needed to serve special populations vs access issues only.
	        − Examples: Recognize role of PCPs in addressing broader

	scope of needs especially in rural or hard to serve areas, permitting alternate provider type exceptions or developing standards through services rendered by providers versus provider type only ○ Improve and make consistent definitions of population sub-groups for possible VBP, measurement and network purposes
9. Streamline Communications/Reduce Administrative Burden • Some plans have been denied approval for lack of one provider but are not informed of who the provider is. It can be difficult and burdensome to compare CMS' entire supply table with a plan's network and overlay with beneficiary locations to identify missing providers; however, CMS has this information readily accessible as part of its review.	• Develop and incorporate streamlined process for CMS to communicate this information to plan, for example including the NPI, provider name, and location in denial details.
10. Mapping and Data Source Challenges • CMS network mapping measures distance "as the crow flies" resulting in inaccurate distance assumptions due to lakes, forests, etc. • Some exceptions have to be submitted repeatedly across several years because providers are not actually available but this information has not been updated in CMS source data • Provider addresses may reflect billing offices not location of provider services • Multiple sources of data for supply files may not be updated • Physician compare contains many Medicare providers that do not service duals, but many Medicaid providers who do may not be listed	• Adjust mapping software to map using driving distance, or adjust criteria to reflect mapping software limitations (e.g., decrease beneficiary coverage requirement to 75%; increase time and distance values); note that an adjustment to mapping software likely also requires an adjustment to the criteria that were developed using that software and the underlying algorithms that map "as the crow flies." • Allow exceptions to apply for multiple years in instances where CMS source data does not show an influx of providers in a given area or where state attests to need for multiple year exceptions (see below). • For integrated plans, collaborate with state on exceptions process to reduce yearly submissions by recognizing state approved/verified exceptions including those related to drive times, geography and mapping. • Create a method to allow plans or other entities to report cases for correction to a business owner within CMS where providers on the list are not actually available (e.g., publishing the supply file publically for comment each year). • Require providers to attest annually to practice locations and specialty types listed in CMS source data. • Define, flag and track serious repeat instances of provider data inaccuracy using information in NPPES and Physician Compare, and send notice of risk of reduction in FFS payment until information is

	attested to/corrected. • Collaborate with states to identify Medicaid providers and remove from CMS source data any providers not also listed as a Medicaid provider (for DSNP mapping)

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