



November 20, 2017

Seema Verma

Administrator Center for Medicare and Medicaid Services

Re: Detailed response to Innovation Center New Direction RFI

The SNP Alliance greatly appreciates the opportunity to provide feedback on the Innovation Center's Request for Information in seeking to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. Our feedback focuses on (1) advancing patient-centered care, (2) transparent model design and evaluation, and (3) small scale testing in seeking to test new market-driven reforms to be advanced through: (a) Medicare Advantage (MA) Innovation Models; (b) State-Based and Local Innovation, including Medicaid-focused Models; and (c) Mental and Behavioral Health Models.

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

FOUNDATIONAL REMARKS

Our recommendations are based on the following assumptions about what we see as particularly important for containing the escalation of Medicare costs while ensuring quality care for those served.

1. The vast majority of Medicare costs and care complexities are related to caring for persons who are poor, frail, disabled, and with late-stage and/or complex chronic conditions.
2. Most MA financing, policy, and oversight requirements do not adequately account for the multi-dimensional, interdependent, and ongoing nature of chronic disease and disability; AND/OR a host of psycho-social and environmental factors affecting health and healthcare outcomes; AND/OR the interdependence between Medicare and Medicaid in seeking to improve quality and cost performance in serving Medicare beneficiaries.
3. Improving Medicare quality and cost performance for these high-cost/high-need persons is dependent upon: a) taking into account the systemic nature of chronic disease and disability as noted above, b) improving the relationship among related care providers in serving these high-cost/high-need persons as their care needs evolve over time and across care settings, and c) improving the alignment of incentives, policy, and oversight requirements between Medicare and Medicaid for dually eligible beneficiaries.
4. MA-Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs) provide an ideal platform for facilitating the delivery of high-quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiencies, and reducing the overall growth in Medicare spending over time. (Current SNP law requires SNPs to go beyond the offering of traditional Medicare Advantage (MA) benefits and services to maintaining a model of care, network of providers, and

team-based care management practices that are tailored to a defined population of high-cost/high-need beneficiaries. SNPs have an incentive to take into account a beneficiary's TOTAL array of care needs, re-order the balance of what is provided to them and the relationship among a full spectrum of related providers, and provide whatever combination of care that is most cost effective, in the aggregate. Over two million of the three million dually eligible beneficiaries served by MA plans are enrolled in SNPs.)

5. For SNPs and MMPs to be successful over time, SNP and MMP financing, policy and oversight must be more flexible, simpler, and more tailored to the unique needs of the poor, frail, disabled and chronically ill subgroups being targeted by SNPs and MMPs— consistent with their Congressional mandate for advancing specialized benefits and services for Medicare's most vulnerable, costly, and fast-growing beneficiary groups.

Our recommendations for ***improving the alignment of Medicare and Medicaid*** builds on the important progress that has been made by the Innovation Center under the Financial Alignment and Minnesota D-SNP demonstrations and under FIDE and D-SNPs. In our comments to follow, we identify the major accomplishments that have been achieved to date through these demonstrations and offer recommendations for moving quickly with a series of practical integration tools and innovations in advancing market-driven reforms through by states and plans. We also offer suggestions for how the Innovation Center, under the leadership of the MMCO and states participating in the Financial Alignment Initiative and Minnesota D-SNP demonstration, can continue to function as an operational laboratory in crafting other next-stage, market-driven tools and innovations of importance for optimizing total quality and cost and performance in serving dually eligible beneficiaries.

We also offer a series of principles and recommendations for ***advancing quality measurement and reporting*** in serving frail, disabled, and chronically ill persons—healthcare's most costly and complex care beneficiaries. We urge CMMI to consider these guiding principles and recommendations when creating innovative SNP and MA model designs that cross-sites and settings of care, extend over time, and involve the most complex and chronic care populations. We believe they would help improve evaluation metrics and methods, and establish the foundation for any ongoing quality/value-based measurement system of future MAO innovative models. In advancing value-based payment methods we also believe it would be useful to advance a well-constructed "learning" design for quality measurement that is accurate, valid, and fair in accounting for the complex and ongoing care needs of high-cost/high-need beneficiaries.

Finally, we recommend that CMMI develop a small-scale initiative to identify, refine, and test a series of evidence-based best practices for ***improving how we care for our nation's homeless population***, with special focus on integrating services across housing, social services and healthcare in an effort to improve clinical and cost outcomes for this costly complex care subset of Medicare and Medicaid enrollees. The study would pay particular attention to the growing problems and costs associated with caring for chronic homeless persons.

We have attached a description of each of these three recommendations. Please let us know if you have any questions or would like to discuss any aspect of these recommendations in more detail.

Respectfully,



Cheryl Phillips, M.D. President and CEO
Special Needs Plan Alliance

1. IMPROVING ALIGNMENT OF MEDICARE AND MEDICAID

Maintain FAI/MMPs and D-SNP Administrative Alignment Demonstrations as an Operational Laboratory for Developing and Testing Next-Stage Tools and Innovations for Aligning Medicare and Medicaid for Dually Eligible Beneficiaries under State, Plan and CMS Partnerships

The 10 million beneficiaries who are dually eligible for both Medicare and Medicaid make up a disproportionate share of costs under both programs, totaling about one third of the costs of each program with a total of over 350 million annual expenditures. The proportion of dually eligible enrollees in both programs is expected to grow rapidly over the next ten years driven by the aging of baby boomers. At this critical time, states, health care advocates, health plans, providers and CMS must maximize their shared responsibility for improving the costs, efficiency and quality of care for this highly complex and costly special needs population. While technically this population has access to a wide range of services, serving this population is complicated by the fact that their care spans two huge health care programs with a plethora of deeply imbedded unaligned duplicative and conflicting administrative procedures, regulations and oversight structures leading to inefficiencies and sub-par clinical outcomes.

Over the past two decades CMS, health plans, states, advocates and Congress (with strong bipartisan support) have worked to develop integrated models that span Medicare and Medicaid for service delivery for this population with some success as outlined below. Currently MA D-SNPs enroll over 2 million dually eligible beneficiaries under coordination agreements and/or contracts (as required by federal law) with 41 states, D.C. and Puerto Rico including over 150,000 enrolled in Fully Integrated Dual Eligible (FIDE) SNPs. Another 450,000 dually eligible beneficiaries are enrolled in MMPs and D-SNPs under unique partnerships between CMS, 13 states and health plans for demonstrations especially designed as learning laboratories for partnering with state Medicaid agencies for improving Medicare and Medicaid integration policy, oversight and administrative procedures for serving dually eligible enrollees. Central to these efforts has been Congress's creation of the Medicare Medicaid Coordination Office (MMCO). The MMCO has provided new opportunities and flexibility to facilitate state/federal/plan partnerships through the Financial Alignment Initiative (FAI) and the D-SNP Administrative Alignment demonstrations as well as added technical assistance to states for strengthening integrated features in their MIPPA contracts with D-SNPs. Through the remarkable efforts by states, plans and MMCO, major strides have been made in removing impediments to alignment of Medicare and Medicaid requirements and more states and plans have been stimulated to engage in integrated Medicare Medicaid programs.

At this point both states and plans see building on this dual integration platform as vital for preserving their investments in these programs, to build on the good work that has been done in seeking to remove the next layer of impediments to integration, and to adopt methods that move the benefits of these programs to the market place more quickly. Therefore, we are pleased to submit the following recommendation for building on this operational laboratory experience in making next-stage advancements on improving care for this population.

