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U.S. Department of Health and Human Services

RE: Effective and Innovative Approaches/Best Practices in Health Care in Response to the COVID-19 Pandemic; Request for Information (RFI)

Introduction

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.

Special Needs Populations

SNP and MMP enrolled populations are comprised entirely of individuals most at risk of COVID-19 serious infections and its most severe complications.

Most SNP and MMP 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 severe and extended impact of changes in communities—including disruptions in health care, behavioral health, long-term services and supports, medical devices and adaptive equipment, nursing facility care, as well as challenges in accessing healthy food, reliable communication devices, transportation, personal protective equipment, and even informal support from family and friends—falls disproportionately on these individuals and on these types of health plans.

Evidence of Disproportionate Harm

The COVID-19 Pandemic has harmed SNP and MMP beneficiaries particularly hard. SNP and MMP beneficiaries have poorer health and complex care needs due to higher rates of disability and chronic conditions than other Medicare beneficiaries. **Due to the poorer**

health and multidimensional needs of special needs individuals, they have not only been disproportionately harmed by COVID-19 pandemic, but the issues facing them have been exacerbated and will continue long after the PHE is declared over. Below are just some of the many examples of dual eligible beneficiaries having higher rates of health conditions:

- **Over half of dual eligible beneficiaries live below the poverty line**
  - 55% of dual eligibles live below the poverty line compared to 5% of non-dual eligible beneficiaries.
    (MEDPAC Data Book: Health Care Spending and the Medicare Program, July 2020)
- **Disability status is much higher among dually eligible beneficiaries**
  - In 2018, 38.6% of dually eligible beneficiaries had disability as their current Medicare status, compared to only 8.4 percent of Medicare-only beneficiaries (*Medicare-Medicaid Coordination Office FY 2019 Report to Congress)*
- **The dual eligible population has a higher prevalence of chronic conditions (Diabetes, Chronic Obstructive Pulmonary Disease, Vascular Thrombosis, Congestive Heart Failure, Major Depression/BiPolar, Drug and/or Alcohol Dependence)**
  - 70% of dually eligible individuals have three or more chronic conditions (vs. 52% of Medicare-only beneficiaries).
    (*Medicare-Medicaid Coordination Office FY 2019 Report to Congress)*
  - 41% have at least one mental health diagnosis (vs. 16% of Medicare-only beneficiaries).
    (*Medicare-Medicaid Coordination Office FY 2019 Report to Congress)*
- **Dual Eligible beneficiaries have higher rates of ADL limitations**
  - 25% of dual eligibles have limitations in 1-2 ADLs compared to 17% for non-dual eligibles.
    (MEDPAC Data Book: Health Care Spending and the Medicare Program, July 2020)
  - 29% of dual eligibles have limitations in 3-6 ADLs compared to 8% for non-dual eligibles.
    (MEDPAC Data Book: Health Care Spending and the Medicare Program, July 2020)

- **Dually Eligible beneficiaries are more likely than non-dual eligible beneficiaries to report being in poor health (16% vs. 5%)**
  (MEDPAC Data Book: Health Care Spending and the Medicare Program, July 2020)

Restrictions on Usual Processes and Practices Due to COVID-19

Special Needs Plans and MMPs have reported throughout the COVID-19 pandemic how they have restrictions on their usual processes and practices around care coordination, preventive and wellness care, and follow-up support—given state mandates, clinical or organizational directives, and federal guidance that are designed to stop the spread of the

virus and protect the public. As noted above, the issues facing the SNP and MMP population have been exacerbated due to the pandemic. This population requires extensive care and care management and the ability to provide those services has been greatly hindered.

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.

Actions by SNPs and MMPs to Meet the Needs of Beneficiaries

We have gathered some examples of actions taken to share with CMMI. This is not an exhaustive list, but helps shine a light on how these special health plans have worked with many others in their communities to try to reach those who need help most.

These actions were taken due to the immediate and ongoing needs of the community and beneficiaries and under the flexibility and relaxation of rules as directed by DHHS and CMS. Many of these actions would not have been possible if the PHE had not been declared with follow up immediate guidance by HHS and CMS. Given that CMMI requested response by topic area in their RFI – we have listed actions according to these topic areas—and some actions are listed more than once, as they fall into more than one area.

