Medicare Advantage D-SNP Contract Oversight and Quality Monitoring

Purpose/Overview

The Integrated Care Resource Center (ICRC) is a national initiative of the Centers for Medicare & Medicaid Services (CMS) to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The ICRC provides frequent opportunities for states working on integrated care initiatives to come together to discuss topics of interest with other states and CMS.

This document summarizes a May 2014 discussion about Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) Contract Oversight and Quality Monitoring Procedures. Participants in the discussion included staff from states, CMS, ICRC, and the National Association of Medicaid Directors (NAMD). Since D-SNPs are required by federal law (the Medicare Improvements for Patients and Providers Act [MIPPA]) to have contracts with state Medicaid agencies to facilitate coordination of Medicare and Medicaid services for those enrolled in both programs, states that have such contracts with D-SNPs are interested in obtaining more information on how CMS oversees and monitors these plans. This discussion provided an opportunity for CMS experts and states to discuss this topic.

Contract Monitoring, the Role of CMS Regional Offices, and Compliance Actions

- Oversight of Medicare contracts that include D-SNPs is very similar to oversight of other MA contracts. The major difference is that all SNPs are required to have a model of care, which must be reviewed, approved, and monitored by CMS.
- D-SNPs are monitored by CMS Regional Office (RO) account managers and the CMS Central Office (CO). Generally, each plan's RO account manager communicates with plan representatives on a weekly or daily basis and refers questions to policy experts at CO as needed.
- Account managers review all aspects of plans, including beneficiary complaints to 1-800 Medicare, enrollment reports, timeliness reports, information on appeals and grievances from Medicare's Independent Review Entities (IRE), data-driven reporting by the plans, and plan self reporting. CMS encourages organizations to self-report issues when they find them.
- CMS also ensures that contracts meet the MIPPA requirements prior to the contract effective date. Account managers review quality improvement plans and models of care to determine how plans will provide quality care to the populations enrolled.
- CMS utilizes a compliance continuum to handle plan issues before enforcement actions are taken. However, CMS may issue a more severe letter or action to start with depending on the severity of the compliance issue. The normal compliance continuum is:
    - Notice of Non-Compliance (NONC) – Small issues generate a notice of non-compliance wherein CMS sends the plan a notice and request for correction of the deficiency.
    - Warning letter – The next step is a warning letter for an ongoing issue the plan has been warned about or a more egregious issue affecting more beneficiaries.
    - Corrective action plan (CAP) – For corrective action plans (CAPs), plans internally implement a CAP that aims to correct the issue, and then the plan follows up within a particular timeframe to demonstrate compliance to CMS.

Audits

- CMS' audit strategy uses a risk assessment that ranks plans from high to low risk (based on star rating and plan performance data); some plans are selected for audit from each category of risk. CMS also receives audit referrals from RO or CO colleagues.
- The audit schedule is developed at the beginning of each year. Plans are notified four weeks in advance of the audit, and the audit lasts two weeks. A draft report is due 60 days after the exit conference, and plans are

offered a chance to comment on the report. Audits are not closed until all findings are validated and all issues have been corrected.

- During the audit, CMS reviews rejected prescription drug claims for errors, plans' handling of beneficiary grievances and appeal rights (e.g., review of claims and letters to and from beneficiaries), plans' Medicare compliance program, and SNP models of care.
  - CMS reviews SNPs against their model of care by, for example, verifying that the right populations are enrolled, the right services are being provided and according to a plan of care, and health risk assessments are being completed.
- During the first week of the audit, the formulary, appeals and grievances, and model of care are reviewed via webinar. During the second week, compliance and program effectiveness are reviewed.
- Audit procedures and results are transparent to plans. CMS issues a memo on a yearly basis that pulls audit findings together and presents best practices for plan reference. Audit scores are posted on CMS' website. Audit protocols are also posted on CMS' website so that plans can conduct a self review prior to an audit. CMS also holds conferences to discuss audit and enforcement practices and holds listening sessions with plans to gather feedback on the audit process so it can be improved.

