Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016

SNP Alliance: Summary

November 2, 2016

On Thursday, October 27, 2016, the Senate Finance Committee's Chronic Care Working Group announced plans to introduce legislation in November containing a series of provisions designed to improve care for chronically ill Medicare beneficiaries. The draft legislation released last Thursday includes policy providing for permanent authorization for ALL SNP types and strengthening the role of the CMS Dual Office. These two policies have been a cornerstone of the SNP Alliance's legislative agenda this Congress. The strong, bipartisan endorsement of these policies from the Senate Finance Committee is a huge victory for the SNP Alliance and is an invaluable and necessary first step in our broader policy agenda.

The following outline summarizes the provisions contained in the Discussion Draft of the CHRONIC Care Act of 2016 (dated October 27, 2016) that are of specific interest to the SNP Alliance. The outline also contains comments and/or recommendations on these provisions, recognizing that while the Chronic Care Working Group is not seeking formal comments on this draft legislation, they are interested in hearing from stakeholders.

While there are several areas where we may want to suggest modifications to the legislative draft, it is important for us to remember that this is just the beginning in a long, deliberative process. Final legislation related to SNP policy must be ultimately approved by both the Senate and the House before it can be sent to the President for signature. It is unlikely that this will occur before the spring of 2017, and perhaps as late as May or June. It is also important to remember that it will be infinitely easier to modify elements of a permanent SNP program rather than a program that exists on short-term extensions.

At this point in time, the SNP Alliance's primary effort must focus on building support for SNP permanency for ALL SNP types while we continue to pursue other improvements in the SNP program over time. As SNP Alliance members review this draft chronic care bill, remember that the Senate Finance Committee views it as a policy of provisions that should travel together as a package. We encourage members to carefully review the provisions and share your interests and concerns, knowing that we will have to prioritize our work effort and craft an overall legislative strategy that will maximize our overall chances for success over the long term.

SEC. 201. ALLOWING END-STAGE RENAL DISEASE BENEFICIARIES TO CHOOSE A MEDICARE ADVANTAGE PLAN

This section would allow individuals with ESRD to enroll in any MA plan beginning in 2021. To help eliminate uncertainty for an MA plan related to costs associated with these complex beneficiaries, the standard acquisition charges (SACs) for kidneys would be removed from the benchmark and bid. The Centers for Medicare and Medicaid Services (CMS) would make payments for SACs for an MA enrollee like they currently do for a beneficiary in the fee-for-service program to limit the risk to an MA plan associated with paying for the acquisition of a high number of kidneys. The Secretary of HHS would be required to conduct an evaluation on whether ESRD-specific quality measures should be included in the 5-star quality rating system. The Secretary would also be required to submit a report to Congress on the impact of the provisions of this section related to spending, enrollment and sufficiency of data under the traditional Medicare and Medicare Advantage programs for ESRD beneficiaries.

SNP Alliance Comments/Recommendations

The SNP Alliance is supportive of this provision but requests assurances that whatever ESRD-specific quality measures are developed for MA plans will be applied to C-SNPs specializing in care of persons with ESRD. We also ask, in the spirit of this provision, that:

1. CMS conduct an evaluation as to whether the star quality rating system should include measures for other conditions being considered for development of specialty care arrangements by MA plans (including SNPs).
2. We believe this evaluation should be done as soon as possible for SNPs serving individuals with ESRD and other complex chronic conditions, such as those with SPMI and HIV-AIDS, where there are no measures in the 5-star system of direct relevance to serving these populations. (We will address more fully some of the non-ESRD issues in another part of this outline.)

SEC. 202. PROVISIONS FOR CONTINUED ACCESS TO MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR VULNERABLE POPULATIONS

In this section, the CMS Medicare-Medicaid Coordination Office would be directed to serve as a dedicated point of contact for states to assist with Medicare and Medicaid integration efforts, and the Secretary of HHS would be required to work through this office to establish a unified grievances and appeals process for individuals enrolled in a D-SNP. This section would permanently authorize the I-SNP, D-SNP and C-SNP, if certain requirements are met. By 2020, a D-SNP contract would be required to have a unified grievance and appeals procedure in place, and by 2021, a D-SNP would be required to integrate Medicare and Medicaid behavioral health services. Beginning in 2019, a C-SNP would be required to meet additional requirements to improve care management for the beneficiaries with severe or disabling chronic conditions enrolled in the plan. By December 31, 2019, the Secretary would be required to update the list of chronic conditions eligible for participation in a C-SNP based on the health needs of the

condition, providers and models of care required, and the prevalence of the chronic condition in the general Medicare population. The Secretary may consider implementing the quality star rating system at the plan level for SNPs and all MA plans.

