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Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services

cc:
Kathryn Coleman; Director, Medicare Drug & Health Plan Contract Administration Group, CMS;
Tim Engelhardt, Director Medicare and Medicaid Coordination Office (MMCO) CMS

RE: COVID-19 CONSIDERATIONS FOR SNPS & MMPS

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 400 special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs), with over 2.2 million enrolled members—about two-thirds of all beneficiaries enrolled in these plans. 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.

The SNP Alliance recognizes and appreciates the enormous work done by CMS in response to the COVID-19 pandemic and the President's declaration of a national emergency. Thank you for that work. We have reviewed guidance through today, April 3, 2020. The purpose of this letter is to offer our additional analysis, specific observations, and information on challenges related to the COVID-19 pandemic, to draw attention to issues that particularly impact vulnerable populations and will affect the special needs health plans that serve them. We offer recommendations for consideration and request that HHS and CMS use their authority during this national emergency as you continue to modify, waive, or temporarily delay specific rules and to issue additional guidance to plans.

In a separate letter, we provided information on COVID-19-related implications relevant to the Proposed Rule: *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-*

Inclusive Care for the Elderly. However, given that we have determined impact beyond the scope of that Proposed Rule, we felt that sharing this information and analysis and offering recommendations via a separate letter would be more appropriate.

SNP and MMP enrolled populations are comprised entirely of individuals most at-risk of COVID-19 serious infections and its most severe complications. Most beneficiaries are dually-eligible for Medicare and Medicaid, with multiple underlying chronic and disabling conditions and high social determinant of health (SDOH) risk factors. The impact will fall disproportionately on these people and on these types of plans.

Most of these at-risk individuals cannot wait out weeks of self-quarantine on their own. Their economic vulnerabilities exacerbate the negative effect of their ongoing medical conditions or behavioral health challenges. Many elderly and at-risk individuals do not have access to a smart phone or computer, and therefore virtual visual visits are not a viable solution. Providers are trying to reach these individuals by phone, when possible. People with housing transience/instability are difficult to locate and may be temporarily staying with friends or relatives or in a shelter. The frail elderly person who lives alone is especially vulnerable. These are but a few of the observed changes that are impacting special needs individuals and the plans and providers trying to serve them.

Examples of difficulty performing usual processes and practices include:

- Inability to make visits to beneficiaries in nursing homes or assisted living facilities due to facility directives
- Preventive screenings and elective procedures being cancelled
- Providers within the plan network having to close or restrict access
- Some facilities are closing completely for an indeterminate time period
- Home care and in-home supportive services are drastically reduced given beneficiary restrictions, lack of availability of workers who are home taking care of family, and other restrictions impacting capacity
- Phone call centers and other telephone or virtual-based services are challenged in trying to provide guidance to the general public and at-risk individuals, and are struggling to keep employees available, given their own isolation or illness

We recognize the significant impact that this virus is having on beneficiaries, providers, and health plans. This is not business as usual, and—as much as we can forecast the rest of 2020 and into 2021 and beyond—the impact will continue to be felt. We offer these recommendations in the spirit of trying to address near-term and longer-term effects for both beneficiaries enrolled in SNPs and MMPs, and the plans trying to best serve them.

During this time of extremely stretched resources within the health care and social support

systems, we must commit to removing burden on providers where we can, adjusting targets and timelines, and recognizing the larger goal of keeping our health and social support systems viable is paramount. The overarching goal of reaching the most vulnerable and using available capacity to focus on them should outweigh other goals that made sense prior to COVID-19. It is clear that COVID-19 has implications for CY2020 and subsequent years, particularly around service, access, sites of care, and on data collection, exchange, reporting, quality measurement, and many other areas.

Background:

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) (as amended (42 U.S.C. 1320b-5)). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

This provides both the necessity and authority to HHS and CMS to waive or modify certain requirements of Medicare Advantage (MA) health plans, and, more specifically, of SNPs and MMPs, as these types of health plans were *designed and authorized by Congress for the most vulnerable and complex beneficiaries*—the very people now *most at risk* by COVID-19. We ask CMS to recognize that current requirements assume capacity and functionality that may not be present for several months, if not longer, in many regions throughout our nation, and make adjustments through additional temporary waivers and exemptions.

COVID-19 Related Recommendations

The SNP Alliance has had extensive discussions with our SNP and MMP plan members, and offers these recommendations for your consideration to help SNPs and MMPs better meet the needs of their members, both in the immediate short-term and longer-term focus, once we are through the pandemic.

2020/SHORT-TERM

We recommend CMS:

- **Confirm that plans can extend the deeming process timeline for SNP members who have moved into an ineligible Medicaid status to ensure dis-enrollments do not occur during the COVID-19 emergency declaration.** This is a critical time for these dually-eligible beneficiaries to maintain as much access to services as can be provided and not to worry about loss of health insurance coverage.

