To: Tim Engelhardt, Director  
The Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”)  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244  

Submitted via electronic submission to MMCOcomments@cms.hhs.gov.

Re: Request for Public Comment on Massachusetts Medicare-Medicaid Integration Demonstration: 
Duals Demonstration 2.0

From: Cheryl Phillips, M.D.  
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Dear Tim Engelhardt,

On behalf of the SNP Alliance, thank you for the opportunity to comments on the proposed 
Massachusetts Duals Demonstration 2.0.

We are very intrigued by the sophistication of this proposal in how it has blended features of current 
demonstrations with existing D-SNP and MA requirements. We think it creates a unique opportunity for 
resolving some of the differences between current multiple platforms for integration of Medicare and 
Medicaid service delivery to dually eligible beneficiaries.

In general, the overall policy, design and carefully chosen features accommodating similarities and 
differences between SCO and OneCare programs and populations is impressive. We certainly can 
understand why the state would want an overarching structure encompassing and better aligning the 
SCO D-SNP and One Care MMP programs. The choices of which features to retain from each platform 
and which to align appear to be practical, reasonable and comprehensive as well as reflective of state 
level local stakeholder input and sophisticated technical expertise. The proposal especially aligns with 
SNP Alliance concerns about the need for development of tailored performance measures appropriate 
for the under 65 population and in our comments below, we are providing an outline of some principles 
that we think can be helpful when considering this aspect of the proposal. We appreciate the inclusion of 
refined models for determining shared savings with states and for incorporating advanced payment or 
value based purchasing models into Medicare-Medicaid programs for dually eligible populations. We 
can also see the potential for such a proposal to result in the advancement of integration through new 
learning opportunities beyond the state of Massachusetts.

However, a proposal of this importance naturally raises a host of questions, and considerations that we 
hope will be constructive as outlined below. Most of our questions relate to which authorities and/or 
waivers of current requirements are necessary for such a demonstration and whether some features 
integral to this demonstration could be implemented under current or newly expanded authorities for 
integration of Medicare and Medicaid as provided under the Balanced Budget Act. In addition to 
providing SNP permanency and outlining additional requirements for integration, the BBA provided
new regulatory authorities to MMCO through amendments to Section 2602(d) of Public Law 111–148 (42 U.S.C. 1315b(d)) by adding the following:

“(8) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the integration or alignment of policy and oversight under the Medicare program under title XVIII of such Act and the Medicaid program under title XIX of such Act regarding specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section 1859.”

We have discussed this language with the Congressional offices of its authors and believe it could be useful in moving toward alignment of some of the very technical and operational features required for program integration, including some of the incremental approaches needed to accommodate some states. Our understanding is that this added MMCO authority was meant to be broadly interpreted in order to address the myriad of often unforeseen barriers that continue to complicate state and plan efforts to align and/or simplify basic operational features fundamental to integration. Rather than having Congress address each potential technical and procedural issue, and realizing also that it is not possible to manage 50 different models, we think it is important that CMS have authority to work with states and plans to develop a menu of practical approaches to these operational issues, utilizing current FAI and FIDE-SNP demonstration and FIDE SNP experience as well as incorporating improvements to existing approaches under the D-SNP platform.

Now that Congress has granted permanency to D-SNPs (contingent on adoption of integrated features) as well as providing this additional MMCO authority for alignment of program policies, we have been hopeful that integration efforts would be accelerated through strategic enhancements to the FIDE-SNP platform that could be extended to other states and FIDE-SNPs. We are expecting that CMS will soon be issuing guidance related to the new BBA requirements for integration and Grievance and Appeals. We would hope such guidance will incorporate experience from the current FAI and Minnesota D-SNP demonstrations and enable relatively quick adoption of some of these strategic enhancements for D-SNP operations and policies without requiring further demonstration authority. These current demonstrations have already tested a number of features that also seem to be implicitly included or proposed as part of this Duals Demonstration 2.0, (such as the use of three-way contracts, integrated member materials including member handbooks, dual specific networks, integrating MLTSS requirements with Models of Care and expanded passive enrollments.) So, while we are supportive of these features being included in the design of this new program, we question whether it is necessary to continue to seek waivers to accomplish them or to specifically include them under demonstration authority.

Ultimately, we are concerned that making these features part of a new temporary demonstration might imply that they are still being tested, therefore impeding the ability to move forward with extension of these features to other FIDE or highly integrated D-SNPs under that permanent platform, while CMS awaits results of another comprehensive demonstration and its required evaluation conducted through CMMI authority under Section 1115A. A number of states have invested in D-SNP contracting, pushing for D-SNPs to become permanent, partly because they favored a more permanent platform over the uncertainty of a temporary demonstration. It is important that CMS not wait for conclusions from new demonstrations prior to allowing them to move forward with access to well established improvements that could be made to the permanent D-SNP platform. Finally, while this is indeed an
impressive proposal, we know that some states will find this comprehensive approach too daunting, and we hope that other more incremental pathways to integration can continue to be pursued for those situations.

