SNP Alliance Comments 6-1-2020

BPC White Paper Recommendations (Pages 9-14)

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. We have been honored to be part of this workgroup, led by the Bipartisan Policy Center (BPC), and greatly appreciate BPC's work and commitment. We very much support this work and the overall direction of this report and the recommendations. We offer the following comments for consideration and thank you for the opportunity to comment.

Eliminate Regulatory Barriers to Alignment:

1. **Consolidate regulatory authority under MMCO**.
   Support: The SNP Alliance supports this recommendation. The recommendation is consistent with long-standing SNP Alliance positions and current language in the BBA that we promoted but has not been interpreted by CMS as all involved had intended. We suggest BPC review those current provisions to see whether they could be tweaked and strengthened as an initial step toward this recommendation.

   - Additional Limited Waiver Authority: We also support efforts by ACAP to add to current statutes, a targeted waiver authority that allows CMS to modify or eliminate certain MA operational and regulatory barriers in order to facilitate Medicare and Medicaid integration. Such authority would be limited and could not be utilized for major policy changes such as eligibility, Medicare benefits, or payment rates.

   - We also suggest that BPC is positioned well to work with stakeholders and CMS to review existing statutory barriers to integration and identify priorities to be considered by Congress for statutory change or waivers as suggested above. For example, new authorities should be tailored to address a long-standing barrier to joint review of Medicare and Medicaid member materials by both CMS and states, as requested by the MMCO in several Reports to Congress.

2. **Adopt Best Practices from FAI.**
   Support: This provision is consistent with long-standing SNP Alliance positions and requests to CMS. In addition to allowing application of other FAI integrated features to D-SNPs such as joint review of integrated member materials, coordinated communication channels, and coordinated models of care, we suggest that BPC consider recommendations to allow alignment of Medicare with FAI MMP and current Medicaid enrollment processes and strategies for D-SNPs as described below.
   - Single enrollment period: BPC should also recommend changing the current quarterly SEP to ongoing SEP, allowing FBDEs to move to FIDE or HIDE integrated plans in any month (similar to the current FAI provision for MMPs where the quarterly SEP requirement has been waived).

   - Enrollment alignment tools: Currently, one of the biggest obstacles to integration is the number of dually eligible individuals who are already enrolled in two separate plans for Medicaid and Medicare. This occurs because of how states choose to procure and contract with Medicaid MCOs, and the resultant lack of their alignment with existing DSNPs or MA plans. Under the FAI, MMPs are allowed to simultaneously enroll duals into both Medicare and Medicaid and to employ passive enrollment (with opt out) enrollment strategies. While initially there were many opt outs, shared learning on best practices for such enrollments has and can further improve these processes. Medicaid MCOs are also allowed to use passive enrollment strategies with or without opt outs for duals, something that has not been controversial in Medicaid. However, as a matter of policy (not statute), Medicare limits such enrollment alignment tools to a couple of very specific situations.

3. **Limit DSNP Enrollment to FBDEs.**
   Do Not Support: The SNP Alliance agrees that integration of operational features (i.e. member materials, communications, integration requirements, etc.) can be more challenging when both FBDE and partially dual individuals are enrolled in the same DSNP Plan Benefit Package (PBP), due to the fact that partially dual individuals do not have access to the full set of Medicaid benefits. However, we do not believe the answer is to eliminate the DSNP option for partially dual individuals:

   - Enrollment in DSNPs is more beneficial for partially dual individuals than enrollment in regular MA plans. Partially dual individuals are poorer and sicker than regular MA enrollees and are more likely to become eligible as FBDEs, especially when they need LTSS. Unlike MA plans, DSNPs are required to have a Model of Care (MOC) with care coordination elements specifically designed to help poorer and sicker populations navigate complex systems of care. It will be harmful to take these additional care coordination benefits away from partially dual individuals.

   - DSNPs tailor supplemental benefits to poor and complex needs populations and with new flexibilities are increasingly in a position to assist states in filling in gaps for

services otherwise not available to partially dual individuals that could assist states in slowing movement to FBDE status.

- There are other administrative options for addressing the challenges to operational integration posed by benefit differences for partially dual individuals that would be less disruptive to this population. For example, CMS has suggested as part of integration requirements implementation, that DSNPs can set up separate PBPs for partially dual individuals and FBDEs, and if operating both they can still meet integration requirements. In addition, CMS could allow reporting at the PBP level instead of the contract level, which would resolve additional issues where multiple plan types and even multiple states are reported at the contract level, obscuring plan and state level results for appropriate comparisons and making such data useless for Medicaid agencies.