RECOMMENDATION 1: CMS should extend the FAI/MMP and D-SNP demonstrations and continue to utilize them as critical learning laboratories for better aligning Medicare and

Medicaid financing, oversight and benefits and services for dually eligible beneficiaries.

Important progress has been made in aligning procurement timelines, contracting, enrollment processes, member materials, quality measurement, data sharing and oversight; as well as advancing new and improved clinical and service delivery methods necessary to better serve dually eligible beneficiaries. Extension of these programs would: a) bring much needed stability to these programs and the markets where services are provided; b) reduce uncertainties for states seeking to advance dual integration efforts, c) preserve investments made by states and plan in improving their plan infrastructures for serving dually eligible beneficiaries; d) preserve the benefit and service arrangements experienced by plan enrollees; and 4) expedite the process of applying acquired learning to other state and plan seeking to advance their own brand of dual integration.

Independent studies have provided documentation of the value of these integrated programs. For example, a recent ASPE study conducted by *an independent research group* on the long standing integrated FIDE-SNP based Medicare-Medicaid program in Minnesota (now operating as the D-SNP Administrative Alignment demonstration) indicates “*the fully integrated plan appears to be...yielding improved consumer satisfaction and service use*” compared to similar beneficiaries enrolled in a non-integrated Medicaid managed care program offered by the same plan sponsors. <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>]

More specifically, the study shows enrollees in integrated plans were:

- 48 percent less likely to have a hospital stay, and if so, had 26 percent fewer stays.
- 6 percent less likely to have an outpatient ED visit, and if so, had 38 percent fewer visits.
- 2.7 times more likely to have a PCP visit, but if so, had 36 percent fewer visits.
- No more likely to have a specialist visit, but if so, had 36 percent fewer visits.
- No more likely to have a long-term nursing home admission.
- 13 percent more likely to have any HCBS.
- 16 percent less likely to have any assisted living services.
- 9 percent more likely to have any hospice care use.
- In urban areas, less likely to have inpatient care and more likely to have PCP care over time between 2010 and 2012.
- In rural areas, no more likely to have assisted living facility use.

In addition, Minnesota state officials cite very low disenrollment rates, high beneficiary satisfaction and significant contributions to rebalancing institutional and community based services under this program.

Under the FAI, dually eligible beneficiaries enrolled in MMPs have also experienced a more coordinated, person-centered care system tailored to their special needs including additional choices for enrollment in new and improved service delivery models designed for them, reduced cost sharing and access to additional flexible benefits, increased access to care through models of care, assessment, care coordination and person centered care plans designed to reduce fragmentation, navigate across both Medicare and Medicaid providers and to coordinate with state MLTSS requirements, simplified enrollment processes and integrated member materials, coordinated Grievance and Appeals systems, coordinated federal/state contract management and oversight, and increased sharing of data between CMS, states, plans and providers.

While it may be too early for conclusive outcomes from all formal MMP evaluations, MMP results thus far indicate an increased understanding among states, consumer advocates, health plans, and providers, of the need for better integration of Medicare and Medicaid primary, acute, long term services and supports and behavioral health for more efficient, cost effective and high-quality services for dually eligible beneficiaries. In addition, these demonstrations have already illustrated high interest and support for the value of integrated programs among many states, especially when they have access to potential savings and the additional staff resources and Medicare expertise to make necessary administrative adjustments. Early evaluations are also indicating improved beneficiary satisfaction on CAHPs surveys, proof that a competitive market place for integrated programs is feasible with robust enrollment in some states, and early savings in some MMPs. Clearly these demonstrations have provided a platform for experiments with improvements and changes for broader application. In fact, CMS has begun to extend successful administrative and policy features tested in MMPs and the D-SNP demonstration into the mainstream D-SNP program.

There is also widespread policy support for extending these programs. The independent BiPartisan Policy Center recently issued a report based on their review of integrated Medicare and Medicaid programs illustrating broad support for continuation of such programs. Their recommendations included providing integrated D-SNPs permanent authorization, extension of the MMPs along with authorization of additional integrated state demonstrations and development of a revised regulatory structure for serving dually eligible beneficiaries including further alignment of programs serving dually eligible beneficiaries within CMS, as well as consolidation of regulatory authority within CMS such as through the MMCO. <http://bipartisanpolicy.org/wp-content/uploads/2016/09/BPC-Health-Dual-Eligible-Recommendations.pdf>

Strengthen Incentives for State Partnerships with MA FIDE SNPs and D-SNPs to Expand Integrated Options

In 2003, Congress established D-SNPs as the preferred platform for advancing integration for dually eligible beneficiaries. However, D-SNPs are not allowed to operate without state agreements as required under the Medicare Improvements for Patients and Providers Act (MIPPA), and states are not required to contract with D-SNPs. Many states also just don't have the capacity and resources to take on the effort involved in establishing and maintaining a dual integration program.

Without state support and involvement, D-SNPs on their own are not able to fully integrate service delivery across Medicare and Medicaid. While many states have pursued integration strategies through their D-SNP contracts, this has been challenging for others. Though state Medicaid agencies are also at risk for increased LTSS and behavioral health expenditures resulting from poor coordination with primary and acute care paid by Medicare, states express concern that provision of MLTSS and other Medicaid services can result in Medicare savings (reduced hospitalizations for example) without opportunity for states to recoup their Medicaid investments. In addition, states often view Medicare as too in-flexible, rigid and complex and many lack resources and/or Medicare expertise to manage more in-depth agreements or contracts with D-SNPs. Further, SNPs must be frequently reauthorized, leading to the perception that this platform may be temporary. Therefore, a number of D-SNPs find that they cannot pursue further integration in certain states in which they operate, even though they are interested in doing that, and advancing integration is part of the D-SNPs federal mandate.

In spite of these impediments, we want to strongly point out that even in states where the state does not include coverage of Medicaid benefits or LTSS through the same Medicare D-SNP plan sponsor (i.e. where states only agree to minimum MIPPA required contracts with health plans, it is clear that enrollment of dually eligible beneficiaries in D-SNPs still represents a significant improvement for the beneficiary over enrollment in separate and different Medicaid and Medicare plans or a Medicaid plan with Medicare Fee-for-Service. D-SNPs offer models of care, additional supplemental benefits, assessment and care coordination tailored to the needs of their specific enrolled dual eligible populations. In addition, D-SNPs provide integrated pharmacy benefits all under the same plan and are required to coordinate with Medicaid benefits even when not provided directly through the plan. D-SNPs can also be an important source of benefits and care coordination for partial duals or those not enrolled in Medicaid managed care contracts. Thus, it is critical to recognize that even non-fully integrated D-SNPs, as well as arrangements used in Arizona and Tennessee, provide an improved platform for care delivery that is far more tailored and able to address the special needs of dually eligible members than is available under most other models. This current flexibility provided under the MIPPA contracts also allows states to move toward greater integration of benefits over time, giving states that are not ready to support FIDE-SNP status, time to work toward further integration.

