2016 Call Letter Updates—Medicare Part C

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Agenda

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- Part C Policy Updates
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  - Standardizing the Health Risk Assessment (HRA)
  - Guidance for In-Home Enrollee Risk Assessments

Overview

CMS has designed the policies contained in this Call Letter to improve the overall management of the Medicare Advantage and Prescription Drug programs with four major outcomes in mind. These outcomes are:

1) Continued program vibrancy and stability
2) Value for beneficiaries and tax-payers
3) Better quality care for beneficiaries
4) Improved compliance for plans and sponsors

CY 2016 Benefits and Bid Review

- Find the most up-to-date CY 2016 benefit and bid review information in the Contract Year 2016 Medicare Advantage Bid Review and Operations Guidance issued via HPMS on April 14, 2015
- Also see guidance provided in the Call Letter
- Additional Part C benefit information can be found in Chapter 4 of the Medicare Managed Care Manual
- For specific bid-related questions, email https://MABenefitsMailbox.lmi.org/

Part C Policy Updates—Value-Based Contracting to Reduce Costs and Improve Health Outcomes

- CMS aims to drive quality improvement through innovative program design
- Value-Based Contracting may:
  - help providers operate efficiently
  - reduce costs
  - improve health outcomes of patients
- In order for such programs to succeed, a critical mass of payers, including CMS, must support these new financial models for health care payment

Part C Policy Updates—Value-Based Contracting to Reduce Costs and Improve Health Outcomes (cont.)

- Before making changes, CMS must first test and evaluate new payment models effectively
- In 2016, CMS is seeking information on how MAOs are currently using physician incentive payments and value-based contracting of provider services to achieve these goals
- Value-based contracting is not required of MAOs at this time
- CMS will reach out to MAOs and sharing information will be voluntary

Part C Policy Updates—Contract Consolidations

- For CY 2016, CMS encouraged MAOs operating more than one MA or MA-PD contract of the same product type under the same legal entity to consolidate these contracts under a single contract ID
- MAOs are not permitted to consolidate contracts of different product types

Part C Policy Updates—Contract Consolidations (cont.)

- MAOs submitted formal consolidation request to CMS by April 15, 2015, for the upcoming contract year
- CMS will include the new contract consolidation process in our ongoing updates to the Medicare Managed Care Manual

Part C Policy Updates—Guidance to Verify that Networks are Adequate and Provider Directories are Current

- Under current program rules, MAOs are required to maintain accurate provider network directories for the benefit of enrollees
- MAOs are expected to:
  - Have regular, ongoing communications with providers to ascertain their availability and, specifically, whether they are accepting new patients

Part C Policy Updates—Guidance to Verify that Networks are Adequate and Provider Directories are Current (cont.)

- MAOs are expected to (cont.):
  - Require contracted providers to inform the plan of any changes to street address, phone number, and office hours or other changes that affect availability
  - Develop and implement a protocol to effectively address inquiries/complaints related to enrollees being denied access to a contracted provider with follow through to make corrections to the online directory

Part C Policy Updates—Guidance to Verify that Networks are Adequate and Provider Directories are Current (cont.)

MAOs are expected to maintain accurate online provider directories by:

- Including all active contracted providers
- Signaling those providers who are closed or not accepting new patients
- Updating online provider directories in real-time
- Communicating with providers monthly regarding their network status

Part C Policy Updates—Guidance for Off-cycle Submission of Summaries of MOC Changes

- MOC changes that require CMS notification include:
  - Substantive modifications
  - Fundamental organizational changes
  - Changes that are essential to MOC processes and functions
- MOC changes that do **NOT** require CMS notification include:
  - Updates on demographic data about the target population
  - Additions/deletions of specific named providers
  - Grammatical and/or non-substantive language changes

Part C Policy Updates—Guidance for Off-cycle Submission of Summaries of MOC Changes (cont.)

- MOC changes should be submitted through the new MOC HPMS module
- The module will be available later in 2015
- Additional module guidance will be available before the module goes “live”
- NCQA will review the summary of changes submitted in HPMS; however, revised MOCs will **not** be rescored
- Changes made to a MOC cannot be used to improve a low score

Part C Policy Updates—Standardizing the Health Risk Assessment (HRA)

- Upon last review, SNPs were using more than 300 different HRA versions
- For CY 2016, CMS encourages MAOs to adopt a standardized HRA framework
- The CDC Model HRA along with the other components of the Annual Wellness Visit can be used to identify the health care needs of enrollees
- CDC Model HRA is available here: http://www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf

Part C Policy Updates—Standardizing the Health Risk Assessment (HRA) (cont.)

Use of a standardized HRA would:

- Assure HRAs are comprehensive and appropriately asses each enrollee's physical, psychosocial, and functional needs
- Provide uniform and comprehensive information to support care planning, health promotion and promote a proactive approach for initiating preventive and other appropriate care
- Provide consistency in CMS' and MAOs' data collection across all plans, making data assessment and quantification easier

Part C Policy Updates—Guidance for In-Home Enrollee Risk Assessments

Best Practices for In-Home Assessments include:

- In-home assessments performed by physicians, or qualified non-physician practitioners, specifically advanced practice registered nurses, nurse practitioners, physician assistants or certified clinical nurse specialists
- All components of the Annual Wellness Visit, including a health risk assessment

Part C Policy Updates—Guidance for In-Home Enrollee Risk Assessments (cont.)

Best Practices for In-Home Assessments include(cont.):

- Medication review and reconciliation
- Scheduling appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources
- Conducting an environmental scan of the enrollee's home for safety risks, and need for adaptive equipment

Part C Policy Updates—Guidance for In-Home Enrollee Risk Assessments (cont.)

Best Practices for In-Home Assessments include (cont.):

- Include a process to verify that needed follow-up care is provided
- Include a process to verify that information obtained during the assessment is provided to the appropriate plan provider(s)

Part C Policy Updates—Guidance for In-Home Enrollee Risk Assessments (cont.)

Best Practices for In-Home Assessments Include (cont.):

- Include a Provision to the enrollee of a summary of the information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources
- Enroll assessed enrollees into the plan's disease management/case management programs, as appropriate

Resources

CY 2016 Final Call Letter available here:

http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Questions?

- **General Questions About the Regulation:**
  - Heather Kilbourne – Heather.Kilbourne@cms.hhs.gov
- **Part C Questions:**
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