SNP Alliance Comments/Recommendations

1. ***SNP Permanency.*** We strongly commend the Committee's decision to permanently extend ALL SNP types. The special needs populations served through these tailored plans is crucial to provide a more customized option for care coordination to these beneficiaries. There is no other issue of greater importance to the SNP Alliance.
2. ***Federal Coordinated Health Care Office.*** The SNP Alliance commends the Committee for establishing the Federal Coordinated Health Care Office "as a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals," and including having responsibility for "developing regulations and guidance related to the implementation of a unified grievance and appeals process." We propose some minor technical edits to strengthen the language.

   We support the Office establishing:
   a. "Uniform process for disseminating to State Medicaid agencies information" related to contracts between such agencies and SNPs, and
   b. "Basic resources for States interested in exploring" options for states in working with SNPs to advance dual integration integrate care under a D-SNP platform, including provision of "a model contract or other tools" to achieve integration.

   While what is proposed is important to advancing dual integration, we would like to talk with the Committee about further strengthening the authority of the Office, consistent with recommendations put forth by the SNP Alliance and Bipartisan Policy Center,. This includes providing the Office with authority to develop and/or modify policies and procedures necessary to: (1) align procurement and contracting schedules and processes; (2) integrate delivery and notification of benefits and services; (3) coordinate enrollment, including use of a single enrollment card, (4) enable states and CMS to jointly review and oversee dual programs; (5) simplify member material and communication; (6) integrate plan assessments and model of care requirements; (7) align performance measures, data collection and reporting, consumer protections, and grievances and appeals; (6) align payment methods; (8) improve care for high-risk/high-need subgroups; (9) align policies and procedures for C-SNPs and I-SNPs with significant dual eligible enrollment, and (10) provide states with needed financing and support to advance integration.
3. ***Grievance and Appeals.*** We commend the Committee's proposed requirement for the Secretary to establish uniform grievance and appeals procedures, to the extent feasible, with input from States, plans, beneficiaries and their representatives.
   a. We support adopting provisions that "are most protective for the

enrollee and compatible with unified time-frames and consolidated access to external review under an integrated process."

b. We also support provisions related to having a single written notification, single pathway for resolution, and notices written in plain language, including non-English languages, unified timeframes, and requirements for how the plan must process, track, and resolve grievances and appeals.
c. We think it would be useful to work closely with the Federal Coordinated Health Care Office to assess, and perhaps further refine some of the language noted, given new regulatory changes designed to enable further alignment of Medicare and Medicaid G&A functions.
d. We think it would be useful to also align benefits determination as an integral part of this process.

4. ***Full Integration of Behavioral Health Benefits for 2012 and Beyond***. While we have questions about what the requirements might be for how D-SNPs "shall integrate with capitated contracts with States for all Medicaid behavior health benefits", we are very supportive of the intent for SNPs to integrate behavioral health service under a State Medicaid contract. Some of our questions and concerns are:
    a. Will these requirements be developed and promulgated by the Center for Medicare or the Federal Coordinated Health Care Office?
    b. Will the definition of what "integrated" means left up to CMS in promulgating the regulations?
    c. While we support the Committee's interests in advancing integration, building off the SNP platform, we are somewhat concerned that a number of States may be resistant to a requirement to integrate "all" Medicaid behavioral health benefits. We'd suggest that the Committee think about substituting language for "integrating ALL Medicaid behavior health benefits" to requiring D-SNPs to "integrate Medicaid behavioral health benefits in accordance with state policy." It might also be useful to align policies for LTSS as well as behavioral health benefits by incorporating language to "integrating LTSS and behavioral health services in accordance with state Medicaid policy."
    d. Until and unless there are strong requirements and incentives for CMS and States to align Medicare and Medicaid financing, policy and oversight, as contained in recommendations by the SNP Alliance and Bipartisan Policy Center, we are concerned that policy alignment may not occur in a number of states by the 2021 deadline.
    e. We think the provisions included in the current draft provide an important foundation on which to build, but would like to explore ways to strengthen and expedite the overall dual integration process over time.
    f. We would also like to explore how these provisions relate to existing regulatory requirements for FIDESNP.
5. ***Improvements to Severe and Disabling Chronic Conditions***. While we are strongly supportive of a permanent extension of C-SNPs, we have some questions and concerns about several of the related draft provisions.
    a. We are supportive of the C-SNP requirements related to: i)