For the reasons outlined above, many states have been reluctant and/or unable to embrace changes necessary for improving the alignment between these the two programs and to work toward FIDE SNP status, even though such realignment is critical for improving total quality and cost performance for dually eligible beneficiaries across the two programs. Current MA statute and regulations already provide the vehicle for accommodating significant variabilities via the requirement that each D-SNP has a MIPPA contract with the state. But plans and states must be provided with greater incentives to fully utilize these contracts to integrate service delivery and operations and to help them overcome current inefficiencies, which are usually rooted in longstanding administrative and operational differences between Medicare and Medicaid. These state issues must be addressed to move toward further efficiency and alignment needed to better serve this population. In order to empower States to further their efforts to simplify program administration, and expedite the process of removing barriers to integration, we recommend the following.

RECOMMENDATION 1. CMS should provide additional incentives for states interested in advancing dual integration initiatives to achieve and/or work toward FIDE SNP status, including additional administrative flexibilities, continued shared savings opportunities, increased outreach and education to states to encourage integration, continued technical assistance for strengthening FIDE and D-SNP contracting, and providing start-up grants to states that want to develop integrated programs that move toward FIDE status.

RECOMMENDATION 2. CMS should strengthen the resource capabilities of the Medicare-Medicaid Coordination Office (MMCO) and the Integrated Care Resource Center (ICRC) in working with states to better align Medicare and Medicaid program activities in care of dually eligible beneficiaries.

There is broad recognition among states and plans participating in the Financial Alignment and D-SNP Demonstrations, as well as among many states contracting with D-SNPs of the excellent support, that the MMCO and ICRC have provided them. Their efforts have been widely praised by plans, states, policy experts and advocates alike—not always a common

experience. It is important that CMS continues to enable MMCO and ICRC to serve as the principal liaison for states in advancing dual integration efforts.

Next-Stage Recommendations for Further Alignment of Medicare and Medicaid for Dually-eligible Beneficiaries

Integrated Medicare-Medicaid programs are rapidly reaching a pivotal crossroads, where additional policy decisions, guidance to Congressional leadership and operational issues must be addressed to sustain and increase the progress that has been made towards true transformation of care for this high-needs population. Ongoing authorization of current platforms (FIDE-SNPs, D-SNP and MMPs) is a critical next step. In order for states and plans to make the long-term investments and commitments needed to take integrated programs to their full potential, permanent program options which streamline duplicative administrative requirements and create aligned delivery system incentives must be secure, supported and clearly communicated. Clearer regulatory authority is also needed for CMS to make technical changes and operational flexibilities that support the necessary FIDE SNP and D-SNP partnerships between states, plans and CMS in order to sustain and grow the programs that are being built. Through current and strengthened authority, such as that provided in the proposed bipartisan CHRONIC Care Act of 2017 (S 870), CMS can build on successful design features of all models to create permanent model options flexible enough to fit the needs of most states and beneficiaries. The following recommendations are designed to facilitate more regulatory and operational infrastructure changes that would support an ongoing platform designed to serve dually eligible beneficiaries through increased partnerships between Medicaid agencies and MA DSNPs.

RECOMMENDATION 1: Support permanent reauthorization of D-SNPs as proposed in Senate 870, HR3168, and provisions being considered by the House Energy and Commerce Committee. Permanent reauthorization of SNPs was approved by the full Senate by UNANIMOUS CONSENT. A complementary set of provisions are being advanced by committees of jurisdiction in the House. State agencies need and want permanency of these options to better enable them to develop forward looking programs and to plan and budget for future program design. SNP permanency is critical for states, plans and consumers in furthering simplification of program administration, improving program efficiencies, and enhancing benefits and services for the 10 million dually eligible benefits jointly served Medicare and Medicaid, representing Medicare and Medicaid's most vulnerable population segments.

RECOMMENDATION 2: Expedite alignment of FIDE SNP and MMP Requirements. FIDE SNPs and MMPs both provide advanced forms of integration and serve similar population segments, yet they operate under slightly different payment methods and administrative structures. CMS should continue to review successful administrative and policy features tested in the MMP and D-SNP demonstrations. Where a particular change in approach has been shown to simplify operation, improve efficiencies, and/or improve care outcomes, the change in policy and/or oversight practice should be quickly applied to non-demonstration FIDE SNP operations and to non-demonstration D-SNPs and/or other SNPs serving dually eligible beneficiaries where applicable. In addition, CMS should also look at best practice features that may work better under the FIDE SNP model and consider extending those features to MMPs.

RECOMMENDATION 3: CMS should seek, support, and/or identify existing authority or create new authority if needed for D-SNPs and MMPs to run on a separate track within the overall MA structure facilitated through the MMCO. This would facilitate options for partnerships with states on integrated Medicare Medicaid models and should include exploring options for merging best practices from these two programs into a new, next-generation program for advancing dual integration over the long term. This should be designed to provide CMS essential programmatic flexibility outside of demonstrations to more nimbly respond to market and service delivery changes as well as to separate or change current MA and/or Medicaid policy and administrative and operational processes where necessary to facilitate efficient operations, reduce duplicative functions, and improve care management and delivery under integrated models serving dually eligible beneficiaries.

Additional Steps to Be Taken to Remove Operational Barriers to Improving Cost and Quality Performance for Dually Eligible Populations

Even under permanent authority, the success of these models rests on a myriad of technical administrative and operational issues that must be addressed to improve the efficiency of these programs and make them less complex and more workable for both states and plans. This will require a careful balance between creating increased flexibilities to accommodate varying state Medicaid operational procedures while still preserving the interface with more centralized similar operational functions under Medicare.

The following key administrative, operational and policy features and changes are recommended to better support state Medicaid and MA partnerships in serving dually eligible populations. The items below have been identified by members and by our expert consultants based on years of experience and observation of best practices in developing and operating integrated programs. These items should not require additional authority or testing as most are either already part of the MA program or have already been utilized in the demonstrations noted above.

RECOMMENDATION 1: Strengthen Joint Enrollment Processes and Enrollment Alignment Strategies. Without increased enrollment alignment, many of the administrative, communication, oversight and clinical efficiencies potentially made possible under integration cannot practicably be achieved. As under MMPs and the D-SNP demonstration, enrollees must be enrolled in the same plan for both Medicare and Medicaid services in order to gain operational efficiencies and align care delivery. However, states and D-SNPs face significant challenges outside of these demonstrations in aligning enrollments. The features that are reported to be most helpful in addressing this issue include:

- Exempt D-SNPs from the moratorium on seamless enrollment and facilitate adoption of this feature for MMPs and D-SNPs in order to preserve continuity of care for high risk populations.
- Provide additional coordinated Medicare and Medicaid options for passive enrollment of dually eligible beneficiaries (with appropriate opt out protections) into FIDE and D-SNPs offered by the same Medicaid plan sponsor in the same service area, to facilitate alignment of enrollment for Medicaid and Medicare under the same plan sponsor. (Currently allowed under MMPs, but not under other D-SNPs).
- Streamline processes for enrollment alignment for both Medicare and Medicaid by providing deeming periods for temporary loss of Medicaid eligibility, and alignment with Medicaid lock-ins and bi-directional Medicare-Medicaid plan assignments.

- Strengthen co-marketing strategies by encouraging and supporting states to co-market D-SNP and Medicaid plan enrollment under coordinated plans under the same plan sponsor through co-branding, educating states about marketing differences between Medicaid and Medicare, co-education campaigns by states and plans informing consumers about integrated plan options and resolving conflicts around brokers by allowing MMPs to use trained Medicaid sales staff.

RECOMMENDATION 2: Advance SNP Specific Networks and Network Alignment Processes.

