Integrated Care Resource Center

December 07, 2017

Spotlight: Additional Detail on Selected CMS Proposed Changes for Medicare Advantage and the Prescription Drug Benefit Program

This Spotlight is a follow-up to the November 22 ICRC e-alert on the Centers for Medicare & Medicaid Services (CMS)' proposed policy changes and updates for Medicare Advantage (MA) and the Part D prescription drug benefit. In this Spotlight, ICRC presents a more detailed description of some of the proposed changes that may be of special interest to states planning or operating integrated programs for dually eligible Medicare-Medicaid enrollees under the capitated model of the Financial Alignment Initiative and through contracts with Dual Eligible Special Needs Plans (D-SNPs).

ICRC has highlighted specific proposed policy changes and noted issues on which CMS has made specific requests for comments. Comments are due by **January 16, 2018 at 5:00 PM EST**. Commenters should review CMS' description of the proposed policy changes in the preamble to the proposed rule and the proposed changes to the text of regulations. The page numbers shown below are from the version of the proposed rule changes published in the Federal Register on November 28, 2017.

Limited Authorization of Default Enrollment (Previously Called Seamless Conversion) from Medicaid Plans into D-SNPs (pp. 56365-56368): CMS is proposing new regulation text to create limits and requirements related to the default enrollment of newly Medicare-eligible Medicaid beneficiaries to provide continuity of coverage from their pre-Medicare plan. Default enrollment would be limited to enrollment in D-SNPs and be subject to five conditions (pp. 56365-56366):

1. The individual must be currently enrolled in an affiliated Medicaid managed care plan, remain in the Medicaid managed care plan after attainment of Medicare eligibility, and be dually eligible for Medicare and Medicaid;
2. The state must approve the use of default enrollment and provide Medicare eligibility information to the MA organization;
3. The individual does not opt out of the default enrollment;
4. The MA organization must provide the individual with a notice of enrollment that meets CMS' requirements; and
5. CMS must approve the MA organization to use default enrollment before any such enrollments are made.

CMS also proposes the following related to default enrollment:

- Coverage would begin on the first day of the month that the individual's Medicare Part A and B coverage is effective;
- MA organizations must issue a notice to the individual no fewer than 60 days before the effective enrollment date;
- MA organizations must implement default enrollment processes in a non-discriminatory manner;

- MA organizations must refrain from selecting only certain members of their affiliated Medicaid plans for D-SNP enrollment; and
- CMS would have the authority to suspend or rescind a plan's approval at any time if it determines that the plan is not in compliance with the requirements.

CMS requests comments on its proposed codification of authority for default enrollment, including whether its approval of D-SNPs for default enrollment should be time-limited. For example, CMS could set a limit on the duration of approval (e.g., 2 to 5 years) (p. 56367).

Changes to the Part D Special Election Period for Dually Eligible Beneficiaries (pp. 56373-56375): CMS is proposing to change the Part D Special Election Period (SEP) for dually eligible and Low Income Subsidy (LIS) beneficiaries from an open-ended monthly SEP to one available only in certain circumstances. The current SEP allows eligible beneficiaries to make Part D enrollment changes (i.e., enroll in, disenroll from, or change Part D plans, including Medicare Advantage Prescription Drug (MA-PD) plans throughout the year. (Note that all D-SNPs are MA-PD plans, meaning the current SEP effectively allows eligible beneficiaries to change MA-PD plans monthly.) Most other Part D enrollees may switch plans only during the annual election period each fall. CMS' proposal seeks to balance beneficiary choice with improving plans' ability to maximize care management and achieve positive health outcomes. CMS notes the current monthly SEP can disrupt continuity of care, especially for states and plans that are coordinating Medicare and Medicaid benefits in integrated care plans; limit plan incentives to invest and innovate in serving high-need members; and encourage misleading and aggressive marketing to dually eligible individuals. CMS cites state and plan feedback that effective care management can best be achieved through continuous enrollment.

CMS is proposing to amend §423.38(c)(4) to limit the Part D SEP for full benefit dual and LIS-eligible individuals to certain specified circumstances outlined on pp. 56374-56375. The circumstances would be considered separate and unique from one another, so it is possible that a beneficiary could use the SEP multiple times per year if he or she meets more than one of the conditions. All eligible beneficiaries may use the SEP only once per calendar year, unless they:

- Have been assigned to a plan by CMS or a state, in which case they may use the SEP before that election becomes effective (i.e., opt out and enroll in a different plan) or within 2 months of their enrollment in that plan;
- Have a change in their Medicaid or LIS-eligible status, in which case they may use the SEP to make an election within 2 months of the change, or of being notified of such change, whichever is later; or
- Are identified as at-risk or potentially at-risk for prescription drug abuse under the provisions in §423.100, in which case the SEP is not available. (See pp. 56351-56352 for details on the reasons for this limitation.)

CMS requests comments on its proposed change to the SEP for dually eligible beneficiaries and highlights several areas (p. 56375) for stakeholder comment:

- Other limited circumstances where the SEP should be available to dually eligible beneficiaries;
- Special considerations CMS should keep in mind if it finalizes this policy;
- Other alternative approaches it should consider in lieu of narrowing the scope of the SEP (see p. 56375 for a discussion of other approaches considered); and

The best ways, in addition to CMS outreach materials, to educate the affected population and other stakeholders on the new proposed SEP parameters.

