



**SNP Alliance Comments on the Centers for Medicare and Medicaid Services and the Center for Medicare and Medicaid Innovation Request for Information on Direct Contracting – Geographic Population-based Payment Model Option
5-24-2019**

Comments due by May 30, 2019 5 p.m.

The SNP Alliance is pleased to provide comments to CMS and CMMI regarding the proposed option announced April 24, 2019 to allow for Direct Contracting (DC) to providers for a geographic Population-based payment (PBP) model option.

The SNP Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent over 390 special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs), with over 1.9 million enrolled members. Our primary goals are to improve the quality of services and care outcomes for the complex populations, served and to advance integration for those dually eligible for Medicare and Medicaid.

We applaud the focus on populations with complex needs and appreciate the importance of multiple models and approaches to provide individuals with options and choice. In addition to focusing on the quality of care and services, we wish to ensure beneficiaries have necessary information to make those choices that best meet their needs.

We do have a number of concerns regarding beneficiary protections, oversight, adequate capabilities of DC providers, and the impact to advancing integration for those dually eligible for Medicare and Medicaid that are not yet fully clarified in this proposal. Although we realize that the actual application process will likely address many of these concerns, we wish to outline them in response to the RFI.

We have provided answers to many, but not all, of the listed questions and summarized our recommendations at the end of our responses.

Summary of SNP Alliance Comments in Response to the Questions Provided:

Responses Related to General Model Design Questions

1. How might DCE in the Geographic BPB model address social determinants of health (SDOH)?

It is unclear how the DC providers will determine which beneficiaries have SDOH needs, what those individual needs may be, how to provide an array of services to meet those needs, how to contract with community-based providers, and how to measure the outcome of providing those services. While the language leaves it to the providers to make such determinations, there naturally arises concerns about beneficiary equity, including transparent determination of benefits and denial processes.

The SNP Alliance is very concerned that there is nothing in the proposed model description that requires any coordination or integration with Medicaid, other than the Medicaid MCO partner option. Dually eligible populations are known to have high levels of needs related to SDOH, some of which can be addressed through access to Medicaid services. In this model, dual eligibles will be attributed to the DCE retroactively based on claims from past Medicare visits, making it even more difficult to assure proactive and comprehensive care coordination and identification of SDOH needs.

However, this program could be an opportunity to promote improved identification and reporting of social determinant factors, such as the use of ICD-10 Z codes. The SNP Alliance would like to also reference the recent HHS/RAND report on SDOH and MA that identified successful strategies (all special needs plans) used to identify SDOH issues.

https://www.rand.org/pubs/research_reports/RR2634.html. Such strategies could be built into the standards for the DCE, and perhaps CMS could tie additional reimbursement to such data, as well as bringing SDOH factors into risk adjustment.

Addressing SDOH factors could also create a basis for creating more formal connections between healthcare and social services. DCEs would then have to demonstrate a certain level of referrals out to social service providers or other LTSS services, together with follow-up to ensure services were received. This would be based on a comprehensive care plan for each person.

The SNP Alliance recommends considering comparable requirements around population identification, key risk characteristics, defined provider networks to address needs, care coordination and care management strategies across services and based on care plan, and quality measures consistent and as applied by Medicare or states with similar populations. We need to ensure even parameters and expectations for quality care, as is required for other contractors who are accountable for groups of enrolled or attributed beneficiaries—such as in managed care plans and accountable health organizations where financial and clinical risk is taken on by the contracting entity.

2. **Construction of a Comparison Group**

It is clear that for any evaluation of a new model, a comparison group is essential. This comparison group, in order to truly allow for a valid analysis, must be similar in risk, LTSS needs, level of disabilities, and social determinants burden. They must have access to similarly sized and structured networks for providers and essential services. In the BPB it is yet unclear how other payment models (eg: MA plans, Managed Medicaid, Integrated Special Needs Plans, or ACOs) will impact the geographical implementation and evaluation. Are such populations in other alternative payment models excluded from the control group in the geographical population as they are in the DC model? Will beneficiaries know which group they are in (demonstration vs control)?

3. **What are the benefits and/or risks to access, quality, or cost associated with the Geographic PBP model in a target region that includes a rural area?**

The Geographic PBP will face similar challenges that other alternative payment models have experienced in rural settings, - particularly in providing an adequate provider and service access. It is unclear how the PBP will require the DC providers to meet the same network adequacy requirements that MA plans must meet, given the existing provider FFS payment structure— limiting access to fewer providers and services may reduce costs, but this will incur potential harm to the individuals enrolled in the BPB. Furthermore, rural providers and beneficiaries already also face challenges in access to adequate LTSS services. It is unclear how this pilot would relieve these many workforce and service provider shortages.