Provide Incentives and Assistance to States:

1. **HHS authority to develop shared savings programs.**
   Support: The SNP Alliance supports the concept of shared savings and the current FAI model, and agrees that many states need stronger incentives as well as a deeper understanding of how and why integrated models can be of benefit to state Medicaid programs.

   - Shared Savings Models for DSNPs: We suggest that, with appropriate consideration of the differences in benchmarks between states, CMS could explore shared savings options for DSNPs, including utilization of rebate and supplemental benefit policies to facilitate shared savings with states.

   - Frailty Adjustment: We also suggest that BPC include in their recommendations a review of the current methodology for application of the frailty adjuster to FIDE SNPs. This adjustment is meant to consider the additional frailty not captured by risk adjustment for dually eligible members who have a similar level of frailty as PACE enrollees. This adjustment could be an important factor in supporting shared savings as incentives for plans and states to achieve further integration. However, few FIDE SNPs are eligible for this adjustment because of issues stemming from methodological problems with the use of HOS data and inequitable comparisons between PACE programs that enroll only members who meet nursing home level of care, compared to FIDE SNPs who must enroll members at all levels of care when required by states.

2. **Resources and TA to States for Integrated Models**
   Support: This recommendation is consistent with long-standing SNP Alliance positions. In addition, we suggest the following:

   - Designated Contact: We also would add a requirement that each state Medicaid Director designate a contact or point person to be responsible for Medicare Medicaid integration policy, implementation, and related activities in that state.

- Additional Incentives for States: Incentives for states to move toward integrated models must be strengthened. This should include increased FMAP for staff resources to support integration and enhanced technical assistance from the ICRC regarding best practices for design, expansion and changes in state programs needed to serve dual populations, and considerations on which populations should be included. See comments under #1 in the final section for additional discussion.

Improve the Enrollee Experience

1. **Collaboration for Outreach and Education**:
   Support: This provision is consistent with long-standing SNP Alliance positions. We also suggest that efforts focus on how to make the consumer experience simpler and more seamless, with operational details between Medicare and Medicaid invisible to the consumer and relegated to the "back room." Attention to language and cultural differences should also be priorities.

   In addition to strengthening the role of the SHIPs, we recommend that state Medicaid managed care enrollment brokers be educated in and required to offer and explain available integrated program options to potentially eligible dual enrollees. Further, Medicare brokers could be provided payment incentives to promote integrated programs where available. BPC should also consider addressing recommendations stemming from MACPAC's upcoming report on need for alignment between Medicare Savings Programs and LIS Part D requirements.

2. **Resources and TA for consumer and provider engagement and education:**
   Support: This recommendation is consistent with long-standing SNP Alliance positions.

3. **Allow States to Implement 12 months of Continuous Medicaid Eligibility:**
   Support: We are aware that many people, particularly seniors and people with disabilities, lose Medicaid eligibility simply due to paperwork issues which in many cases is due to slow processing by states and other entities. Relatively few lose eligibility permanently for financial reasons. The majority of dually eligible individuals are reinstated (many even retroactively), but the gaps in eligibility are confusing and time-consuming for individuals as well as plans, providers, and even states. We do expect some states will consider this costly, but we suggest that costs could be mitigated and balanced against the current costs of administration. If there is concern about any costs of this proposal for dually eligible individuals, further research into the cost of administration of the current system should be considered.

Require Full Integration of Medicare and Medicaid

1. **Require Full Medicare-Medicaid Integration (MMI) Within 5 years:**
   Support with Qualifications: This recommendation is generally consistent with SNP Alliance' previous positions, but we have some concerns we hope can be addressed through the following suggestions:

   - Timelines: While we support the "within 5 years" goal and believe we cannot simply continue with current incremental changes, we are concerned that states and plans must make dealing with the current pandemic a priority and recognize this may delay potential implementation of integrated features. At the same time, it appears the dually eligible population is likely to bear the brunt of the pandemic's tragic impact and we cannot afford to wait longer to implement integrated features for this population that would improve health outcomes and cost efficiencies as it appears possible under integrated models. Therefore, we recommend continuing to work toward the goal of implementation within 5 years while revisiting that deadline if necessary as we move forward.

   - Defining Fully Integrated: Before there can be consensus on such a broad statement, we believe there must be some consensus on a policy and vision framework for what is meant by "full integration." Integration is a term that has many different interpretations. Besides addressing the financing and operational aspects of MMI, we believe that MMI integration must also support care delivery and clinical models designed to better serve complex populations. The SNP Alliance offers as a template the attached integration brief, which outlines our longstanding vision and goals for elements required for fully integrated models, with recent updates to align with BPC recommendations.

