SNP Alliance
The National Voice for Special Needs and Medicare-Medicaid Plans
A National Nonprofit Leadership Organization

SUBMISSION VIA EMAIL: daniel.lehman@cms.hhs.gov

September 6, 2019

Ms. Kathryn Coleman
Director

Mr. Daniel Lehman
Health Insurance Specialist

Medicare Drug & Health Plan Contract Administrator Group
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information (RFI) on Severe and Disabling Chronic Conditions and Enrollment in Medicare Advantage (MA) Chronic Condition Special Needs Plans (C-SNPs)

Dear Ms. Coleman and Mr. Lehman:

The SNP Alliance is pleased to provide comments to CMS and CMMI regarding the definition of Severe and Disabling Chronic Conditions as amended by the 2018 BBA; the current list of severe and disabling chronic conditions; whether those conditions could be further clarified; and if there are any potential conditions missing from the list.

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 2.1 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 have long been ardent supporters of C-SNPs and recognize the unique value they provide individuals with serious chronic and disabling conditions – through focused Model of Care design, care coordination across setting and providers, and the ability to design benefits that meet the specific needs of the unique populations served. C-SNPs facilitate both chronic and acute care management, and proactive interventions to address physical, social and personal health needs of individuals enrolled in these specialized managed care plans.

The SNP Alliance supports the current list of C-SNP conditions, with some opportunity for further clarification to be noted below. Because C-SNPs have significant administrative burden to establish and to provide needed support for those beneficiaries enrolled, we believe *stability* in over-all plan design, and *consistent* criteria are essential for both plans and beneficiaries.

While we value the opportunities for innovation and flexibility in Value-based Insurance Design and Supplemental Benefits for Chronic Illness, we do not see these as substitutes for the team-based,

person-centered approaches to managing the specific conditions for which the C-SNP has defined in their plan design.

Response to CMS Specific Questions:

1. **Does the current list of chronic conditions as noted in Medicare Managed Care Manual adequately cover all conditions that could be reasonably considered as severe or disabling under the new definition? Are there other conditions that the panel should consider?**

   We support the addition of Chronic Obstructive Pulmonary Disease (COPD) to the list of chronic lung disorders. At the time of the 2008 panel, it was determined that COPD was a non-specific diagnosis, and was coded in ICD-9 as such. In ICD-10 it is now a billable code. Furthermore, according to the Center for Disease Control and Prevention's 2015 National Center for Health Statistics, it was recognized as the fourth leading cause of mortality and morbidity in the United States. https://www.cdc.gov/nchs/data/hus/hus15.pdf. Thus, its prevalence and severity warrant consideration for inclusion. We recommend that advanced stages of severity of COPD meets the intent for C-SNP designation.

   The 2018 Global Initiative for Chronic Obstructive Lung Disease (GOLD) report defines the criteria and describes the seriousness of this condition in its advanced stages. This link summarizes that report in the Mayo Clinic Proceedings: https://www.mayoclinicproceedings.org/article/S0025-6196(18)30409-9/pdf.

   Although COPD can be broken down and captured by coding for chronic bronchitis and emphysema, most patients and clinicians identify COPD in advanced stages as a specific, and life-threatening, condition. Failure to include this condition results in added beneficiary and provider confusion regarding true eligibility for the C-SNP category. It also, then, denies these individuals the benefit of a coordinated and team-based care as provided by the C-SNP structure.

2. **Should the panel further clarify and/or revise the set of diseases and disorders that accompany the current list of chronic conditions?**

   While the SNP Alliance is not looking for any reductions in the conditions listed, we believe that further clarification of "paranoid disorder", under chronic and disability mental health conditions would be helpful. Also "spinal stenosis" by itself is a broad condition with a range of manifestations, and may be improved by clarifying related conditions such as chronic pain, immobility or other related neuropathies related to spinal cord compression.

   We note that any expansion or restriction of a given condition category must take into account appropriate Hierarchical Condition Category (HCC) calculations and calibrations to ensure appropriate payment for the condition categories covered by the C-SNP plan.

