Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

SEPTEMBER 2017

Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans

Many states are exploring strategies to integrate the financing and delivery of services for individuals dually eligible for Medicare and Medicaid. Through their Medicaid agency contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), states have the opportunity to integrate care for dually eligible beneficiaries.

Depending on a number of factors, including a state's policy goals, Medicaid agency staff capacity and resources, and the state's managed care landscape, Medicaid agency contracts with D-SNPs can require varying degrees of integration and alignment between Medicare and Medicaid administrative and care management functions.

At the most minimum level, contracts require D-SNPs to address only the eight elements outlined in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), known as the "minimum MIPPA requirements." [1] As the level of integration increases, contracts can require coverage for beneficiaries' Medicare cost-sharing payments and a variety of Medicaid acute care, wraparound services, and long-term services and supports (LTSS). At a higher level of integration, a D-SNP's corporate sponsor can be required to offer a "companion" Medicaid plan in the same geographic area through a state's Medicaid managed long-term services and supports (MLTSS) program. At the highest level, a D-SNP can be required to become Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), which must coordinate and be at risk for coverage of Medicaid LTSS, and have procedures in place to align Medicare and Medicaid administrative processes and materials.

Regardless of the level of Medicare-Medicaid integration a state hopes to achieve, Medicaid agency staff may benefit from becoming more aware of the annual timeline and contracting milestones to which all Medicare Advantage plans, including D-SNPs, must adhere. By becoming more familiar with this calendar, state Medicaid agencies can more proactively and thoughtfully plan their own contracting activities. The Integrated Care Resource Center (ICRC) regularly sends email alerts regarding upcoming Medicare Advantage deadlines and other issues related to state interactions with D-SNPs.[2]

The following calendar of key Medicare Advantage dates was developed to assist states interested in advancing integrated programs by contracting with D-SNPs (Exhibit 1). It describes Medicare Advantage milestones by month and explains what activities state Medicaid agencies may want to undertake to prepare for or respond to a particular Medicare Advantage event. The calendar also provides links to resources containing more information. Additional resources that may be useful to states are included in Exhibit 2.

Exhibit 1. Calendar of Key Medicare Advantage Dates

Medicare Advantage Milestone	Description	Potential State Activities	Resources
January			
Annual LIS Medicare Part D reassignment occurs	The Medicare Part D low-income subsidy (LIS) provides extra help for beneficiaries who have limited income and resources to help them pay for their Medicare prescription drug plan (PDP) premiums, co-payments,[1] and the annual deductible. Each year, the Centers for Medicare & Medicaid Services (CMS) reassigns LIS beneficiaries from PDPs that are above the regional LIS benchmark and from PDPs and Medicare Advantage plans that are terminating or reducing their service areas. These beneficiaries are reassigned into new PDPs effective January 1.	While there is no specific action required by states related to LIS Part D reassignment in January, they should be aware of this annual process because of its potential impact on dually eligible D-SNP enrollees.	• CMS *2017 Reassignment of Low-Income Subsidy Beneficiaries in Prescription Drug Plans:* https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/2017-PDP-Reassignment-Memo.pdf
D-SNPs submit Model of Care renewals	All D-SNPs must have a Model of Care (MOC) that describes the basic care management framework under which the plan will meet the needs of each of its enrollees. MOCs are reviewed and scored by the National Committee for Quality Assurance (NCQA). Depending on their score, MOCs can be approved for 1, 2, or 3 years. MOCs can be submitted over a period of several weeks in January and February each year.	States seeking to create aligned D-SNP/MLTSS programs may require their contracted D-SNPs to insert Medicaid LTSS care management requirements into D-SNP MOCs. States will want to start this process well in advance of the February deadline for MOC submission. States may require D-SNPs to submit these MOCs to the state as part of their MIPPA contracts.	• CMS *Medicare Managed Care Manual*. Chapter 5: Quality Assessment: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf • CMS/NCQA *SNP Approval and Model of Care Review Process*: http://snpmoc.ncqa.org/ • CMS *Changes to Special Needs Plan and Medicare-Medicaid Plan Model of Care Submissions and Updates in the Health Plan Management System*: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/January142016HPMSmemo.pdf

[1] Beneficiary co-payments may vary by full or partial dual eligibility status, income, and institutional status.

