Integrated Care Resource Center

Spotlight: New Medicare Advantage Rates and CMS Guidance: Implications for States Seeking to Better Integrate Services for Medicare-Medicaid Enrollees

On April 4, 2016, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. (The CY Advance Notice and draft Call Letter were issued on February 19, 2016. See information about key areas on which states were invited to comment in State Comments Invited on CMS' Draft Medicare Advantage Rates and Guidance for States Seeking to Integrate Care for Dual Eligible Beneficiaries).

The April 4 announcement includes information relevant for states participating in capitated model financial alignment demonstrations or contracting with Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs). Following are highlights by topic area:

Medicare Advantage Rates

- **New HCC Risk Adjustment Model.** CMS finalized proposed changes to the HCC risk adjustment model that will help improve payment accuracy, including addressing under-prediction of costs for full benefit dually eligible enrollees, particularly for individuals residing in the community. Adopted changes include:
    - Transiting from one to six community segments (non-dual aged, non-dual disabled, full benefit dual aged, full benefit dual disabled, partial benefit dual aged, partial benefit dual disabled) that will allow more accurate cost prediction for each group.
    - New adjustments for disease interactions, including a "psych HCC group x substance abuse HCC group" for individuals who qualify on the basis of a disability. This could result in more accurate risk scores for plans that enroll a significant number of members with co-morbid mental health and substance abuse conditions.
- **Expected Average Change in MA Plan Payments.** CMS issued a fact sheet on April 4 that estimates the impact of policy changes and coding trends on MA revenue for 2017. This estimate is based on an average of all MA plans (which tend to enroll disproportionality fewer Medicare-Medicaid enrollees as compared to their distribution in fee-for-service Medicare), and individual plan experience will vary.
- **Updated FIDE SNP Frailty Factors.** The 2017 Announcement finalizes the frailty factors for FIDE SNPs as proposed in the Advanced Notice (p. 60). This may result in higher rates for FIDE SNPs that have enrollees with frailty levels comparable to those in PACE.

Provisions related to D-SNPs

- **Non-Renewals.** In response to broad support in public comments, CMS will develop procedures to provide early notification to states of pending non-renewals, service area

reductions, and terminations of integrated D-SNPs that deliver Medicaid benefits. Early notification will allow states to make preparations to minimize any disruption in service delivery to plan enrollees. CMS will work with states and plans to develop procedures for early notification and to improve the model nonrenewal notice (p. 185).

- **Model of Care (MOC).** CMS will create a process for interested states to add specificity to the CMS MOC review criteria for D-SNPs that deliver Medicaid LTSS, and plans to develop a process for concurrent state and NCQA review of D-SNP MOCs. CMS notes that the joint review process would not change the current CMS requirements for review and approval of D-SNP MOCs by NCQA. Lastly, CMS reminds states that they may use their D-SNP MIPPA contracts to require that the MOC address delivery of Medicaid benefits, in particular LTSS, and to require their contracted D-SNPs to revise their MOCs to meet state requirements (pp. 185-186).
- **Marketing Materials.** In response to comments in support of using CMS administrative flexibility to further the use of integrated model marketing materials to more states, CMS will explore the feasibility of allowing integrated D-SNPs to use existing model material templates developed in the Financial Alignment Initiative demonstrations in lieu of the Medicare Advantage and Part D models (p. 184).

Medicare-Medicaid Plans (MMPs)

- The Call Letter addresses various topics including network adequacy, model of care, formulary and supplemental drug files, integrated plan benefit package submissions, and the use of past performance information to determine eligibility for passive enrollment that are relevant to MMPs participating in the capitated financial alignment demonstrations. MMPS should review the MMP-specific section of the Call Letter (pp. 223-227) to ensure compliance with any new demonstration requirements. In addition, CMS issued a memorandum on April 8 providing guidance about which provisions in other sections of the Call Letter do and not apply to MMPs.

Other Related Topics

- **MA Star Ratings.** CMS will implement an interim analytical adjustment to address the impact on star ratings for plans with disproportionate enrollment of dually eligible beneficiaries, beneficiaries who receive the Part D low income subsidy (LIS), and beneficiaries entitled to Medicare because of a disability. The Categorical Adjustment Index (CAI), will be implemented for the 2017 Star Ratings, and CMS will request comments on an annual basis as to the subset of measures to be included for adjustment in succeeding years. For the 2017 ratings, the rating-specific adjustment factor that will be applied to contracts' overall and summary Star Ratings using the plan proportion of LIS, dually eligible and disabled beneficiaries. CMS will continue to perform additional research and collaborate with stakeholders to determine what is driving any differences in Star Ratings for plans with a higher composition of these beneficiaries. The final Call Letter includes details of the CAI methodology (pp. 118-138).

  CMS also described new measures under consideration for 2018 and beyond. Of interest to states and plans integrating care for dually eligible beneficiaries, CMS continues to request comments on care coordination measures that could be developed using MA encounter data (p. 140).

- **Prohibition on Billing Medicare-Medicaid Enrollees for Medicare Cost-Sharing.** CMS reminds all MA plans about their obligation to protect dually eligible beneficiaries from incurring liability for Medicare cost-sharing by educating providers about applicable billing prohibitions. Federal law prohibits balance billing of this population and exempts QMB individuals from paying any Medicare cost-sharing, regardless of whether a state pays providers the full amount of Medicare deductibles, coinsurance, and copayments. Under CMS

regulations, plans must specify billing prohibitions in contracts with providers and are encouraged to conduct affirmative outreach to providers to address common points of confusion and problems areas revealed by plan grievance and Complaint Tracking Module data. CMS reiterates that this remains a high-priority issue and continues to explore further measures and administrative options to address and track billing problems and to promote adherence to billing rules.

Related Resource

- Key 2016 Medicare Dates (Integrated Care Resource Center/April 2016). This calendar of key Medicare dates should assist states and health plans in the implementation of integrated Medicare and Medicaid programs for dually eligible beneficiaries. The calendar is found on the home page of the ICRC website. ICRC's monthly newsletter, the *Integrated Care Update*, also notes important upcoming dates. Because states may not be familiar with the events in the calendar, ICRC publishes frequent e-alerts to explain those activities and any actions that states should be considering related to the implementation of integrated care programs for Medicare-Medicaid enrollees.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for individuals dually eligible for Medicare and Medicaid. The state technical assistance activities are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit http://www.integratedcareresourcecenter.com.