- **Identify areas where additional short-term relief can be provided regarding documentation and data transfer requirements from providers to health plans and between providers**. We must lessen the burden on providers and facilities due to the additional volume in care needs they are experiencing. While this is being done in some states, such as New York, the state-by-state approach leaves gaps and can add to confusion, particularly when beneficiaries cross state lines to receive care and when plans' provider networks span multiple states. This disproportionately impacts SNPs and MMPs, as their enrolled beneficiaries typically have multiple chronic conditions requiring different specialty medical, behavioral health, home care, skilled nursing services and social support providers. Individuals interact with many parts of the health system given their complexity.

- **Delay implementation of the Interoperability Rule by at least one year.** The rule requires substantial investment of time and resources by providers, plans, and others to meet the goals around improved health information exchange and information access between and among plans and providers and to consumers. This capacity and operational sophistication, even in the best of times, is extremely varied. We all agree and want to improve the speed and quality of health information transfer for better care management and targeted quality improvement. Unfortunately, neither plans nor providers are unlikely to have bandwidth in the next year to invest resources or time in working toward more robust health information exchange or capabilities.

- **Use HHS and CMS emergency authority to make additional modifications around Medicare Stars measures for the most affected health plans, such as providing additional adjustment to the Stars rating, providing some kind of set-aside to adjust the quality bonus payment, or other remedies that address underlying population disparities .** The SNP Alliance appreciates the flexibility for data collection and reporting the Agency provided in the March 31, 2020 memo on Part C and Part D Star measures reporting, but there are additional issues to address. We have reviewed Medicare MA 2020 Star measures and conducted initial analysis of

current challenges being experienced, which are restricting ability of providers and plans to follow normal processes. ***For 2020, we determined most measures are likely to be impacted by COVID-19.*** Those measures consist of HOS, CAHPS, HRA, HEDIS, and other Part C and Part D measures.

  - The HHS/CMS guidance provided as of April 3, 2020 is welcome, but it does not go far enough to address the issues we are observing. Plans are already reporting that generating Star measures will be challenging for the foreseeable future. Difficulties with data collection will impact some plans more than others. Understandably, providers' documentation, capture of all relevant diagnostic codes, and transmittal timeframes for claims and other data to health plans is slowed or spotty/incomplete. This is unlikely to change any time soon. As SNPs and MMPs have populations with many more conditions to manage, their beneficiaries and these data issues are more pervasive for these types of plans. We anticipate greater difficulty among SNPs and MMPs to capture/obtain the data needed to generate Star measures beyond 2020 & 2021 and into 2022, 2023, and even 2024 for some measures based on data needed, records that will be available, and other constraints. The measure specifications and methodology used by CMS in Stars quality measurement and the changes in practice/documentation mean that the impact could persist for more than a few Star measures for some time.

- **Suspend use of the Health Outcomes Survey in 2020 and 2021.** Particularly for SNPs and MMPs, the results will not be valid. Especially for HOS measures such as for PCS and MCS, results are likely to be severely compromised, as the self-report survey asks the beneficiary if he/she has maintained or improved his/her physical or mental health in the last year. Moreover, given the methodology of HOS and two-year look back time period, the impact will continue to be felt. COVID-19 would make conclusions invalid for data collected in 2020 when compared to 2018, and likewise call into question data collected in 2022 that would be compared to 2020. Postponement will not address these issues. We believe it is prudent to cancel this survey and help redirect those resources to patient care and member outreach for assisting them to address their complex conditions.

- **Maintain the FIDE-SNP frailty adjuster as determined from 2019 data** –so that the current adjustment extends from 2020 and 2021 to hold harmless FIDE-SNPs. We recognize that some FIDE-SNPs that had not applied for this last year would be shut out, and request CMS consider how to accommodate these fully integrated dually-eligible special needs health plans.

- **Postpone implementation of any new Star measures in 2020 and 2021 and extend for two years the time period for Display measures.** Neither plans nor providers have the bandwidth to begin collecting additional data for new measures. Several of the new measures coming online require substantial data capture, transmission, notification and follow-up by providers which is just not possible in many communities at this time. This was not addressed in CMS guidance to date.

- Issue immediate guidance to SNPs to **allow for waiving of specific Model of Care processes until such time as the "all clear" is sounded in each state and usual practices by providers and plans can resume.** This would include waiving or substantially modifying the following factors and elements within the Model of Care: Health Risk Assessment, Interdisciplinary Care Team, Individualized Care Planning, Provider Training, Transitions of Care, Quality Improvement. Plans will continue to work with providers and beneficiaries to maintain these practices, but these areas are all but certain to be impacted as they require additional effort. These activities are only required of special needs health plans, not general Medicare Advantage plans.