In order to better understand the differences between the current and new authorities and what is possible for the future of integrated options within and without demonstration structures, we would like to know more about the authorities and waivers that would be used and/or are deemed necessary for this new demonstration. We can understand that some features such as the shared savings, and Medicare payment changes would have to be done under CMMI 1115A authority and also that for many reasons, CMS would want to bundle up all of the changes into one demonstration for evaluation and management purposes. However we continue to hope that some features will be or can be done outside of demonstration authority in order to allow integration to move forward without having to wait for the often prolonged results of yet another demonstration evaluation. This generates the following questions:

- Can CMS outline which of the operational components of the proposed demo (as outlined in the proposal) would or could be accomplished through the following authorities?
  - CMMI 1115A
  - New BBA Integration Requirements
  - BBA MCO authorities including added language regarding responsibility for developing regulations and guidance for alignment of Medicare and Medicaid policy and oversight
  - Current D-SNP authorities
  - Medicaid waivers
  - Other authorities

- What is the default status for any plan and operational or procedural policy that is not explicitly required for the demonstration? Could CMS clarify which parts of this demonstration could be done under the current FIDE-SNP platform, or with some global enhancements under the new authorities provided to CMS and the MMCO and ensure that only the provisions that require specific waivers of statute be included under this demonstration?

- This clarification would also be helpful in understanding what the future pathway for the two types of plans involved would be when the demonstration is completed, i.e.:
  - Do SCOs remain D-SNPs under this new demo or would they be considered MMPs?
  - Do One Care MMPs become D-SNPs or would they still be considered MMPs?

- What waivers of Part D provisions are required?
  - For example, currently under the FAI, states have been allowed to choose to waive the new SEP restrictions (the move from monthly to quarterly) that are being implemented for 2019. As part of the FAI extension, it is our understanding that dually eligible beneficiaries enrolled in PDPs who would normally be restricted to a quarterly SEP will be allowed to move out of the PDP into a One Care MMP in any month similar to the older Medicare policy. However, this provision does not apply to integrated D-SNPs. Therefore, we understand that prospective D-SNP members (such as those seeking to enroll in SCO) would not have the same opportunity.
Under the passive enrollment proposals in the proposed 2.0 demo, would members seeking to enroll in D-SNP SCOs also be allowed to leave the PDP at any time, in order to facilitate enrollment alignment opportunities and effective dates with proposed state passive enrollment changes?

- Is our understanding correct that Medicare and Medicaid rates would be set and paid separately under this demonstration though there would be both a combined and separate MLRs?
  - Are we correct in understanding that plans can continue to combine Medicare and Medicaid funds (such as Medicare cost sharing if the state chooses to do so) at the plan level to pay providers under VBP or APMs without requiring a CMS waiver?

- We understand that this proposal includes Medicaid withholds and Medicare bonus payment opportunities as well as risk corridors and both separate and combined MLRs. Since this is a very complex design with many moving elements, we are not able to discern exactly how the expected savings are achieved or calculated. Can CMS provide further information on the relationship between capitation payments to participating plans and the shared savings model, specifically, is there a proposed “claw back” of capitations already paid out as part of the shared savings model after the determination of any savings is evaluated, or is there another method proposed? Will the shared savings impact trust fund projections or future D-SNP rates? We hope that the ultimate MLR calculation methods for shared savings can overcome tensions related to cross-subsidizations between funding sources and the ability to use aggregate dollars flexibly to deploy services as appropriate to the needs of individuals and we assume more work will be done on this part of the financial design prior to implementation. We know that it is imperative that this demonstration is financially sustainable. We hope this proposal can provide a critical opportunity to explore these new approaches to shared savings and rate setting with careful testing in planning and demonstration modes prior to consideration or adoption of any new policies.

- If approved, would CMS consider application of this model or features of this model to other states? If so, would those states have to wait until this demonstration is completed for that to be allowed?

As noted earlier, we are very appreciative of and interested in this proposal’s attention to the need for measurement alignment between Medicaid, ACOs and Medicare Stars and across both fee for service and managed care, with special attention to more appropriate measures for the under 65 dually eligible population. The SNP Alliance has been consulting with many experts, clinicians and policy makers on this topic and has developed a set of measurement principles shared below. These might be helpful to CMS in the review or development of further detail for this proposal and to those involved in the demonstration should it move forward. We recommend that the demonstration consider:

- Alignment across Medicare MAO, hospital, physician, home health, and ACO etc. programs and Medicaid LTSS programs toward having a core set of key meaningful chronic care and behavioral health quality measures and ensuring identical measure specifications on at least a core set of measures to avoid unnecessary complexity, duplicity, and burden and to align quality improvement efforts.
• The critical influence of social determinant of health risk factors on health outcomes observed, with specific methods in the Demo to identify and address SDOH factors in the care management approach and include in quality measurement systems.

• Setting up the value-based payment, rewards, incentives so that they are, at least in part, tied to longitudinal, not episodic, outcomes and are used to drive collective action around a core set of quality targets, versus dividing QI efforts through attribution or payment to smaller units (e.g. settings/providers).

• Ensuring stratification in reporting quality outcomes where there is substantial difference in the enrolled populations - that is, if demo organizations have significantly different enrollee characteristics (age, racial composition, urban/rural, low-income, care complexity, etc.) displaying measure results that groups like organizations together.

Again, we very much appreciate the opportunity to review and comment on this proposal, and look forward to following its progress as it evolves. We think it has great potential to educate all involved in integration activities as to future options to improve delivery of Medicare and Medicaid services for dually eligible populations and we believe it should move forward. However, we hope that its approval will not inhibit long awaited efforts to enhance the permanent D-SNP platform in order to facilitate increased integration for other states, FIDE and D-SNPs. We ask that CMS use its new authority to extend operational features that have already been tested as well as other practical modifications to other states and FIDE and D-SNPs.

We continue to appreciate MMCO’s leadership and the hard work you and your staff are doing to move integrated programs forward each day. We look forward to our continued conversations about how we can be most helpful in our mutual goals to improve service delivery for people with dual eligibility.

Respectfully,

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