Integrated Care Resource Center

April 11, 2017

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

On April 3, 2017, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information. (The CY 2018 Advance Notice and Draft Call Letter were issued on February 1, 2017. 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 3 announcement includes information relevant for states contracting with Medicare-Medicaid Plans (MMPs) participating in capitated model financial alignment demonstrations or with Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs). Highlights of the announcement are summarized below, with references to the specific pages where more detail is available. There is a calendar showing key dates and timelines for Medicare Advantage and Part D operational activities in calendar year 2017 and early 2018 on pp. 69-76.

Request for Information

The announcement includes a request for information on pp. 8-9 in which CMS solicits ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to promote innovative approaches for providing Medicare Advantage and Part D benefits. Responses may be submitted through ***April 24, 2017*** at PartCDcomments@cms.hhs.gov and should include "2017 Transformation Ideas" in the subject line.

Medicare Advantage Rates

- **Expected Average Change in MA Plan Revenue.** CMS issued a fact sheet on the April 3 announcement estimating that policy changes described in the 2018 rate announcement will increase plan revenue on average by 0.45 percent in 2018 (up from 0.25 percent in the February 1 Advance Notice), which, along with the expected growth in coding intensity, will bring the total expected average increase in revenue to 2.95 percent (up from 2.75 percent in the February 1 Advance Notice). 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.

Provisions Related to D-SNPs

- **SNP-Specific Networks** (pp. 138-139)**.** Given the different needs of SNP populations and based on the feedback from SNP stakeholders, CMS will move forward on developing SNP-specific network adequacy evaluations. CMS will work with MA organizations, providers, and other key stakeholders to better understand SNP networks and improve SNP enrollee health care experiences.

- **Plans with Low Enrollment** (p. 115). In March 2017, CMS sent MA organizations a list of plans that it does not intend to renew due to low enrollment. The list includes D-SNPs with fewer than 100 enrollees that have operated for three or more years as of March 2017. MA organizations must eliminate such plans, consolidate them with others, or provide a justification for renewal. CMS will

consider special factors that lead to low enrollment, such as specific populations and geographic location, in making renewal decisions.

- **Maximum Out-of-Pocket (MOOP) Limits** (pp.120-122). CMS released mandatory and voluntary MOOP range amounts for various plan types for 2018. Currently, D-SNPs have the option to limit cost sharing for enrollees to $0. If a D-SNP does charge cost sharing for Part A and B benefits, it must track enrollees' out-of-pocket spending to make sure MOOP limits are not exceeded.

Medicare-Medicaid Plans (MMPs)

- **Section IV - Medicare-Medicaid Plans** (pp. 165 - 171). CMS again incorporated annual guidance specific to MMPs in this year's Call Letter. It provides an overview of the CY 2018 Medicare requirements and timeframes for MMPs, including network adequacy determinations, models of care, formulary and supplementary drug files, and plan benefit packages. CMS provides links to other previously released guidance on p. 165. CMS also reiterates its policy regarding the use of past performance information for determining MMP eligibility for passive and opt-in enrollment. CMS will consider ways to improve DME alignment, network adequacy determinations, culture competence resources, and Additional Demonstration Drug (ADD) file submissions based on commenter feedback.

- **Medicare-Medicaid Coordination Office April 4 Memo to MMPs.** MMCO provided further guidance on the applicability of the CY 2018 Final Call Letter provisions to MMPs in a separate memo sent to the plans on April 4. A six-page table shows which provisions do and do not apply to MMPs, and which partially apply. The table also includes comments and references to additional guidance.

Enhancements to the 2018 Star Ratings and Beyond

MMPs are required to report on all Part C and D quality measures, including SNP-only and display measures. The summaries below highlight aspects of the Star Ratings likely to be of most interest to states, MMPs, and D-SNPs, with an emphasis on changes since the February 1, 2017 Draft Call Letter.