Health Promotion and Prevention of COVID-19 and Non- COVID-19 Medical Conditions

Health Promotion and Prevention Actions Taken by SNPs and MMPs:

1. SNPs and MMPs increased home visits
2. SNPs and MMPs made direct calls (Interactive Voice Response and live) to engage high risk beneficiaries in health and safety during the COVID-19 PHE:
    a. Engage and support high risk members who also have high levels of isolation and a mental health flag in health and safety
    b. Connect with beneficiaries for COVID-19 screening and to connect beneficiaries with needed resources
    c. Follow up with beneficiaries with a confirmed past COVID-19 diagnosis, pregnant members, and additionally identified high risk member groups
3. SNPs and MMPs increased and improved access to behavioral health services through telehealth.
4. SNPs and MMPs purchased and delivered masks to beneficiaries, group homes, transportation and non-physician allied providers.

5. SNPs and MMPs purchased and delivered remote home monitoring kits for management of chronic medical conditions
6. SNPs and MMPs suspended utilization review and other before care administrative authorizations that could have been a barrier to immediate action, and provided additional support for inpatient and residential stays.
7. SNPs and MMPs relaxed "refill too soon" edits to allow for early refills due to COVID-19.
8. SNPs and MMPs expanded delivery service options for/to beneficiaries.
9. SNPs and MMPs extended prescription prior authorization approvals so that the individual could receive a 90-day vs. 30-day only level of medication.
10. SNPs and MMPs worked within their Medication Therapy Management (MTM) programs with outreach prioritizing members who have been discharged from the hospital with a diagnosis of COVID-19 to complete medication reconciliation.
11. SNPs and MMPs purchased and hand-delivered and trained individuals on iPads to promote visual connections for isolated beneficiaries.
12. SNPs and MMPs provided education and support to promote the seasonal flu shot and get beneficiaries vaccinated through various community distribution channels.

Nutritional Support & Promotion Actions Taken by SNPs and MMPs:

1. SNPs and MMPs provided Pandemic Response Meals in response to food insecurity due to the pandemic.
2. SNPs and MMPs – redeployed staff to get delivered meals to the home of beneficiaries following discharge.
3. SNPs and MMPs rovided nutritious snack packs, hand sanitizer, tote bags, socks, and care packages to individuals and organizations directly affected by COVID-19:
    a. Homeless shelters, food shelves, childcare facilities
    b. Healthcare essential workers
    c. Fire departments
    d. Community organizations
    e. Providers

COVID-19 Member Materials Created by SNPs and MMPs:

1. SNPs and MMPs utilized national and state guidance materials and developed COVID-19 resource guide, lists of websites and other materials for COVID-19 health and safety.
2. SNPs and MMPs contacted beneficiaries through call center staff, care management teams, and others to communicate COVID-19 covered services to beneficiaries.

Screening/ Surveillance/Case Identification of COVID-19 and Non- COVID-19 Medical Conditions

Actions to Screen, Surveil, and Identify by SNPs and MMPs

1. SNPs and MMPs increased home visits
2. SNPs and MMPs conducted direct calls (Interactive Voice Response and live) to engage high risk beneficiaries in health and safety during the COVID-19 PHE:
    a. Engage and support high risk members who also have high levels of isolation

and a mental health flag in health and safety
    b. Connect with beneficiaries for COVID-19 screening and to connect beneficiaries with needed resources
    c. Follow up with beneficiaries with a confirmed past COVID-19 diagnosis, pregnant members, and additionally identified high risk member groups
3. SNPs and MMPs increased and improved access to behavioral health services through telehealth.
4. SNPs and MMPs worked with their Medication Therapy Management (MTM) outreach prioritizing members who have been discharged from the hospital with a diagnosis of COVID-19 to complete medication reconciliation.
5. SNPs and MMPs Purchased iPads and taught members to use them - to promote visual connections for isolated beneficiaries.

Treatment for COVID-19 and Non- COVID-19 medical conditions

Actions to Fill Gaps in Service and Access by SNPs and MMPs

1. SNPs and MMPs increase home visits
2. SNPs and MMPs made direct calls (Interactive Voice Response and live) to engage high risk beneficiaries in health and safety during the COVID-19 PHE:
    a. Engage and support high risk members who also have high levels of isolation and a mental health flag in health and safety
    b. Connect with beneficiaries for COVID-19 screening and to connect beneficiaries with needed resources
    c. Follow up with beneficiaries with a confirmed past COVID-19 diagnosis, pregnant members, and additionally identified high risk member groups
3. Increased and improved access to behavioral health services through telehealth.
4. Provide masks to beneficiaries, group homes, transportation and non-physician allied providers.
5. Provided remote home monitoring kits for management of chronic medical conditions
6. Suspended authorizations and provided additional support for inpatient and residential stays.
7. Relaxed “refill too soon” edits to allow for early refills due to COVID-19.
8. Expanded delivery service.
9. Extended prescription prior authorization approvals.
10. Medication Therapy Management (MTM) outreach prioritizing members who have been discharged from the hospital with a diagnosis of COVID-19 to complete medication reconciliation.
11. Purchase iPads to promote visual connections for isolated beneficiaries.