interdisciplinary teams, ii) face-to-face encounters; iii) rolling initial assessments into individual care plans; iv) having the Secretary take into account whether the plan fulfilled the previous year's goals; and v) having C-SNPs meet minimum benchmarks for model of care elements, recognizing the benchmarks are established by CMS and assuming they are reasonable. We have a few suggestions for strengthening them.

b. We are concerned that the newly proposed definition for severe and disabling chronic conditions to be effective in 2021 may ultimately preclude offering specialty care for persons in need of some important specialty care arrangements, e.g., persons with diabetes. While we are supportive of CMS providing general MA plan more flexibility to specialize in care of certain populations, it's not clear they will be given enough flexibility to provide the kind of specialty care that can be provided through C-SNPs. We would like to work with the Committee to build on the permanency provisions and explore other complementary arrangements for advancing specialized care for persons with complex chronic conditions as outlined by the SNP Alliance.

6. ***Quality Measurement at the Plan Level for SNPs and Determination of Feasibility of Quality Measurement at the Plan level for All MA Plans a**nd use of HOS Survey Instrument.* The SNP Alliance is generally supportive of quality measurement at the plan level and appreciates that a final decision on this provision is at the discretion of the Secretary, after further study. We believe this offers the potential for more accurate quality measurement, reporting, and adjustment. However, there are three complementary issues requiring additional language in order to ensure that the measures are meaningful and that the data methods including sampling are robust enough to provide a dataset that is strong enough to make accurate determinations for special needs populations. These three issues are:
    a. Request to compare high dual plans to other high dual plans (e.g. 51% or higher dual enrollment) in the quality management system,
    b. Provide for measure substitution and targeted exclusions or exceptions for certain measures, e.g., when a person is at end of life, has severe dementia or other cognitive impairment, and has a condition such as AIDS with an indicator (such as viral load) which is more relevant as a quality indicator of care management, and
    c. There is a more robust adjustment of measures for social risk factors that have a demonstrated impact on health outcomes—independent of care provision or care organization. Thus, we request that the Committee consider requiring the Secretary to more completely account for social risk factors of enrolled populations (such as seen among the dually-eligible) on Star performance ratings before this action is taken in order for there to be a fair comparison of performance. This is particularly important when SNPs are compared with general MA plans that have few or no dual beneficiaries enrolled.

Finally, we note that the Health Outcomes Survey is overdue for review and tailoring to accommodate diverse subpopulations of Medicare beneficiaries. Specifically, the HOS instrument and data sampling methodology needs to be revised to better reflect the diversity of the beneficiary population in terms of

culture, language, and health literacy, and the instrument and data collection methods must be revised to accommodate special populations so that these individuals can participate in the quality measurement process and so that the items asked in the self-report section of the instrument are meaningful and conclusions drawn are likewise meaningful and accurate.

7. ***GAO Study of States Contracting With Managed Care Entities for Medicaid Long Term Services and Supports Delivery and With Dual SNPs Under MA***. The SNP Alliance is strongly supportive of aligning MA and Medicaid LTSS for duals under the SNP platform. We also appreciate and are supportive of a GAO study. However, the purpose of the study is not clear. What is Congress seeking to learn?
8. ***MedPAC Study and Report on State-Level Integration Between Dual SNPs and Medicaid.*** We are also supportive of the proposed MedPAC study, but want to caution Congress that dual integration is still an evolving art. It is not possible for SNPs to fully integrate benefits and services until and unless CMS and States establish payment, policy and oversight structures that enable rather than impede full integration. Whatever analysis is done needs to take these developmental aspects of integration into consideration.
9. ***ASPE Study.*** Once the ASPE study to identify social risk factors that affect the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment is released, we would like to work with the Committee in exploring other policy options for improving SNP performance ratings in ways that more fully account for social factors and factors related to care complexity in performance ratings. We would also like to explore methods that more fully account for the vast array of unique differences that exist within the dual population and that are important for plans specializing in care of certain targeted subgroups.