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Deadline for Highly Integrated D-SNPs to notify CMS of intent to offer flexible supplemental benefits	CMS allows qualified D-SNPs to offer flexible supplemental benefits that provide community supports (e.g., non-skilled in-home support services; in-home food delivery; supports for caregivers of enrollees; home assessments, modifications, and assistive devices for home safety; and adult day care services) to individuals who do not receive these services through Medicaid. (Flexible supplemental benefits are further defined in Chapter 16B, Section 20.2.6 of the Medicare Managed Care Manual.) For a D-SNP to offer these benefits as part of the next contract year's plan benefit package, it must meet the requirements and approval process outlined in this section. In January, Medicare Advantage organizations must submit to CMS a non-binding notification of their intent to offer flexible supplemental benefits. CMS will provide a determination of whether the D-SNP is eligible to offer flexible supplemental benefits later in the spring.	States interested in expanding access to community supports for their Medicare-Medicaid enrollees may want to work with their state-contracted D-SNPs that may be eligible to offer these supplemental benefits to assess what benefits may be most useful in a particular state.	• CMS *Medicare Managed Care Manual*. Chapter 16B: Special Needs Plans: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf
Release of MedPAC-MACPAC Data Book on Dually Eligible Beneficiaries	In January of each year, MedPAC and MACPAC release the *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, which provides a current snapshot of demographic, health care utilization, and health care spending information for individuals dually eligible for Medicare and Medicaid. The Data Book gives an overview of the full dually eligible population and also compares sub-groups, including fully-eligible and partially-eligible individuals, individuals over 65 and under 65, non-dually eligible Medicaid beneficiaries, and non-dually eligible Medicare beneficiaries (as comparison groups).	States may want to review ICRC's summary of items in the Data Book that are especially relevant to states with Medicare-Medicaid Financial Alignment Initiative demonstrations or with D-SNP-based integrated care programs. ICRC features excerpts from the Data Book in a Working With Medicare webinar in January or early February of each year.	• MedPAC/MACPAC *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*: https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf • ICRC e-alert: http://www.integratedcareresourcecenter.com/PDFs/2017%2001%2025%20Integrated%20Care%20Update.pdf • ICRC Working with Medicare webinar *Medicare 101 and 201 – Key Issues for States*: https://chcs.webex.com/chcs/lsr.php?RCID=ff5e2e2f79c74054bda76d205c90df2d

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February			
CMS release of Advance Notice of MA payment policies and draft Call Letter	Each February CMS releases a combined Advance Notice and Draft Call Letter for the coming Medicare Advantage contract year. The Advance Notice document discusses proposed updates and changes to MA and Part D payment methodologies, and the Draft Call Letter seeks broad stakeholder comment on proposed policies, including changes to quality measurements, for the upcoming contract year. States interested in promoting Medicare-Medicaid integration may be interested in reviewing and submitting comments on the Advance Notice and Draft Call Letter.	States may want to read ICRC's e-alert summary of items in the Advance Notice and draft Call Letter relevant to states with Medicare-Medicaid Financial Alignment Initiative demonstrations or with D-SNP-based integrated care programs. States may consider commenting on items where CMS requests feedback.	• CMS *Medicare Advantage Rates & Statistics*: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html • CMS *CY 2018 Advance Notice and Draft Call Letter*: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html • ICRC e-alert *State Comments Invited on CMS' Draft Medicare Advantage and Part D Rates and Guidance for Calendar Year 2018*: http://www.integratedcareresourcecenter.com/PDFs/2017%2002%2008%20Advance%20Call%20Letter.pdf
April			
CMS release of Final Call Letter and MA capitation rates	In early April, after considering feedback on the February draft, CMS releases its Final Call Letter with changes in Medicare Advantage policy and payment information and guidance, and Medicare Advantage capitation rates for the upcoming contract year.	States may want to read the ICRC e-alert summarizing any changes from the draft to final versions and note areas where they may need to adjust their processes or procedures for plan oversight or contracting. For example, the CY 2018 Final Call Letter indicated that CMS will move forward on developing SNP-specific network adequacy evaluations.	• CMS *Medicare Advantage Rates & Statistics*: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html • CMS *CY 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html • ICRC e-alert *Spotlight: New Medicare Advantage Rates and CMS Guidance*: http://www.integratedcareresourcecenter.com/PDFs/2017%2004%2011%20Spotlight%20New%20Medicare%20Advantage%20Rates.pdf
May			
CMS release of model marketing materials: Annual Notice of Change (ANOC) /Evidence of Coverage (EOC) document	In May, CMS releases model marketing guidelines and materials for the upcoming Medicare Advantage contract year.	States can begin working with D-SNPs on incorporating Medicaid information into D-SNP marketing materials, including the Summary of Benefits, in which D-SNPs have greater flexibility to describe benefits in an integrated fashion.	• CMS *Medicare Advantage Model Materials*: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html