   - Defining State Models: While we understand that multiple models may be necessary for accommodation of different state choices and different stages of integration, we also have concerns that not all models are equal or ideal in their ability to produce positive results while protecting this vulnerable set of consumers over the long-term. We remain wary of increased competition between new FFS- or ACO-based demonstrations that do not provide the additional consumer protections provided under HMO licensure including financial protections for reserves and risk and MCO and MA oversight and regulation, and current FAI or DSNP models that already have long experience without indications of harm to dually eligible members. All models considered should, similar to the FAI, meet the requirements for the definition of "fully integrated" as discussed above.

   - State Adoption of Models: We agree with the recommendation that states should notify the Secretary of their intent and written plan to implement one or more defined payment and delivery models as provided by the Secretary. We envision that such models would include MMPs, FIDE SNPs, and PACE.

   - Incentives for States: Increased FMAP for implementation and provision of LTSS and Behavioral Health services delivered through fully integrated programs would both

encourage and enable states to reach specific measurable milestones, providing a secure and predictable pathway to fully integrated models that can be tailored to meeting state specific goals for reaching each defined stage of integration within their plan and implementation period. Increases in FMAP percentages for LTSS and Behavioral Health services could be earned, tiered or accelerated based on a menu of defined stages and timeframes and could also be titrated to shared savings expectations.

Progress on reaching each stage on the pathway to a fully integrated model could be measured through a combination of milestones and measures agreed upon by both the state and CMS such as the proportion of the state geography and/or dual populations with access to fully integrated programs, increased proportions of duals enrolled in the same plan or plan sponsor with fully aligned enrollment (Applicable Integrated Plan-AIPs), increased numbers of contracts with FIDE and HIDE SNPs, or implementation of added operational integration features in SMAC contracts such as integrated MOCs, networks, member materials and reviews, member services, G&A, enrollment provisions, sharing of encounter data, and tailoring of supplemental benefits.

2. **Require all MA Carriers to Offer One FIDE SNP in each Service Area**
   Do Not Support: We think this idea is highly unworkable for the following reasons:

   - First, this is written as a requirement on MA plans, but they do not have the means to accomplish it. FIDE SNP status is dependent on the presence of a contract with the state Medicaid agency for **Medicaid,** as well as the presence of some form of MLTSS capitation as allowable in that state. States are not required to contract with DSNPs nor to require them to provide any Medicaid services, and can choose which services to include or exclude if they do choose to contract with them.

   - In addition, states use their own procurement criteria for choosing Medicaid contractors and most have periodic open re-procurement criteria addressing additional experience or investment in serving poor and complex populations. Medicare offers ongoing renewal for qualified MA plans, which may or may not align with state Medicaid criteria. Therefore states may not see MA plans or even DSNPs as their preferred partners for Medicaid.

   - Finally, we believe this recommendation would require additional statutory requirements directing state contracting choices, likely generating strong objections from states.

3. **Allow States to Notify Secretary of Intent and Plan to Implement One or More Payment Delivery Models**
   Support: As outlined further above in # 1, this is also compatible with long-standing SNP Alliance recommendations to CMS. It should be coupled with clarification of models, goals, and incentives as described previously.

4. **Direct Contracting Models in States that Choose Not to Integrate as Federal Fallback with Clawback**.
   Partial Support with Qualifications: The SNP Alliance has been involved in integration activities in one form or another for the past 25 years. We believe strongly that additional incentives for states are critical to moving forward with integration, and that **state-led plan-based locally run models** are most successful in serving the dually eligible population. As stated earlier, in our experience, direct contracting models lack elements necessary for effective integration.

   We also believe we cannot afford to continue the current incremental approach to integration endlessly into the future and that current provisions are not strong enough to reach the goal of simpler access and improved care for our most costly and complex populations through integrated models. In what is hopefully an unlikely case that there is no response to the increased incentives outlined in #1 above, as a last resort we would support a federally run capitated health plan-based fallback program with appropriate claw backs.

Again, the SNP Alliance has been pleased to participate in this important discussion. We look forward to the on-going dialogue and are happy to answer any questions you may have related to the above comments.

Respectfully,

Cheryl Phillips, M.D.

President and CEO
Special Needs Plan Alliance
202 204-8003
cphillips@snpalliance.org