The SNP Alliance is pleased to be working closely with CMS staff to provide advice for developing SNP specific networks tailored more closely to the needs of specific SNP populations such as dually eligible beneficiaries and SNF residents.

- Our recommendations include consideration of extension of MMP network modifications to D-SNPs, use of telehealth, mobile clinics and SNF-specific provider networks, changes to the exceptions processes and access standards based on population size and patterns of care, and other network criteria being tested under the demonstrations.
- In addition, network criteria for integrated plans should consider the availability of Medicaid networks for behavioral health, home health and other overlapping services and should take into account where providers refuse services to dually eligible individuals or groups.
- Further, CMS should consider modifying its data sources, mapping technologies and reporting for improvements in accuracy of source data from participating providers and consider how network requirements should align and support Value Based Purchasing strategies.

RECOMMENDATION 3: Increase Coordination of Model of Care (MOC) and Health Risk Assessments with Medicaid MLTSS.

- As already allowed under MMPs, CMS should clarify pathways for D-SNPs to create MOCs tailored to state specific MLTSS requirements and to clearly reflect multiple subpopulations and PBPs within contract level MOC templates.
- CMS should include MOC flexibilities to coordinate, integrate or align Medicare HRA and MOC requirements, including timelines and deadlines for assessment, with MLTSS assessment processes, care plans and care coordination requirements to reduce duplication and improve the efficiency of the care coordination process across Medicare and Medicaid.

RECOMMENDATION 4: Improve Beneficiary Communications through Simplification of Member Materials and Coordinated Review Process. While CMS has made good strides in simplifying member materials tailored to dually eligible beneficiaries, additional steps needed include:

- Extending the use of the simpler and clearer MMP and D-SNP demo member handbook format to integrated D-SNPs. (This may require additional or repurposing of resources at CMS for review.)
- CMS should extend the joint communications member materials review process used in the MMP and D-SNP demonstrations to integrated D-SNPs.
- CMS should add flexibility in language blocks and translation requirements to meet local and state needs, work with states and FIDE SNPs and integrated D-SNPs to reduce or consolidate duplicative notices, including support for legislation to modify duplicative integrated denial notice (IDN) requirements, and reduce the language levels

used in CMS required documents to levels used in Medicaid (5th to 7th grade Flesch tests).

RECOMMENDATION 5: Improved Coordination of Procurements. CMS should create options for further alignment of state/federal procurement mechanisms for integrated D-SNPs and Medicaid managed care plans to address off schedule and unforeseen situations such as plans leaving the market or to address the need to increase plan options through Service Area Expansions. It now takes a minimum of 18 months to realign plan availability, leaving significant gaps in choices and care coordination for beneficiaries. CMS could look to the PACE program where states and providers are provided additional flexibility for program initiation and readiness review timeframes that are mutually agreeable to all parties.

RECOMMENDATION 6: Integrated Grievance and Appeals (G&A). While some additional alignment of Medicare and Medicaid G&A might be achieved under the Medicaid Mega Rule provisions, there are still a number of remaining obstacles to integration of Grievance and Appeals processes that need to be addressed, including policy and/or statutory differences between Medicare and Medicaid around the following issues:

- Requirements for duplicative integrated denial notices (IDN) under Medicare, even when services are covered by Medicaid (recently addressed by CMS but not fully resolved due to statutory interpretations),
- Auto-forwarding of appeals to separate entities and separate hearing rights including federal rights to Medicaid hearings,
- Medicare “amounts in controversy” levels (Medicaid usually does not have such requirements),
- Requirements for aid pending appeal (not allowed in Medicare),
- Possible time frame differences depending on implementation of the new Medicaid rules, and
- Handling of provider level appeals.

RECOMMENDATION 7: Coordinate State and CMS Audits and Oversight. Under the FAI and D-SNP demonstrations, CMS and states have partnered to demonstrate coordinated integrated contract oversight and communications processes. However, outside of these demonstrations, most SNPs and D-SNPs are still subjected to multiple and duplicative state and federal financial and performance audit and oversight processes for dually eligible beneficiaries enrolled under both programs.

CMS should build from lessons learned from states and MMPs under the current FAI demonstration to create a coordinated Medicare and Medicaid oversight process for both demonstration and non-demonstration platforms that reconciles duplicative and often conflicting data collection, auditing protocols, and timelines, and streamlines, integrates and coordinates those processes and related communications to reduce administrative burden for all parties.

RECOMMENDATION 8: Continued Promotion and Support for Data Sharing. Under the FAI and D-SNP demonstrations, CMS has made great strides in providing additional Medicare data to states and plans to fill in gaps for dually eligible beneficiaries. They have also extended some of this data sharing to other interested states. However, there are certain “blind spot” encounters and claims that need to be shared. For example, without using both Medicare and Medicaid data, behavioral health conditions will be severely underrepresented. In addition, states do not always have the resources or the motivation to set up systems to access and

utilize the Medicare data; and providers may still be confused about who can share or access what data under what arrangements. Finding solutions to these issues should be a priority.

RECOMMENDATION 9: Improved Supplemental Benefit Flexibility. While the CMS manual allows more flexibility to D-SNPs that meet a “high standard of integration and specified performance and quality-based standards” in the provision of supplemental benefits designed for dually eligible members, to our knowledge no D-SNPs are providing additional benefits under that mechanism. We believe this is partly due to confusion about the criteria, and partly due to the fact that many of the specified benefits are already included under Medicaid for D-SNPs. We appreciate that CMS recently made some adjustments to this policy and that MMPs have additional flexibility to work with states to tailor these benefits to the needs of dually eligible populations in their states. We have collected and submitted additional information to CMS around this problem, including the need for additional flexibility for D-SNPs to address issues around social determinants of health. CMS has indicated that further clarification will be forthcoming.

RECOMMENDATION 10: Improved Methodology for Access to the Frailty Adjustor. Congress provided authority for FIDE SNPs with similar average frailty scores to PACE to receive an additional frailty adjustor payment to recognize costs of caring for a high concentration of dually eligible members. However, very few FIDE SNPs qualify for this payment largely because of state Medicaid enrollment requirements. PACE enrolls only members age 55 and over who are already assessed for community services at a nursing home level of care while most integrated state managed programs enroll all ages and/or both frail and relatively well dually eligible members, leading to an unfair “apples and oranges” comparison. Addressing this problem could provide an incentive for more states and D-SNPs to work toward FIDE SNP status.

- Frailty scores should be compared to like populations.
- In addition, the HOS M instrument used to determine frailty may not be an accurate representation of frailty, due to questionable proxy methodologies, inaccessibility to non-English speakers, and questions not designed for this purpose, a better instrument or data source should be constructed.
- Further, CMS notifications to plans of their qualification for the frailty adjuster comes nearly 8 months after the bids are submitted, making it impossible for plans to incorporate it into their beneficiary services.
- These problems could also be resolved with a different design, for example frailty could be incorporated into individual risk scores instead.

RECOMMENDATION 11: Value Based Purchasing (VBP) Arrangements under Integrated Programs. Integrated D-SNPs are an excellent platform for extension of VBP strategies to dually eligible beneficiaries across Medicare and Medicaid provider types and payer sources.