3. **Does the current list of chronic conditions listed in the MMCM as commonly co-morbid and clinically-linked conditions adequately identify groupings of co-morbid and clinically-linked conditions that CMS should approve for multi-condition C-SNPs?**

   The current list of 5 groups, as defined in MMCM Chapter 16b, section 20.1.3.1, should be expanded to include:

   a. Dementia and Diabetes; Dementia and Cardiovascular Disease; Dementia and Chronic Heart Failure – as it is recognized that the presence of dementing illnesses creates additional challenges for the management of these other conditions, increases costs, and increases the complexity of care management.
   b. Chronic Lung Disease and Cardiovascular disorders, as this combination is common and adds significant burden to the individual.

   However, the SNP Alliance supports potential flexibility afforded by multi-condition SNPs where the beneficiary need only have one of the qualifying conditions for enrollment – allowing the C-SNP to customize the unique care needs of the individual with comorbid chronic conditions. Few Medicare beneficiaries present with a single chronic condition in isolation. Where C-SNPs can make a profound difference to the individuals being served is by addressing the complexity that comes with multiple comorbid conditions.

4. **MAOs may develop their own multi-condition C-SNPs that use groupings of the severe or disabling chronic conditions, identified in the MMCM for C-SNPs. To be eligible for such a multi-condition C-SNP, enrollees much have all of the qualifying commonly co-morbid and clinically linked chronic conditions in the MAO's specific combinations. To date, MA organizations have underutilized this type of multi-condition C-SNPs. CMS is seeking comment on multi-condition C-SNPs that are designed by MAOs, as opposed to using specific groupings identified by CMS. Specifically, what are the benefits of keep this option versus the risks to removing it?**

   As noted above, we believe there is value in MAOs developing specific multi-condition C-SNPs that best meet the needs of the populations served. Having a limited, CMS-defined, list of qualifying comorbid conditions would likely limit the ability to meet the needs of a given population of beneficiaries. MAOs should be able, through their plan benefit design and Model of Care Structure, identify how best to serve individuals with multiple severe or disabling conditions identified in the MMCM for C-SNPs. We recognize that, to date, this opportunity has been underutilized. However, we believe that C-SNPs should continue to have this flexibility in the future for the above reasons.

Additional Opportunity to Improve C-SNPs Through Simplified Model of Care Reviews.

The SNP Alliance offers the recommendation to reduce administrative burden for C-SNPs through modification of the annual Model of Care (MOC) review for C-SNPs, as defined in the Bipartisan Budget Act of 2018, Section 50311. Specifically, section (B)(iv) required that beginning in 2020 and subsequent years, C -SNPs will submit MOCs annual for evaluation and approval.

Beginning with CY 2020, C-SNPs may only receive MOC approvals for a period of one-year, regardless of whether their MOC achieved a high mark in scoring, allowing for two-year or three-year review cycles. **This is unnecessary paperwork and burden on C-SNPs without benefit and over and above all other Medicare Advantage plans and other SNP types**. Based on information provided from a set of health plans, the proposed change will increase administrative and paperwork burden on C-SNPs—not reduce burden as seems to be the statutory intent. One health plan estimated that this change to an annual MOC review would require approximately 100 additional hours each year. This involves of a range of clinical, quality, and program management individuals within the organization, with review and approval processes involving multiple layers of authority.

We recommend that C-SNPs be asked to only submit a redline version of their existing Model of Care to NCQA for an abbreviated annual review. Only substantive changes would be required. This annual check-in and notification by each C-SNP with NCQA would meet statutory language. Plans would note if there were any substantial or significant changes in their population or their care model. The definition of "significant or substantial change" would be defined by CMS with clarity.

We recommend that the process for annual check-in be simple, carry no additional fees and that the NCQA reviewer use the same criteria as the original reviewer. We recommend that plans be allowed to make and self-certify changes they conduct to follow any recommendations from NCQA arising from this expedited check-in without additional subsequent review. Finally, we recommend that CMS and NCQA clarify the timetable for quality improvement actions around any of the MOC elements—if such activities require more than one year to conduct then these activities should not be reviewed prior to their being done in the original timetable. For additional background and details, you may read our response letter to the CMS RFI "Patients over Paperwork", August, 12, 2019. http://www.snpalliance.org/media/1320/snp-alliance-comment-letter-cms-patients-over-paperwork-rfi-august-12-2019.pdf

The SNP Alliance appreciates the opportunity to respond to this important request for information. We believe in the value and opportunity provided by the SNP Alliance member C-SNPs to beneficiaries with severe and disabling chronic conditions. We would be happy to answer questions or provide additional information, if helpful.

Respectfully,

Cheryl Phillips, M.D.
President and CEO
SNP Alliance