Beneficiaries in rural areas, as well as non-rural areas must be afforded ALL the same protections that are included in MA, including:

- Transparency in enrollment
- Reserve requirements related to assuming risk
- State managed care and other licensing requirements
- A process for grievance and appeals

- Model-of-Care requirements A defined network of providers with oversight and quality of care reporting requirements

Questions Related to DCE Eligibility

1. Additional Selection Criteria for DCE

The SNP Alliance believes strongly that the selection criteria must include:

- Demonstrated ability to, and history of, assuming risk
- Demonstrate adequate risk reserves
- Capacity to manage “back office functions” such as grievances and appeals, marketing, enrollment, quality measurement and reporting, contracting, provider oversight, and general beneficiary assistance in navigating benefits and coverage issues.
- Ability to integrate LTSS and Behavior Health, including joint care coordination and case management functions
- Require DCEs to submit a Model of Care – identifying essential domains of needs/services for the population (s) service and describe the process for addressing these including care coordination.
- Require the DCE to conform to the same Star Measures and MAOs and the CMS QMS for evaluating and reporting performance – not only does this drive quality, but it will provide additional transparency for consumers as they better understand options

2. Should States be allow to participate in the Geographic PBP model and what conflicts of interest issues might arise?

While the SNP Alliance recognizes a number of states may wish to explore this opportunity, it does raise additional concerns for those dually eligible:

- How will the states align the Medicare and Medicaid benefits under such a model?
- Will the state ensure the same Medicare protections that those enrolled in MA or who have FFS Medicare are afforded?
- How will this impact the State’s efforts to advance integration of Medicare-Medicaid in D SNPs, Medicare-Medicaid Demos or PACE? Will individuals already enrolled in such be excluded from the PBP Model?
- Given the experience of several states with the MMP demonstrations, it is clear that providers can have a significant influence over choice options for their patients. This is done outside of actual “marketing”, and yet can have a significant impact on individuals electing to opt out of an integrated program and participate in a model for which the provider organization may have an incentive to advance enrollment, whether or not it is in the individual’s best interest.

The SNP Alliance recommends:

- Ensure the rates states pass through to MCOs are actuarially sound
- Ensure quality targets are reasonable given this is still ultimately a FFS population; identify core quality measures that can be used nationally (e.g., subset of stars) but also work with states to identify “core” metrics that might apply specifically to duals and aligned with state programs
- Create disincentives to having beneficiaries disenroll from integrated models in order to be attributed to a DC provider

Questions Related to Beneficiary Alignment

1. Transparency /notification requirements

It is essential that beneficiaries are offered adequate notification in clear and understandable language. They must be provided with the same scope of information that MA plans are required

to provide, including (but not limited to) network, grievance and appeals process, and the ability to opt-out of this model.

2. What safeguards should CMP put in place to ensure that any beneficiary incentives provided do not negatively impact quality of care, program costs or competition?

DC providers must meet the same requirements regarding market guidelines as do MA plans for the very reasons that they provide needed beneficiary protections. Furthermore, there must be protections against disrupting current LTSS provider networks by aggressive market contract rates, or by incentives that would restrict network access for MA, D-SNP or Managed LTSS network provider relationships.

And finally, there must be protections to ensure that providers will not be able to coerce their patients off from such rolls and into the BPB pilot, or suddenly opt out of MA networks and, as a result, drive members out of MMPs/DSNPs and into this demo. As above, we would recommend disincentives for DCE providers to move individuals already enrolled in integrated models into their BPB program.

Closing Comments and General Concerns

The SNP Alliance recognizes the importance of exploring novel approaches to payment and service delivery design for those with chronic conditions and who are high-risk and high cost. We recognize that such models, such as the Geographic PBP may provide an additional vehicle to meet the needs of these populations. However, we remain concerned that these models may function much like Medicare Advantage – but without the inherent beneficiary protections that managed care provides under legislative and regulatory mandates.

We are concerned about the impact on network adequacy for existing payment models if providers withdraw from current network arrangements to exclusively participate only in their own direct contracting model.

We are concerned that beneficiaries may not know their full range of options in a given market, and that this Geographic PBP may pull dually-eligible individuals away from exiting integrated options, such as D-SNPs, MMPs and PACE programs. This is a particularly concern if beneficiaries are not given full information regarding choices and all options within their service area.

Lastly, we are concerned that state-based models may distract states from needed work in integration Medicare and Medicaid, given that there is nothing within this Geographic PBP proposal that directly addresses integration of Medicare-Medicaid benefits, including all of the protections afforded those enrolled in D-SNPs, MMPs and PACE.

We appreciate the opportunity to comment and look forward to additional details regarding Direct Contracting models for Providers, including the Geographic Populations-Based Payment Model Option.

Respectfully,



Cheryl Phillips, M.D.