Limited Expansion of Passive Enrollment Authority (pp. 56369-56371). CMS is proposing a limited expansion of current passive enrollment authority for full-benefit dually eligible beneficiaries from a non-renewing integrated D-SNP into another comparable D-SNP. Currently, passive enrollment into an MA plan is limited to mid-year MA contract terminations or cases of potential beneficiary harm. CMS proposes to revise these rules in order to allow passive enrollment of dually eligible beneficiaries who are enrolled in an integrated D-SNP into another integrated D-SNP, in cases when integrated Medicare or Medicaid coverage would otherwise be disrupted. These cases include, for instance, non-renewal of integrated D-SNPs and state re-procurements of Medicaid managed care contracts that, absent passive

enrollment, would result in enrollees in integrated D-SNPs receiving coverage in separate plans for Medicaid and Medicare benefits.

CMS proposes that passive enrollment would only be authorized if, after consulting with the state Medicaid agency contracting with the integrated D-SNPs, CMS determines passive enrollment would promote integrated care and continuity of care for full benefit dually eligible beneficiaries. Passively enrolled beneficiaries would receive advance notice of the pending enrollment and have a SEP under this process. To be eligible to receive passive enrollment, D-SNPs would need to:

- Meet specified criteria for the integration of Medicare and Medicaid benefits;
- Have substantially similar provider and facility networks as the plan(s) from which they are receiving passive enrollment;
- Have an overall quality rating of at least 3 stars (unless the plan is too new or too small to receive a star rating);
- Not be subject to CMS sanctions prohibiting new enrollment;
- Have premiums and cost sharing appropriate for full benefit dually eligible beneficiaries; and
- Have the operational capacity to receive passive enrollment and agree to receive passive enrollment.

CMS requests comments on its proposal for a limited expansion of passive enrollment authority. In addition, CMS specifically requests comments on the process for determining qualifications for passive enrollment under this proposal and particularly on the minimum quality standards (p. 56370). CMS is also considering limiting this proposed new passive enrollment authority to circumstances in which it would not raise the total cost to the Medicare and Medicaid programs, and is seeking comment on this potential further limitation (p. 56370). In addition, CMS seeks comment on alternatives regarding beneficiary notices, including comments about the content and timing of such notices (p. 56371).

Revisions to Timing and Method of Disclosure Requirements (pp. 56431-56433). CMS is seeking comment on two proposed changes related to the information that MA organizations and Part D plans, including D-SNPs, must disclose to enrollees. First, MA plans and Part D sponsors would be required to provide disclosure information – including Evidence of Coverage (EOC) -- by the first day of the annual election period, instead of 15 days before. This is to mitigate concerns that beneficiaries may become overwhelmed by the EOC since it is difficult to navigate and understand, as well as to give plans two extra weeks to check the EOC for accuracy. CMS proposes to keep the requirement to send the Annual Notice of Change (ANOC) 15 days prior to the first day of the annual enrollment period.

Second, MA and Part D plans would be allowed to provide certain information, such as the EOC, electronically, with hard copies of the information provided only upon request, although all information would still need to be posted on plans' websites. Plans would be required to notify enrollees how to request hard copy materials and how to locate information on their websites. Plans would still be required to provide the ANOC in hard copy. This proposed change extends the discretion that CMS already extends to plans to provide their formulary and provider and pharmacy directories electronically. It also aligns MA and Medicare Part D requirements with those in the Medicaid managed care rule.

Codification of Quality Rating System Methodology (pp. 56375-56407): To provide additional transparency of the Star Ratings system for MA and Part D plans, CMS proposes to codify in regulations major aspects of the Quality Rating System that have previously been developed through annual Call Letters and other sub-regulatory guidance. CMS proposes to largely maintain the current Star Ratings system, with some changes to the methodology for assigning Star Ratings to contracts that have recently consolidated (pp. 56380-56382). D-SNPs may be interested in commenting on the discussion about changing the level at which ratings are calculated (plan level vs. contract level) on pp. 56380. States may be especially interested in the discussion of the Categorical Adjustment Index (CAI) on pp. 56404-56406. The CAI modifies the Star Ratings for certain measures to take into account the impact on performance of the proportion of dually eligible beneficiaries and beneficiaries with disabilities enrolled in a contract. CMS proposes to continue using the CAI while they work toward developing a long-term approach to accounting for socioeconomic status and other social risk factors.

CMS requests comments on various aspects of the Quality Rating System, including the proposed methodology and criteria for the selection of measures for adjustment (p. 56405).

Removal of Quality Improvement Project for Medicare Advantage Organizations (pp. 56454-56455): To minimize administrative burden, CMS is seeking comment on a proposal to remove the requirement that Medicare Advantage (MA) organizations develop and implement Quality Improvement Projects (QIPs). Other elements of the Quality Improvement Program remain in place, such as the requirements that MA organizations maintain a health information system, report measures to CMS, and implement a Chronic Care Improvement Program (CCIP).

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.