Enforcement Actions

- CMS uses a range of enforcement actions for Medicare Part C (Medicare Advantage) and Part D (prescription drug) plans, including:
  - Civil money penalties (CMPs);
  - Intermediate actions; and
  - Termination.
- CMPs are usually for a single point-in-time violation where the violation is likely easily correctable.
- CMS imposes intermediate sanctions for more egregious violations; these have usually occurred over a long period of time, require an extended process to fix, and pose serious threats to beneficiaries' health and access to services. An example of a sanction would be to suspend a plan's ability to market to and/or enroll new beneficiaries.
- Typically sanctions are imposed when the organization has significant deficiencies but also has demonstrated the ability to reasonably correct the deficiencies identified. Historically, a plan's average time under sanctions is approximately 300 days. CMS provides technical assistance to the plan, gives them an opportunity to fix the issue, and then checks that it has been fixed.
- CMS does not limit how long a sanction can be in place.
- Terminations are CMS-initiated as a result of a plan's substantial non-compliance.

Medicare Star Ratings

- CMS has published quality information on plans, including HEDIS and CAHPS measures on clinical and patient experience, since 1999. In 2006, CMS expanded these measures to include Part D, and the star ratings system was introduced. In 2007, CMS implemented the star rating system for both Part C and D to help beneficiaries choose a plan.
- Star ratings incorporate individual measures based on information from member satisfaction surveys, plans, and providers, and provide an overall score for each plan (ratings from 1-5, with 5 being excellent). Star ratings are updated each fall.
- CMS enhances the star ratings every year. Currently, plans are measured on 50 measures, covering both Medicare Part C and D services. There are a number of plan incentives related to star ratings. For example, five-star contracts can market and beneficiaries may join anytime year-round. Plans performing well on star ratings are also eligible for quality bonus incentive payments.
- The Medicare plan finder online tool includes which plans received a low performing icon for having fewer than three stars in either Part C or Part D for three or more consecutive years. CMS can terminate contracts with these low performing plans.

- CMS provides plans with multiple opportunities to provide feedback on proposed changes to the star ratings (i.e., changes to measures and measure specifications or how scores are calculated). Every October, CMS sends out a request for comments and input on changes to the star ratings. CMS also sends out a call letter each year to plans announcing proposed changes to measures in advance.
- Plans can review their star rating during preview periods, prior to their posting on Medicare.gov.

Past Performance

- Measurement of past performance takes into account all oversight activities discussed above, as well as additional areas (e.g., financial solvency requirements and financial audits).
- CMS reviews past performance of MA organizations at the legal entity level (a legal entity may hold more than one contract with CMS to offer multiple plans), compares them to other organizations each month, and identifies outliers.
- Past performance outliers may not expand their current business to new areas and will not be awarded new contracts with CMS.

State Questions/Discussion

State Question	CMS Response
Does CMS notify states where a D-SNP is operating of any violations, sanctions, or other performance concerns?	CMS posts enforcement actions publicly at: http://cms.hhs.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Part-C-and-Part-D-Enforcement-Actions-.html. CMS RO account managers may also reach out to beneficiary advocacy groups to alert them in these cases. However, they do not necessarily call the state. Managers will work with the Medicare-Medicaid Coordination Office to inform states in the case of plans with a high level of Medicaid enrollment.
D-SNPs have expressed concern about the star ratings, saying that they are like a moving target. They note that the measures included in the star ratings change year-to-year and it is difficult to maintain consistency in performance. Can you explain the rationale for the ratings changing each year?	On average, CMS changes 1-2 measures out of 50 total measures annually. In most cases, CMS announces this to the plans a year or more in advance. CMS encourages plans to focus on overall performance rather than specific star ratings. CMS finds that plans that do well overall also do well on individual measures.
Does the CMS RO account manager ever communicate with the state about beneficiary complaints about D-SNPs?	CMS RO account managers do not generally reach out to the state. CMS tracks Medicare beneficiary complaints at the contract level, so if an organization operates four plans under its contract with CMS, one of which is a D-SNP, it is difficult to separate out the D-SNP-specific complaints. However, there will be more CMS/state/plan communication around Medicare-Medicaid Plans' performance in the capitated model financial alignment initiative.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

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