Payment Actions by SNPs and MMPs

1. Efforts to support providers with flex payment in telemedicine.
2. Increased COVID-19 related service payments and waived cost sharing.

Telehealth

Telehealth Actions by SNPs and MMPs

1. Many plans have transitioned assessments to either fully telephonic or video, with face-to-face assessments often fully or partially suspended.
2. Efforts to support providers with flex payment in telemedicine.
3. Purchase iPads to promote visual connections for isolated beneficiaries.
4. Direct calls (Interactive Voice Response and live) to engage high risk beneficiaries in health and safety during the COVID-19 PHE:
    a. Engage and support high risk members who also have high levels of isolation and a mental health flag in health and safety
    b. Connect with beneficiaries for COVID-19 screening and to connect beneficiaries with needed resources
    c. Follow up with beneficiaries with a confirmed past COVID-19 diagnosis, pregnant members, and additionally identified high risk member groups
5. Increased and improved access to behavioral health services through telehealth.

Telehealth appointments, although imperative to providing care to the special needs population and a vital resource in the midst of a pandemic, does not cover everyone due to lack of phone or working phone or lack of knowledge on how to use the phone, which got worse as the pandemic continued into the year. Beneficiaries often do not have the money to pay for a phone or other type of electronic access.

Mental Health/Behavioral Health and Substance Use Disorders

Actions to Improve Access for Beneficiaries by SNPs and MMPs

1. Increased and improved access to behavioral health services through telehealth.
2. Efforts to support providers with flex payment in telemedicine.
3. Purchase iPads to promote visual connections for isolated beneficiaries.
4. Direct calls (Interactive Voice Response and live) to engage high risk beneficiaries in health and safety during the COVID-19 PHE:
    a. Engage and support high risk members who also have high levels of isolation and a mental health flag in health and safety

Issues Facing SNPs, MMPs, and Beneficiaries Due to COVID-19

The RFI requests information about what needs to be continued and what barriers are faced when trying to continue these positive actions. We have selected some of the most immediate issues with evidence of harm or disruption and need for regulatory, policy, and other response to maintain flexibilities or address issues that are making the impact worse on the most vulnerable populations and the SNPs and MMPs serving them. This is not an exhaustive list. We urge CMMI and CMS to work across departments and divisions to address these issues as soon as possible. Our comments here are on:

- Quality measurement
- Telehealth
- Referrals

- Health and Health Risk Assessments
- Managed Care Staff Infected with COVID-19

Quality measurement – HEDIS, CAHPS, HOS

Quality measure results and rates from measuring health outcomes or rates of medical compliance of patients (e.g., medication adherence, getting a mammography or colonoscopy, feeling that one's physical and mental health is better than two years ago) – are worse. The measures within MA Stars Ratings are showing decline compared to previous years. This is especially apparent among special needs, high risk populations. Beneficiaries are often not showing up to appointments, even when made, because they are very apprehensive about making appointments and following through due to fear of COVID-19. Because special needs populations have multiple chronic conditions, and substantial behavioral health and/or long-term support services needs—they have more appointments and have to see more doctors and specialists and therapists. They have personal care assistants, home care workers, and other people who are supposed to come into their home on a weekly or daily basis. All of this is upended. We know that any delay or disruption in their medical treatment, follow up or support at home causes additional medical complications, functional impairment, and other decline. The ill effects are more immediate, severe, and long-lasting. The impact on these people is profound. Even with all of the SNP and MMP and provider and community action to try to fill gaps—the disparities are apparent and getting worse. We are very concerned about SNPs and MMPs being measured using the same yardstick when their populations are so different. The net effect of this is that these very health plans that do not achieve a "quality bonus" will then have less resources next year to try to combat the effects of this pandemic. It is a negative cycle.

SOLUTION – The effects will continue for the foreseeable next few years—into 2022 and 2023 as the data for Stars ratings come from the measurement years of 2020 and 2021. It is time to provide some relief to health plans with a high share of persons who are low income, disabled, and/or dually eligible in MA Star Ratings.

Limitations in Telehealth

Telehealth has been a godsend. For people with broadband access and smart phones or devices, it has helped them continue to have needed medical and behavioral health appointments. It is imperative to providing care. However, telehealth does not reach everyone. The population of low income, dually eligible, and disabled people often lack a smart phone. They may have a track phone that runs out of minutes before the end of the month. They may share their phone with extended family members. They may be frail or cognitively impaired and cannot work an iphone or ipad—even if they did have access to one. A simple telephone call may be their only avenue for talking with their doctor or therapist. This is a vital lifeline.