- As part of their VBP strategies, all SNPs should have the same flexibility as other MA plans to design supplemental benefits and consumer incentives under VBID arrangements, including opportunities to address social determinants of health and additional non-medical services that improve the overall health of individuals with chronic diseases.
- In addition, CMS should include Part D benefits for SNPs under VBID arrangements which could help reduce cost sharing requirements that may act as barriers toward adherence to medications and/or enhance the SNP’s ability to help steer their members’

decisions toward value-based drugs. Adding this feature may improve utilization patterns and help reduce costs.

RECOMMENDATION 12: Collection of Performance and Financial Data at the Plan Benefit Package (PBP) Level. While MMPs and D-SNPs operating under demonstration authority report all data under separate and distinct contract numbers, many other D-SNPs are required to be part of broader contracts where key items such as HOS and CAHPs data are reported across multiple PBPs. This may be efficient at one level; but it also obscures plan specific performance data, making performance data for dually eligible beneficiaries enrolled in D-SNPs hard to track for CMS, plans and states, hampering evaluation of specialized initiatives to address complex enrollees' needs and leading to duplicate data collection and survey efforts. To make data more useful to partnerships with state Medicaid agencies, for evaluation of outcomes for dually eligible populations, and to reduce administrative duplication, these data should be reported at the PBP level, while still linked to the sponsoring plan for other purposes.

The SNP Alliance is pleased to have the opportunity to make these recommendations for creating a permanent transformative platform for state/federal/plan Medicaid and Medicare partnerships necessary for improving the quality and efficiency of care delivery for dually eligible beneficiaries. We would welcome the opportunity to work with CMS in exploring these options. The SNP Alliance membership contains broad representation from the full spectrum of MMP and FIDE SNP programs, and those involved in developing these recommendations have decades of experience at the plan and state levels in advancing integrated care for this population.

2. ALIGNING POPULATION-BASED MANAGEMENT AND PERFORMANCE MEASUREMENT

To move toward the goal of fostering an affordable, accessible healthcare and social support system under Medicare and Medicaid, government and private organizations are giving increased attention to models of care, payment, and quality measurement that align clinical and social service providers, consumers, and health plans. There is recognition of the importance of addressing high-risk/high-need beneficiaries, such as those with complex chronic conditions, behavioral and mental health needs, and social risk factors. Individuals such as frail elders, adults with disabilities and functional limitations, and persons with severe and disabling chronic conditions are among these most complex beneficiary populations.

Special needs plans and related care providers are giving increased attention to addressing the influences of social risk factors on health and healthcare outcomes. Such factors indicate that further development of care models and processes, service array and flexibility to tailor care approaches, as well as regulatory and policy changes to support these new care models--are needed. As the Medicare and Medicaid programs move toward use of value-based payment (VBP) methods, all in the field follow. The effects may be especially felt by providers and plans serving a high proportion of complex and high need/high cost beneficiaries.

The shift to VBP could either provide important incentives and guidance to promote and support attention to these highest cost and most complex populations, or create an inequitable system which further reduces resources to achieve health equity. Safety net providers and SNPs serving these populations are examining where there are impediments to achieving positive health outcomes and are important for stakeholders in making progress. This is the time to more fully align key principles involved in population-based management, value-based

purchasing, and performance measurement, with an intentional focus on the most complex and vulnerable populations—Medicare’s most costly and fast growing subgroups.

In keeping with the stated goals of this RFI, the SNP Alliance recommends that CMMI establish a national initiative to design, develop and test the use of new performance metrics for four major subsets of high-cost/high-need MA plans and aligned healthcare providers; increase effectiveness of measurement, care, and cost strategies; and promote the transparency and utility of relevant information for consumers. This three-part focus could also offer small scale testing of value in restructuring and redesign of quality/performance measurement for VBP.

Dually Eligible Beneficiaries as the Pilot Focus

We recommend that this design, development, and testing of more of a population-based approach to performance measurement begin with high-risk/high-need subgroups of dually eligible beneficiaries.

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

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

When we more closely examine the characteristics of people who are dually eligible, there are distinct subgroups that emerge. In addition, when we look at the SNP enrolled populations—specializing in care of dually eligible beneficiaries and of vulnerable persons with high cost conditions--we find that beneficiaries can be grouped based on age, social risk, language, functional status/frailty, behavioral health/substance dependency, chronic condition, and stage of condition characteristics. For example, groupings that would be useful for purposes of quality measurement and improvement could include the following (based on SNP member discussions about key characteristics that drive care management and provider services):

- (1) Younger persons with physical disabilities and mental/behavioral health issues where the behavioral health and substance dependency issues drive condition management;
- (2) Frail elderly with multiple chronic conditions, advanced functional limitations—also often cognitive impairment where functional and cognitive status drive or greatly influence condition management;
- (3) Younger disabled persons with a severe/life-limiting chronic disease that represents the principle diagnosis/condition, and where managing this condition is a principle goal of

health and social services care/support around which other care must be organized (e.g., HIV/AIDs); and

- (4) Dually eligible persons of any age with multiple chronic conditions and social risk factors, particularly those who are foreign born, have very limited understanding of the healthcare system, have limited English proficiency and/or need an interpreter. The social risk characteristics for this group greatly influence all clinical, social services, and other services and care management that can be provided and how/where these services and care can be provided.

These groupings, which would need further stakeholder input and refinement, are used to illustrate how characteristics influence care and the care approach—and thus the definition of “quality” and a quality measurement and improvement approach.

Flexibility in Networks

In a restructured approach to quality measurement and improvement for people dually eligible for Medicare and Medicaid, the care management efforts and quality targets would be set across settings, services, and disciplines for these particular subgroups. Such an aligned approach would *define both population subgroup and systems performance measures*, so that the many entities (providers/services/plans/stakeholders) involved in care and accountable to the beneficiary subgroup--would be working in tandem rather than with disparate measures, goals, and sometimes counter-productive objectives. Specialized and defined provider (medical/clinical, behavioral health, long terms services and supports) networks would need to be allowed. Flexibility in current provider network adequacy standards would be required.

Core Measurement Set

We would recommend the measurement set be drawn from a variety of measures that have been appropriately tested among diverse populations of dually eligible beneficiaries—the four subgroups offered above. The measurement set could include some of the current Stars measures under MA and would also need to include measures that key service providers find meaningful (e.g., disability, behavioral health therapists/clinicians, geriatric specialists), where the same measures would help them meet their MIPS/APM requirements. Additional measures of social and functional support would be needed that align with state requirements (e.g., characteristics indicating effective outcomes from use of LTSS services). Finally, measures in use by behavioral health and disability providers to assess meaningful outcomes would be needed. This measurement set should be targeted, validated, and endorsed by stakeholders. The focus should be on identifying a small core set of measures—not a wide-ranging comprehensive set – to ensure feasibility, appropriateness, and sustainability. Given that providers are likely to be in multiple health plan provider networks in a given area—we anticipate that a consensus process for clinical, behavioral, and long-term services and support providers which are key to serving dually eligible population subgroups (together with the health plans that are held accountable and consumers/beneficiaries and families)—would be necessary for development of a core measurement set.

This consensus core measurement set that would be applicable across settings (medical/clinical, behavioral health, and long-term services and supports) would have an explicit and purposeful focus on dually eligible beneficiary subgroups. The set would be chosen based on defined criteria (e.g., measure has utility for quality improvement efforts, effective interventions and best practices for impacting measure exist, measure is meaningful to support cross-setting, cross-discipline practice standards and patient/client goals, etc.).

