



A National Nonprofit Leadership Organization

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To: Seema Verma, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–
Baltimore, MD 21244–8013

**Federal Register Notice Vol. 83, No. 217, published Thursday, November 8, 2018;
Document Identifier CMS–10565 and CMS– 10325**

AND

**To: Kathryn Coleman, Director, Medicare Drug & Health Plan Contract
Administration Group, CMS**

Medicare Part C Policy Mailbox <https://dpap.lmi.org>

The Federal Register notice published November 8, 2018 sets out a summary of the use and burden associated with the following information collections: CMS–10565 - Off-cycle Submission of Summaries of Model of Care Changes and CMS–10325 - Disclosure and Recordkeeping Requirements for Grandfathered Health Plans under the Affordable Care Act.

The first information collection type, and what we are commenting in this response letter, refers to off-cycle submission of summaries of Model of Care Changes which the ACA, Section 3205e requires for all SNPs, that their MOC be approved by NCQA. This approval is based on NCQA's evaluation of SNPs MOC narratives using MOC scoring guidelines. The Bipartisan Budget Act (BBA) of 2018, Section 50311 modified the MOC requirements for C-SNPs in section 1859(b)(6)(B)(iii) of the Act, specifically requiring that beginning in 2020, C-SNPs will submit MOCs annually for evaluation and approval.

On November 28, 2018, Kathryn A. Coleman, Director of the Medicare Drug & Health Plan Contract Administration Group provided further guidance from the Centers for Medicare and Medicaid Services (CMS) via a memo to Medicare Advantage Special Needs Plans RE: *Changes to the Model of Care Submission Requirements for Special Needs Plans*.

This memo clarified that beginning with CY 2020, C-SNPs may only receive MOC approvals for a period of one-year, regardless of whether their MOC achieved a high mark in scoring, allowing for two-year or three-year review cycles.

This memo further refers to section 1859(f)(5)(B)(v) of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) that requires a minimum scoring benchmark for each element of a C-SNPs Model of Care and permits approval only if each element of the MOC meets the applicable minimum benchmark.

Finally, the memo states that CMS will pursue rulemaking to adopt new scoring benchmarks beginning in 2021 and states that: “*given that population needs are similar across all SNP types, will also apply the new scoring benchmarks to D-SNPs and I-SNPs.*”

Special Needs Plan Alliance Comments:

Considerations

We have identified four important issues in moving forward and ask CMS to carefully consider these and the implications:

- 1) ***Undue Burden*** - Unnecessary paperwork and burden on C-SNPs without benefit and over and above all other Medicare Advantage plans and other SNP types. Based on selected information from a set of health plans, the proposed change will increase administrative and paperwork burden on C-SNPs—not reduce burden. It is the review/revision process, not the submission process which is the greater burden. One health plan estimated that this change to an annual MOC review would require approximately 100 additional hours each year. This includes involvement of a range of clinical, quality, and program management individuals, with review by others within the organization and confirmation and approval.
- 2) ***Substantial Differences in Populations by SNP Type*** – We do not agree at all that all SNP populations are the same. This is antithetical to why the different SNP types were established in the first time and is counter to the Model of Care elements and focus. We recommend greater attention to recognize the substantial and important differences between SNP types, their populations, care management approaches, tailored care, and the legislative intent in forming the different SNP types in the original legislation. We do not believe the intent of the section of the BBA referenced was to eliminate the different SNP types or discount population characteristic differences that need to drive model of care and care management approaches.
- 3) ***Limitations in MOC Template and Challenges with Review*** – There are current anomalies and constraints within the existing Model of Care template which need fixing. This also

complicates the development by the plan and review by NCQA. This hampers the ability of plans to effectively describe their tailored care approaches within their D-SNP, I-SNP, or C-SNP—as there are frequently sub-group populations within these plans. These plans work with clinical, behavioral health, and long-term services and support experts to customize their approach for assessment, team development and communication, care planning and follow-up, and quality improvement focus areas. The plans also work to identify unique characteristics, social and other risk factors, and emerging best practices. These will be very different by population-subgroup and chronic conditions. The plans currently attempt to describe these tailored care approaches for each subgroup population within the current “one size” Model of Care template. This can lead to confusion when reviewers attempt to trace the elements from population through to care management approaches. We recommend improvement.

- 4) ***Potential for Unintended Harm*** – Based on the guidance issued to date, we see the need for greater stakeholder input and attention to the Model of Care to ensure that the approach is sound, reasonable, useful, and does not cause unintended harm to SNPs or the complex, vulnerable populations that they serve.

Feasible Approaches/Options

C-SNP Review - We believe statutory intent may allow for recognition of the process currently used to review MOCs of CSNPs, based on how well they have addressed the MOC elements, with a 1-2, or 3 year cycle approval as the starting point. An annual check-in and notification by each C-SNP with NCQA could still be followed as the legislation states. However, if the plan received high scores, (2 or 3-year cycle) an additional full MOC review would be conducted ONLY if there were substantial and significant changes in their population or their care model. The definition of “significant or substantial change” would be defined by CMS with clarity. We recommend that the process for annual check-in be simple, carry no additional fees, and that the auditor checking in be the same person who conducted the full review (if at all possible). We recommend that any challenge of the MOC in an expedited check-in process provide specific guidance on changes that could be made and certified by the plan without additional subsequent review. Finally, we recommend that CMS and NCQA clarify the timetable for quality improvement actions around any of the MOC elements—if they require more than one year, this should be taken into account in the annual check-in process.

Population Differences - We do not agree that I-SNP, D-SNP and C-SNP populations are similar- in fact they are quite different. Therefore, while the key domains or elements to address may be similar, the benchmarks, targets, and sub-elements may not. We’d appreciate greater attention to this issue of benchmarks and what they should address and where differentiation based on population differences is warranted. This is a very important issue.

MOC Template Suppresses Customized Differentiation - We request greater attention to the formatting/template for MOC where there is already difficulty when one SNP has several

different sub-groups within its enrollment and the plan has enhancements for each, through a triaged or customized approach . We request that CMS consider changes to the MOC format/template —that it be modified to allow for the plan to better identify, describe, or trace the customization for each sub-group.

Need for Stakeholder Input – There is the potential for greater burden, unnecessary paperwork, administrative costs, and other consequences that could harm both special needs plans and the people they serve by diverting resources without benefit to the consumer. We ask that all types of SNPs and the SNP Alliance be involved as a key stakeholder group, together with others, to offer insights.

Thank you for the opportunity to comment. We look forward to working with CMS and NCQA, at their invitation, to further develop guidelines which follow the intent of the law and provide benefit to consumers while balancing burden on plans.

We are pleased to discuss this further if you have questions or request additional information. I am be reached by phone at (202) 204-8003 or by email at cphillips@snpalliance.org.

Respectfully submitted,

A handwritten signature in black ink that reads "Cheryl Phillips, MD". The signature is written in a cursive, flowing style.

Cheryl Phillips, M.D.

President and CEO, Special Needs Plan Alliance