SOLUTION – Telephone calls must be considered acceptable for people without access to technology that is necessary for visual/audio visits. Furthermore, diagnostic coding from both telehealth and telephone visits should be considered equivalent where members lack access to internet and communications devices that support visual visits except for instances without previous relationships with the provider or in case of new diagnoses.

Disruption in Referrals
COVID-19 has impacted referrals as well, due to many specialists closing and/or not accepting patients in office. Plans are often in the position of processing referrals that beneficiaries may not be able to use due to the provider being closed. In response plans often would extend the authorization to accommodate/facilitate the care of the member.

SOLUTION – Beneficiaries with complex chronic conditions requiring specialty care should be approved to receive extended authorization for service beyond normal parameters.

Health and Health Risk Assessments
Many plans have transitioned assessments to either fully telephonic or video, with face-to-face assessments often fully or partially suspended.

SOLUTION - Such processes should be fully accepted and the resulting assessments considered meeting requirements.

Managed Care Staff Infected with COVID-19
Plans have had issues with managed care staff being infected with COVID-19, with numbers as high as 40% of managed care staff over the course of the PHE, which results in a 10-14-day quarantine. This causes delays in completion of quality of care, outreach, follow up, care management and other actions due to this type of absenteeism, in addition to the negative impact on beneficiaries.

SOLUTION – Recognize plans with a high level of staff infection and quarantine in considering performance, considering the impact on usual administrative processes and timeframes.

Moving Ahead

SNPS and MMPs Respond
We've provided examples of how special needs health plans have been reaching out and working with community services to reach these individuals—including paying for or delivering meals, providing smart technology, using mobile vans, providing grants to community service providers, providing PPE to service agencies and volunteers, conducting weekly telephone check-ins, enhancing help/customer service lines, and other actions.

Nevertheless, these plans are concerned about the extended duration of the pandemic and the impact on their members and on communities. Resources are more severely stretched in these communities and among providers that specialize in serving the dually eligible/low-income, disabled, and immigrant or populations of color. "Business as usual" is not returning in these communities. We see the ongoing and increasing challenges on home and community-based services providers, clinics/health centers, outreach and substance use services, nursing facilities, and other services, such as food shelves and transportation. Since many of the needed services rely on people who are frequently also experiencing challenges (e.g., personal care attendants making minimum wage, older volunteers who need to stay home,

community health or other workers with risk factors)—the scarcity of resources is expected to continue well into 2021.

SNP Alliance Recommendations

The SNP Alliance had extensive conversations with our SNP and MMP plan members over this past year. We have worked to synthesize the information and identify viable options. We offer these recommendations for your consideration to help SNPs and MMPs better meet the needs of their members for the remainder of the PHE and long-term. To date, we appreciate the many substantive and supportive actions taken by CMS to allow for flexibility in meeting the needs of SNP and MMP beneficiaries. Thank you.

We recommend CMS:

1. **Continue exercising enforcement discretion of the temporary policy with respect to MA organizations that choose to delay to a later date the involuntary disenrollment of enrollees who are losing special needs status and cannot recertify SNP eligibility due to the COVID-19 PHE until the PHE is over. CMS should also continue until the end of the PHE:**
    - **a.** Not taking action against MA organizations that have a policy of deemed continued eligibility and choose to delay to a later date the involuntary disenrollment of enrollees who fail to regain special needs status during the period of deemed continued eligibility due to the COVID-19 PHE; **and**
    - **b.** Not enforcing the requirement for mandatory disenrollment at § 422.74(b)(2)(iv) and will allow MA organizations to extend the period of deemed continued eligibility under § 422.52(d) during 2020.

    As the December 31, 2020, deadline approaches, SNPs and MMPs are facing a termination cliff with thousands of duals facing termination at the end of this month. Care continuity is extremely important for this vulnerable population, especially during a PHE.
2. **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.
3. **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.
4. **Issue additional guidance around measurement for 2022, 2023, and 2024 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.

5. **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.
6. In 2021 and 2022, **modify CMS audits so that plan changes such as in their Model of Care actions-- made in 2020 and 2021 which had to be done outside of the pre-COVID processes-- are not penalized and/or are part of the audit universe or data request.**
7. **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.
8. **Delay low enrollment sanctions for SNPs, particularly I-SNPs, until the end of the PHE.**

Conclusion

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 people and organizations across the spectrum have worked tirelessly to respond, to re-work normal processes and standards and to work together. Nonetheless, the effects on special needs populations and their communities are profound. We have much to do to rebuild and to work together to reduce health disparities and serve those in need.

We appreciate the enormous work done already by HHS and CMS to address SNPs' and MMP needs and issues. We urge additional guidance for special needs health plans. We 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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