This pilot test with a core measurement set would help demonstrate the potential for reducing the ever-increasing proliferation of measures and additional measure silos that have been created. Increasingly these siloes represent a burden on the beneficiary, providers and plans and do little to promote sustained and aligned quality improvement efforts. This is the case even though the various providers and plan are attending to the same beneficiary. One primary goal of measurement should be to provide sufficient and useful information for accountability and quality improvement that is meaningful and relevant to these dually eligible subgroups.

Pilot Components – Considerations

Results from such a dually eligible subgroup pilot by CMMI, designed well, would greatly advance an aligned and population-based approach to care, quality measurement and analysis, and understanding key drivers of “value.” The following are suggested considerations for establishing the project design. These considerations offer some detail for elements that would be included in defining the scope and parameters for a field study:

- Define the dually eligible population subgroups for the pilot with data element specificity and attention to data sources and standardization;
- Plans with a high (e.g., 75% or more) proportion of dually eligible enrollees would be eligible to participate in a 3 to 5 year voluntary pilot;
- Separate these plans by plan type, size, and geographic location where they operate;
- Finalize the parameters of the voluntary pilot in terms of scope, focus, duration, stakeholders, and required elements, with the robust evaluation design, metrics, implementation and outcome measures clarified;
- Establish minimum provider/service network components or allowable substitute services to ensure beneficiary needs are met via a pilot;
- Working with external expertise as well as plan and provider-based applied evaluators, craft an implementation evaluation with quantitative and qualitative components that will serve to inform and provide ongoing feedback for the pilot;
- Plans apply to participate;
- An independent review panel selects participating plans for the testing;
- Waive plan participants from the existing CMS QMS Stars Rating for the 3 to 5 year pilot period;
- Each plan works to identify relevant provider partners and beneficiary members;
- Design/Operational teams, advisory group(s), and evaluation team(s) are established;
- Plans identify relevant subgroups within their currently enrolled beneficiary set. Baseline data is collected. Plans separate their enrollment by:
 - Subgroups as defined, and
 - Beneficiaries who have been continuously enrolled for at least one year from those who are transient/recently enrolled (no history)
- Plans and relevant provider partners re-work and re-organize pathways of care and information exchange structures and processes with these subgroup populations in mind;
- Plans reshape their Models of Care (MOC) accordingly to craft care management and continuum services around each beneficiary subgroup;
- MOC requirements, audits, protocols are revised by CMS with greater flexibility or waiver of specific elements;

- Working on the national level, the participating organizations identify an alternate set of quality measures –selecting a core set arranged and/or designed around dually eligible beneficiaries from a family of measures—which could include some of the Star measures but may also include other endorsed measures. Measures selected would have face validity with providers and plans, have evidence of scientific validity and reliability, be have been tested with a dually-eligible, diverse group of beneficiaries, and have been piloted for use in the field. There would be preference for measures that had been endorsed by the National Quality Forum (NQF);
- Organize measures into a set of domains (for example: safety and standards of care, continuity/follow-up, communication, person/family involvement and education, care management effectiveness, preventive/proactive, supportive of goals and preferences... etc.);
- Match the alternate measurement set to the defined subgroups – allow for tailoring of the measurement set at the plan level -- based on the characteristics of their enrolled subgroup population, e.g., with specified # of measures set for each domain, but some flexibility—measures would each be weighted the same (e.g., 1);
- Plans utilize these core measures in lieu of participating in the existing QMS with 47 Star measures;
- CMS provides stability in QBP/VBP during the years of pilot testing. Plans participating would be “held harmless” –carried forward for 3 to 5 years;
- Data time period for collection, analysis, review is shortened—that is, the revised set of measures would use data that is more recent (e.g., last year’s data for these beneficiaries);
- Some elements, such as HOS would not be included—rather substitute self-report or beneficiary derived measures would be substituted.
- CMMI provides support for data review, analysis and integration—claims, encounter, EHR, and also provides technical support and analysis to each plan;
- CMMI provides data set at the neighborhood level for geographic area/enrollment area for each health plan, which provides additional SES/SDOH risk factor information;
- The plan and CMMI set minimum, expected, and “reach” targets for each measure in the selected measurement set, corresponding to the enrollment population characteristics;
- CMMI determines quality measurement and improvement results for these enrolled dually eligible individuals within these plans for the defined period--based on the set minimum, expected, and “reach” targets—and as compared to baseline for that plan/sub-group;
- Results are grouped/stratified at PBP level (not the contract level) and at a dually eligible subgroup level;
- CMMI provides reports on outcomes by specific subgroup segments of the dually eligible population and in plan peer groups—comparing like plans to like plans; and
- CMMI provides subgroup analysis to offer dually eligible-specific data for benchmarking and quality improvement among participating plans. Successful improvement results are shared around specific subgroups and quality measures.

Make Adjustments and Improvements in Current QMS

In order to analyze this pilot in comparison to the current quality measurement system under Medicare (QMS), we suggest that CMMI work with CMS Medicare and Medicaid and the Federal Coordination Office units to simultaneously improve stratified analysis for all Medicare Advantage quality measurement reporting—in order to advance the field while the pilot is underway — such as:

RECOMMENDATION 1: Stratify Populations to Compare Quality Ratings for Similar Beneficiary Populations and Compare SNPs with similar enrolled populations – Many scientific and expert committees have recently issued reports suggesting that stratification of populations into similar groups by using Dual-eligibility and Disability status as a proxy for social risk factors and other characteristics which increase vulnerability is warranted. This would increase understanding, accuracy, comparability, utility, and conclusions about measurement results. Variables of interest are: LIS/Dual, Disability status, selected SDOH characteristics (such as nativity, neighborhood poverty, education, and ESL/Language), as well as age, and number of selected high cost conditions (including behavioral health, substance dependency, dementia/cognitive impairment, among the conditions) segmenting variables. Thus, the population characteristics across MAOs and across SNP types would be better understood for meaningful comparisons and quality improvement efforts.

RECOMMENDATION 2: Tailor Measures under Medicare Star Ratings – Better methods and measures that are tailored to specific population characteristics should be considered. Exceptions and exclusions definitions need to be re-examined to ensure meaningful measurement and reporting (e.g., some measures may not be applicable at the end of life/palliative care, with those who are cognitively impaired).

RECOMMENDATION 3: Improve the effectiveness of the CAI by: a) adding additional Star measures into the calculation, b) incorporating additional factors in the CAI, and c) adding one or more complexity of care and functional status factors into CAI. This will help move toward a measurement and payment system that is more equitable.

RECOMMENDATION 4: Issue guidelines for quality measure developers and stewards to re-test their measures for effect of SDOH/SES factors, including dual status, disability status, and low-income status at the smallest neighborhood level geographic unit. Guidelines should specify a consistent minimum sample size that includes oversampling of the Duals, a minimum set of social risk factors to be tested, and results should be reported separately between the Duals and non-Duals tests. This should include a review of Star measures.

RECOMMENDATION 5: Re-examine the validity and reliability of self-reported HOS and CAHPS surveys for persons who do not speak English, have low health literacy, or have significant cognitive/memory impairment (data from these surveys are used to calculate several of the Star measures). Currently, these survey tools and the methods do not fully accommodate those Medicare/Medicaid Dual status beneficiaries who have social risk factors that affect their ability to participate in the survey and their understanding of the survey questions. This has the strong potential to impact the validity and accuracy of results.