- **Temporarily suspend graduated implementation of the progressive blend of encounter data in CMS-HCC risk adjustment models**—particularly since availability of these data will be uneven or nonexistent for some period in some regions. The capacity of providers to send timely encounter data to health plans varies widely. We also request evaluation of how such telehealth "visit" and contacts may be captured into Encounter Data for risk adjustment going forward.

- **Suspend all CMS audits and enforcement activities for 2020 for SNPs and MMPs** (those not already on hold via the CMS memo dated March 30, 2020), until such time as 90 days after the "all clear" is given in each state/region. Plans will need longer than 30 days to prepare even when the crisis has passed. This includes data validation, program, and financial audits. These audits divert resources from operations at a critical time.

- **Delay deadline for Bid submissions, and plan-related applications.**

- **Suspend requirements that currently direct SNPs to submit a revised Model of Care document to NCQA during off-cycle submission timeframe (July through December) for 2020.** Instead, ask plans to provide a brief description of actions by the end of the year that had to be taken given COVID-19 which changed care management practices around MOC factors—for information only. That is, NCQA would deem the plan in compliance in 2020, versus conducting a substantive review of the information.

- Using the authority under this national emergency declaration, **substantially modify**

the proposed new requirements for C-SNPs, recognizing that the current factors and elements within the NCQA MOC Scoring Guidelines already provide detailed specifications for C-SNPs to follow. Many of the new requirements, such as face to face visits, additional access to specialty providers on IDTs, and fulfillment of the previous year's MOC goal will be severely reduced or will not be able to be pursued at all, given the COVID-19 changes in healthcare delivery, access, and bandwidth of providers. Some, such as face to face visits are prohibited by state, regional, or public health directives. Some State Departments of Health, such as New York, have waived many requirements including for providers to document visits.

2021 AND LONGER-TERM

We recommend CMS:

- **Conduct a careful review of impacts and timelines for the look-alike transitions and consider timeline extensions or temporary waivers when requested by states for specific delays to accommodate problems arising from the current COVID-19 pandemic process,** and to ensure that disruptions to dually eligible members are minimized and that plans have adequate time to develop additional products and/or respond to state changes in procurement policy related to this proposal.

- **Consider additional risk-adjusted payments and the base rate of all SNPs and MMPs to account for the increased and unanticipated costs associated with COVID-19, beyond the existing risk-corridors for outlier costs**. With a template or other guidance from CMS, plans could submit information about the types of costs, actual and projected size/scale of the costs, and proportion of enrollment or operations impacted.

- **Consider extending D-SNP deadlines for meeting integration requirements on a state by state** basis depending on state ability to enter into D-SNP contracts on a timely basis in 2020 for 2021 and provide Federal guidance to states on this issue as soon as possible. We understand that some states may not be ready with their contracts by July 2020 for 2021, while other states may be able to finish that process without too much disruption. We do not want to lose momentum in moving towards implementation of integration standards, however, we also recognize that some D-SNPs may be unable to comply with these requirements due to state issues caused by the COVID crisis. We suggest that CMS should allow states to request such a delay with appropriate rationale as to why it is necessary. Additionally, CMS should also allow states that are able, to go ahead and implement it. This option would recognize that in some states it could be more work for everyone to stop the process in mid-stream.

- **Issue additional guidance around measurement for 2021 and 2022 Star ratings** to take into account and implement remedies arising from the differences among plans' enrollment in order to recognize plans with the highest proportion of vulnerable populations and adjust measurement ratings and quality bonus payments **to hold harmless** plans serving the most vulnerable.

- Going forward, even when the crisis is passed, we strongly recommend that **CMS consider plan stratification based on proportion DE/LI/Disabled prior to setting cut points.** A longer-term goal would be to identify more tailored set measures with methods that recognize diversity, social risk factors, and comorbidities and complexities of these individuals served by SNPs and MMPs.

- In 2021 and 2022, **modify CMS audits so that Model of Care and related care management processes that occurred in 2020 are *not* part of the audit universe or data request.**

- **Include diagnoses from telehealth encounters in risk adjustment.** Not including telehealth diagnoses and encounters acts as disincentive to SNPs to expand their telehealth in response to new incentives and new COVID flexibilities provided by CMS. This will be critically important as SNPs experience spikes in illness rates where telehealth will be an even more important tool in serving vulnerable enrollees.

We have all seen events unfold that are upending lives and impacting our entire society, especially health care and social support services. We have seen how all providers across the spectrum are needing to quickly re-work normal processes and standards of practice to respond to the virus. The effects are profound.

We appreciate the enormous work done already by HHS and CMS to address providers needs and issues. We also appreciate additional guidance for special needs health plans and would be happy to have follow-up discussions with you or other staff more directly related to specific aspects of these recommendations.

Respectfully,

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