SEC. 302. EXPANDING SUPPLEMENTAL BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL MEDICAID ADVANTAGE ENROLLEES

In this section, the bill would authorize the Secretary to waive the uniformity of benefits requirements for Medicare Advantage enrollees with chronic conditions. The bill also would expand the definition of supplemental benefits to allow a Medicare Advantage plan to provide benefits that have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and these supplemental benefits may not be limited to being primarily health related benefits.

SNP Alliance Comments/Recommendations

The SNP Alliance supports providing general MA plans increased flexibility to tailor benefits and services for persons with certain chronic conditions. However, while C-SNPs are allowed to exclusively serve certain Medicare subgroups, they currently are required to follow the same payment and program requirements of general MA plans, including rules regarding uniformity of benefits, restrictions on supplemental benefits, payment bids, marketing, contracting, audits, and

compliance. Some of the features being considered for general MA plans have never been made available to C-SNPs. For example, currently, C-SNPs are not allowed to provide additional supplemental benefits that are not presently allowed by general MA plans. Such supplemental benefits may be non-medical in nature but contribute directly to improved health care outcomes for chronically ill beneficiaries. Additionally, SNPs are not allowed to reduce cost sharing for items/services by site of service nor are they permitted to adjust provider network requirements beyond what is permitted by other MA plans for the purpose of providing care focused on preventing, delaying or minimizing disease progression.

To enable C-SNPs to fulfill their Congressional mandate, Congress should require CMS to:

- Provide C-SNPs at least as much flexibility as it provides to general MA plans in establishing specialty care programs
- Provide C-SNPs with additional flexibility to fundamentally transform benefits and provider operations in accordance with whatever is necessary to prevent, delay or minimize disease and disability progression as beneficiary's condition(s) evolve over time. This could include non-medical benefits and services, including custodial services that change the trajectory of health outcomes, caregiver support activities, and interventions designed to alleviate the adverse effects of social determinants of health.

It is important to clarify how this provision relates to supplemental benefit requirements for FIDESNPs and other SNP types as well as other flexibilities that may be considered for general MA plans seeking to specialize in care of certain chronic conditions.

SEC. 401. ENSURING ACCURATE PAYMENT FOR CHRONICALLY ILL INDIVIDUALS

In this section, the Secretary would be required for 2019 and later years:

- To make payment adjustments to account for the total number of diseases and conditions that a Medicare Advantage enrollee has (with adjustments as the number of diseases/conditions increases);
- To use two years of diagnostic data;
- To make separate adjustments for full benefit dual eligibles and partial dual eligibles;
- To evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model; and
- To evaluate the impact of including diagnosis codes related to the severity of chronic kidney disease in the risk adjustment model.

SNP Alliance Comments/Recommendations

We applaud the Committee's effort to make further refinements to the HCC to help eliminate disincentives for targeting and serving high-risk/high-need persons as a matter of priority. We are particularly supportive of CMS evaluating the impact of including

additional diagnosis codes related to mental health, substance abuse, and the severity of chronic kidney disease.

While applying more than one year of data to the HCC model may improve the accuracy of payment in some cases, we have not seen analyses of these options sufficient to fully understand the magnitude of the change on populations served by various SNPs. There are also a variety of methods that CMS could use to calculate the number of conditions; depending on which one is applied, the level of improvement in payment accuracy and related adjustment in payment could vary. We would encourage the Committee to work closely with CMS during implementation to help ensure implementation of these provisions have the effect intended by the Committee.

We would appreciate further clarification of what the Committee has in mind regarding making separate adjustments for full benefit duals and partial benefit duals.