RECOMMENDATION 6: Provide Data Guidance and Technical Support on SDOH - to improve data availability and standardization to obtain individual and community-level social determinant of health (SDOH) risk factor information and use it to stratify, analyze, and report on beneficiary populations and quality measurement results. The Final Report of the *National Quality Forum Disparities Standing Committee* (July 2017) noted that data limitations and methodological issues significantly restrict the ability to make progress in adjusting individual quality measures to take into account social risk factors. Their work brings attention to the need for: data standardization and availability on social risk factors,

refinement of risk adjustment models to be conducted and analyzed at the smallest (neighborhood) geographic level, and inclusion of community factors in models.

RECOMMENDATION 7: Customize measure sets & reporting - Select key quality measures to allow consumers to simultaneously compare a) plan type, b) enrollment characteristics, and c) quality measure results – providing better information to the consumer when making comparisons.

RECOMMENDATION 8: Test rapid cycle approaches for quality improvement in lieu of existing 2-3 year look-back quality measure reporting. Allow for some flexibility and customization related to population characteristics among all MAOs serving a high proportion of dually eligible beneficiaries and special need populations. Reporting on QI success efforts with matched comparison groups could be voluntary or mandatory or offer opportunity for additional QBP. This would offer the advantage of disseminating effective practice more quickly.

Should CMMI be interested in pursuing these recommendations further, we would welcome an opportunity to discuss this idea in more detail.

3. NATIONAL HEALTHCARE INITIATIVE TO INTEGRATE CARE FOR HOMELESS SENIORS AND ADULTS

Program Summary

The SNP Alliance proposes that the Center for Medicare-Medicaid Innovation (CMMI) establish a five-year national homeless care initiative targeting dual eligible beneficiaries served by SNPs, and include homeless Medicaid beneficiaries served by the same MCO under a separate Medicaid contract. The SNP Alliance would bring together 5-7 Special Needs Plans, allied care providers, aligned Medicaid plans, and housing partners to identify, refine, and test a series of evidence-based best practices for integrating services across housing, social services and healthcare in an effort to improve clinical and cost outcomes. The study would pay particular attention to the growing problems and costs associated with caring for chronic homeless persons.¹ We would recommend the Medicare-Medicaid Coordination Office (MMCO) work with an aligned group of state Medicaid offices with special expertise in serving the homeless to help identify and remove financial and regulatory barriers for improving total quality and cost performance. In particular, we recommend capitated funding as a core component of the initiative. The initiative would also evaluate and document what works and what doesn't (assuming models might vary among participating states and plans) and disseminate findings to nonparticipating states, SNPs, MMPs, and other MCOs in order to expedite the process of moving program innovation to scale ASAP.

Problem Statement

There is nearly universal agreement that healthcare problems experienced by poor, frail, disabled, and chronically ill people require a fundamental change in how we finance, administer and deliver their care. Perhaps the most vulnerable and complex subgroup of this

¹ Chronic homeless is defined as a person with a disability who has been continuously homeless for 1 year or more or has experienced at least four episodes of homelessness in the last 3 years where the combined length of time homeless in those occasions is at least 12 months. Meghan Henry, Rian Watt, Lily Rosenthal, and Azim Shivji, Abt Associates, *The 2016 Annual Homeless Assessment Report (AHAR)*, a report produced for Housing and Urban Development, November 2016.

high-cost/high-need population segment is the 500,000 to 1.5 million persons who are living on the streets.

- Homelessness affects men more than women. At least 70% to 85% of all homeless are men.² About 12 percent of all homeless adults are veterans.³
- More than 40 percent of sheltered homeless people have a disability.⁴
- An estimated 26.2% of all sheltered persons who were homeless have a severe mental illness.⁵
- About 50% of people who are chronically homeless have co-occurring substance abuse problems, with as many as 60-80% of chronically homeless individuals having substance use disorders.^{6 7}
- The elderly homeless population is also known to have "higher rates of geriatric syndromes, including functional decline, falls, frailty and depression, than seniors in the general population. Many of these conditions may be easily treated if detected".⁸
- Housing instability is also associated with serious mental illnesses as well as many physical conditions, including obesity, cardiovascular disease, diabetes, HIV/AIDS, hypertension and other chronic conditions.⁹
- Homeless populations, particularly the chronically homeless, are extremely costly to Medicaid and Medicare due to high utilization of emergency departments and frequent hospitalizations.^{10 11}

In an article published on October 24, 2017 by National Public Radio on a iPhone App entitled, *In a Push to House the Homeless, High Prices Are Eroding Gains*, Salinas, a national expert involved in caring for homeless persons says, "By the time they engage us and they start working with us, the crisis or the thing that we have to focus on most quickly, right away, is not getting their income turned on or finding a landlord, but it's stabilizing them in a medical home." He says, "Some of their clients are so ill they could easily die before getting settled in permanent housing."

Purpose, Goals and Results

The overall **purpose** of the proposed initiative would be:

² [Wayback Machine](#)" (PDF). December 1, 2015. Archived from [the original](#) (PDF) on December 1, 2015. Retrieved September 16, 2017.

³ [The 2013 Annual Homeless Assessment report \(AHAR\) to Congress](#)" (PDF). The U.S. Department of Housing and Urban Development. p. 42.

⁴ U.S. Department of Housing and Urban Development, "[The Annual Homeless Assessment Report to Congress \(2008\)](#)", July 2009.

⁵ [Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States](#)" (PDF). Substance Abuse and Mental Health Services Administration. May 10, 2007. Archived from [the original](#) (PDF) on May 10, 2007.

⁶ Supportive Housing's Vital Role in Addressing the Opioid Epidemic in New York State, in CSH Policy Brief. 2015, Corporation for Supportive Housing.

⁷ Caton, C.L., C. Wilkins, and J. Anderson. People who experience long-term homelessness: Characteristics and interventions. in *Toward understanding homelessness: The 2007 national symposium on homelessness research*. 2007. US Department of Health and Human Services and Department of Housing and Urban Development Washington, DC.

⁸ "[Boston's Elderly Homeless Sicker Than Others, Research Finds](#)", *Science Daily*, September 13, 2011.

⁹ *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health*. 2014, Corporation for Supportive Housing.

¹⁰ Culhane, D.P., S. Metraux, and T. Hadley, Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing policy debate*, 2002. **13**(1): p. 107-163.

¹¹ Rosenheck, R., et al., *Cost-effectiveness of supported housing for homeless persons with mental illness*. *Archives of General Psychiatry*, 2003. **60**(9): p. 940-951.

- To identify, refine, and test evidence-based best practices for providing medical care for homeless persons under capitated financing arrangements.

The **overall goals** would be to:

- Redesign clinical interventions to more fully account for the personal and environmental circumstances that adversely affect a homeless person's health and healthcare outcomes; and
- Better align the relationships among medical care, mental health and behavioral health professionals with homeless shelters, affordable housing programs and related social services programs serving homeless persons.

Individual-level Results

- Reduce homelessness and increase housing stability rates;
- Reduce drug dependencies, stabilize underlying mental illness symptoms, and improve self-care capabilities among homeless persons served;
- Reduce use of jails and time on the streets where illnesses are exacerbated; and
- Reduce emergency room visits and hospital usage in comparison to a comparable group of homeless persons.