- **Modifications to Measures for 2018** (pp. 79-84)**.** CMS will add one new measure, Medication Reconciliation Post Discharge (Part C) and return one measure, Improving Bladder Control (Part C) for 2018. One measure, High Risk Medication (Part D), will be removed from the Star Ratings and moved to the display page for 2018. CMS will also make some changes to update and enhance measures.
- **Adjusting Star Ratings for Audits and Enforcement Actions** (pp. 84-86). In a March 8, 2016 HPMS memo, CMS suspended the reduction in the overall and summary Star Ratings of contracts that are under sanction while CMS re-evaluates the impact of sanctions, audits, and civil money penalties (CMPs) on the Star Ratings. Specific audit findings could lead to CMPs or sanctions that lower performance on the Beneficiary Access and Performance Problems (BAPP) measure. After consideration of feedback, CMS will retain the current BAPP measure in the 2018 Star Ratings, and not reinstate the reduction in the overall and summary Star Ratings of contracts that are under sanction for 2018. For 2019, CMS intends to retire the current BAPP measure and introduce a revised BAPP measure on the 2019 display page. CMS will continue its dialogue with stakeholders and examine the interplay between audits, compliance/enforcement actions, and the Star Ratings, as well as further specification changes to the BAPP measure and the role it should play in Star Ratings.
- **2018 Categorical Adjustment Index (CAI)** (pp. 89-95). CMS implemented a new interim analytic adjustment to a subset of Star Rating measures in CY 2017 to adjust for the impact on measure performance of plan enrollment of dually eligible enrollees and enrollees receiving the low income subsidy, as well as enrollees with disabilities. CMS will continue to use the same methodology for CY 2018, using updated information.
- **2018 Display Measures** (pp. 97-103). Display measures are not part of the Star Ratings but include measures being tested for inclusion in the future. New or revised measures for 2018 that may be of interest to states include: Formulary Administration Analysis, High Risk Medication, Drug-Drug

Interactions, Antipsychotic Use in Persons with Dementia, and Use of Opioids from Multiple Providers in Persons without Cancer (to be added to the 2019 Part D display page). The final 2018 Call Letter describes slight changes to methodologies and reporting requirements for some of these measures. In response to comments received, CMS decided against reporting the Non-Recommended Prostate-Specific Antigen-Based Screening in Older Men measure on the 2018 display page (p. 99).

- **Forecasting to 2019 and Beyond** (pp.103-109). CMS described several changes to existing measures or potential new measures that may be of particular interest to states seeking to integrate care for their dually eligible populations:
    - **Frequency of Patient Safety Reporting** (p. 104)**.** CMS had proposed to change the frequency with which it generates Patient Safety Reports for Part D contracts from monthly to quarterly. However, based on sponsor feedback, it will continue to post monthly reports and send quarterly outlier notices.
    - **Existing Care Coordination Measures** (p. 105**).** CMS had proposed to increase the weight of care coordination and transitions measures starting in 2019, but it has decided not to move forward with changes at this time.
    - **New Transition of Care Measure** (pp. 107-108)**.** CMS received feedback on a new HEDIS transition of care measure with four indicators (notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge), and has shared all comments with the National Committee for Quality Assurance.
    - **Follow-up after ED Visit for Patients with Multiple Chronic Conditions** (p.108)**.** CMS is considering a new HEDIS measure assessing follow-up after an ED visit for patients with multiple chronic conditions.

Other Updates to Medicare Advantage and Part D Affecting D-SNPs

- **CMS Monitoring and Compliance Activities Regarding Encounter Data** (pp. 130-135). CMS has been conducting basic monitoring of MA organizations' encounter data submissions since 2012 and will now be using performance measures related to encounter data submission to guide oversight and enforcement in this area, with the goal of further ensuring complete and accurate submissions. CMS is implementing compliance actions for some failures to comply with regulatory submission standards and will include MMPs in these efforts as appropriate.
- **Changes to Opioid Overutilization Monitoring in Part D** (pp.153-161). CMS finalized a number of changes to measure criteria for identifying individuals with potentially unsafe levels of opioid prescriptions. These include reducing the measure timeframe from 12 to six months, modifying dose specifications, and grouping providers to reduce false positives. Although CMS will not finalize a proposal for all Part D sponsors to implement a formulary-level hard opioid safety edit, it expects sponsors to implement at least a soft edit and provides guidance on a formulary-level soft edit. CMS noted that the rulemaking process for the Comprehensive Addiction and Recovery Act is underway; it will address how implementation of this Act affects its opioid policy as soon as possible. Starting in 2018, CMS expects sponsors to implement revised internal opioid overutilization identification criteria. Specifically, dosage identification should not exceed an average daily morphine equivalent dose of 90mg for any duration during measurement periods.