System-level Results

- Improve homeless person access to public health and primary medical care services necessary for addressing undiagnosed, untreated and inappropriately managed medical problems and related disabilities;
- Expand access to publicly assisted housing;
- Improve the integration of housing and healthcare delivery;
- Better align funding and oversight for Medicare, Medicaid, substance abuse, law enforcement, mental health, housing and social services for homeless persons;
- Eliminate Medicare and Medicaid financing and regulatory barriers to serving homeless persons;
- Produce scientific evidence of what works and what doesn't; and
- Improve the competencies of Medicare and Medicaid program officials, SNPs, MMPs, and other MCOs and programs serving homeless persons.

Framework for Advancing New Care/Financing Models

The initiative would give primary attention to braiding the funding of related benefits and services; coordinating related medical, housing and social services, and removing regulatory impediments to advancing more cost effective options for serving homeless persons. While there may be (and should be) variation in how care is provided from one setting to another, we would propose the following care/financing framework to be used in crafting new and improved clinical and oversight practices, given prevailing capabilities.

1. **Integrated financing with a capitated payment strategy.** The multiple, disconnected funding streams that exist for healthcare, housing and social services lead to challenges in creating an integrated model for serving homeless individuals. Additionally, the federal, state, and local offices overseeing this funding have distinct leadership that reinforces silo-based approaches to care. This initiative would look at the full array of financing arrangements for serving homeless persons within any given community; and seek to better align public (federal and state) funding and oversight for related homeless programs, and coordinate with aligned philanthropy— all designed to optimize TOTAL cost and quality performance for homeless persons served through related public and private financing. We recommend rooting this initiative in a capitated payment strategy that aligns related funding, as much as possible, through a single source.

2. **Nontraditional outreach in nontraditional settings.** The homeless are transient, hard-to-find, and difficult to maintain a meaningful relationship. Most do not have a mailing address or telephone. This initiative would develop and test alternative ways for maintaining contact with homeless persons in need of medical care and engaging with related homeless care programs. It is critical for homeless persons to: 1) be aware of important health and wellness consideration, 2) be able to monitor their own health and health related conditions, 3) access medical services when needed, and 4) receive follow-up monitoring and support when a condition has been diagnosed and treated.
3. **Flexible benefit and service design.** In serving homeless persons, it is frequently not possible or preferable to follow traditional protocols for diagnosing and treating a given illness or injury, or for dispensing medication and monitoring compliance. Frequently, a nontraditional or nonmedical intervention is as or more critical for achieving a preferred health outcome than a traditional medical intervention might be. This initiative would identify, develop and test options for varying benefits design, use of supplemental benefits, definitions of network adequacy, etc.— to improve health outcomes of unique importance to homeless persons.
4. **Interdisciplinary care teams.** Like care for any high-cost/high-risk subgroup, interdisciplinary care teams are the glue to effective care. Helping homeless persons stay out of jail, in stable housing, and off the street are important in achieving personal and social, wellbeing as well as health outcomes. Mental health and substance abuse services are also of heightened importance. This initiative would a) build on existing approaches in defining or re-defining the use and composition of care teams in serving homeless persons, including methods for assigning primary care responsibilities; b) work with indigenous providers and allied primary, acute, pharmacy, behavioral health and long-term care providers; and c) establish protocols for allied clinics, pharmacies, hospitals, mental health clinics, and substance abuse programs. The overall goal would be to reduce inappropriate use of emergency rooms and hospitalization rates and prevent, delay or minimize the progression of chronic disease and disability.
5. **Addressing population differences and social risk factors.** Effective clinical care requires changes in treatment protocols to more fully account for the effects of cultural, ethnic and race differences; the influences of social risk factors on health and healthcare outcomes; and key population differences. The initiative would build off of existing tools in seeking to identify, develop and tests ways to more fully account for demographic differences and social factors, as well as tailor screening, diagnosing, triage and care management to more fully account for differences in serving transient vs chronic homeless persons as well as between younger adults and seniors. This would include recommending modifications in care methods by allied clinics, pharmacies, hospitals, and other aligned healthcare professionals.
6. **Partnership with affordable housing and local community service programs.** Most outside contact for homeless persons is through an array of food bank and clothes closet programs, homeless shelters and affordable housing providers, local police, crisis intervention centers, victims of abuse and crime programs, HIV & STD treatment centers, and mental health centers. The initiative would look at ways to stabilize housing for homeless persons; and better align medical care with other care provided to improve their overall access and effectiveness, including ways to align Medicare, Medicaid, and HUD interests.

7. **Co-location of medical clinics with affordable housing and community-center services.** As a matter of priority, the initiative will identify and test options for: a) co-locating a core set of clinic services with a particular housing or community service program or cluster of programs, b) identifying what combination of services is the most viable option for improving efficiencies; what medical services are best to co-locate, such as screening, health education, and diagnostic services; and c) identifying those arrangements that are most important in addressing the interdependence of medical, psychosocial, and environmental concerns.
8. **Integrated plan administration.** Improving homeless care requires revisiting relationships between Medicaid managed care and Medicare managed care, whether that is by staff working within the same SNP or MMP, or by SNPs and other Medicaid managed care organizations serving the same homeless persons. This initiative will explore where and how to vary roles and responsibilities for addressing marketing and enrollment, member service functions, provider contracting, plan staffing, information systems design, regulatory compliance, performance evaluation and quality improvement methods.
9. **Program oversight.** We propose the CMS Medicare-Medicaid Coordination Office (MMCO) work with and through the Center for Medicare-Medicaid Innovation, and in collaboration with an aligned group of state Medicaid agencies, on efforts to align financing, policy and oversight among the array of government programs involved in serving homeless persons. MMCO has a strong history of experience in dealing with alignment issues related to serving special needs populations and could be very helpful in finding more efficient and effective ways of monitoring programs for homeless persons by removing financial and regulatory barriers to effective care and aligning interdependent administrative relationships.
10. **Leadership and Performance Evaluation.** We propose the SNP Alliance provide overall leadership in facilitating communication among participating plans, states, and affiliate programs working together to craft and test best practices, remove related legislative and regulatory barriers, and serve as a resource in moving prototype methods to scale ASAP. We propose CMMI contract with a separate national organization to evaluate the performance of interventions being advanced through this national initiative; and in developing reports on ways to improve the total quality and cost performance of serving homeless persons...particularly for chronic homeless persons...nationwide.

Conclusion

Homeless persons are visible to virtually every person, in every city and community in America. Their medical problems are real and growing. Virtually everyone involved in care of homeless persons knows our current methods are broken. The CMMI has a unique opportunity to advance new and improved methods for serving homeless adults with important long-term quality and cost implications. The upside is high. The down side is low. The time to act is now.

4. SUMMARY AND FEEDBACK TO QUESTIONS

The SNP Alliance again appreciates the opportunity to provide feedback to CMI on innovations to promote patient-centered care and test market-driven reforms. We have included the concepts of the guiding principles provided in the RFI in each of our 3 sections of recommendations.

We believe that each of the proposed recommendations are consistent with improving choice, incentives, patient-centered care, and benefit design. We have also included recommendations for improved model design and evaluation.

Lastly, in Section 3, The National Health Care Initiative to Integrate Care for Homeless Seniors and Adults we have provided structure and approach for this model, as well as an innovative financing strategy and opportunities for novel beneficiary outreach and engagement.

We look forward to further dialogue with CMS on these important issues for vulnerable high-risk and high-cost populations.