Medicare Advantage Milestone	Description	Potential State Activities	Resources
June			
Deadline for Medicare Advantage organizations to submit bid and plan benefit package for upcoming year	In early June, all Medicare Advantage organizations, including D-SNPs, must submit a Plan Benefit Package (PBP) and completed Bid Pricing Tool (PBT) to CMS. Additionally, D-SNPs must tailor their PBP and bids so they are consistent with any state requirements. CMS includes guidance on D-SNP submission of bid, PBP, and associated plan service area information in the final Call Letter.	States can require D-SNPs to submit this Medicare bid and PBP information, which would indicate if the D-SNP plans to offer supplemental benefits and the amount of beneficiary cost sharing that it plans to pay through Medicare rebate dollars. This information could help the state to establish appropriate Medicaid payment rates for Medicare beneficiary cost-sharing and services covered under an integrated D-SNP contract. This information could also help states assess the financial status of the D-SNPs operating in their state, which can be an indicator of the relative attractiveness of the state to D-SNPs, and to the potential for future D-SNP entries and departures.	• CMS *CY 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information:* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html
Medicare Advantage organizations not renewing contracts must notify CMS	In early June, Medicare Advantage organizations, including D-SNPs, deciding not to renew their plans must notify CMS in writing. D-SNPs can elect to voluntarily not renew their contract with CMS, or may implement service area reductions.	States that are contracting with D-SNPs, or planning to do so, should request that D-SNPs doing business in their state submit information on plans to non-renew a D-SNP contract to the state in order to assist with state planning for these changes, such as preparing messaging for SHIPs and enrollment brokers and including Medicaid information in D-SNP nonrenewal notices delivered in the fall.	• ICRC *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options* (see p. 14): http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf • ICRC *Medicare Advantage D-SNP Non-Renewals, Service Area Changes, Terminations, and New Entries: CMS Requirements and State Options*: http://www.integratedcareresourcecenter.com/PDFs/ICRC_D-SNP_Entries_and_Departures_September_2017.pdf
July			
Medicare Advantage organizations must submit MIPPA D-SNP contracts to CMS	D-SNPs are required to submit a State Medicaid Agency Contract (SMAC or "MIPPA contract") to CMS for each state they seek to operate in for the upcoming contract year by July 1.[2] This is required by MIPPA and the Affordable Care Act. States have the option of contracting with all, some, or none of the D-SNPs seeking to operate in the state.	States should be aware of this deadline and work with D-SNPs in advance to determine the scope of service and financial responsibility that D-SNPs must assume, and that will be reflected in the MIPPA contract D-SNPs must submit by July 1.	• ICRC *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options* (see p. 14): http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf

[2] While D-SNPs are expected to contract directly with state Medicaid agencies, CMS recognizes that some states may only be able to contract with a limited number of D-SNPs due to state statutory requirements, budgetary concerns, or limited staff resources. Therefore, in limited circumstances, and with state approval, CMS may consider a D-SNP's subcontracting

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D-SNPs request review for FIDE SNP status	By July 1, D-SNPs wishing to be reviewed for qualification as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) for the upcoming contract year must submit required documentation to CMS. FIDE SNPs must provide access to a full range of primary and acute care and long-term services and supports (LTSS), consistent with state policy, under risk-based financing through a single managed care organization. D-SNPs must submit their state Medicaid MLTSS contracts.	States should work with potential FIDE SNPs to ensure that these plans have a Medicaid contract that includes the required MIPPA elements and that the plans' contracts to provide MLTSS on a capitated basis have been submitted to CMS.	• CMS *Medicare Managed Care Manual*. Chapter 16B: Special Needs Plans: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf
September			
D-SNP approval letters sent by CMS	CMS notifies plans of D-SNP approval.	States can request plans to notify them of CMS approval of D-SNP applications and any changes such as in service area, so they can work with CMS and plans to better coordinate beneficiary coverage options, including taking into account the availability of plans covering Medicaid benefits for Medicare-Medicaid enrollees. Additionally, for states with established integrated D-SNP programs where a D-SNP is exiting the market, states can use this information to facilitate enrollment into other established D-SNPs in the state in order to maintain integration for Medicare-Medicaid enrollees.	• CMS *SNP Comprehensive Reports*: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

arrangements with a state Medicaid managed care organization (MCO) to be equivalent to a direct state contract as long as the subcontract contains all of the MIPPA required elements. For example, if a state wanted Medicaid MCOs that provide LTSS to Medicare-Medicaid enrollees to partner with a D-SNP to provide Medicare benefits to these enrollees, the Medicaid MCO could enter into a subcontract with a D-SNP rather than requiring the D-SNP to have a separate contract with the state.

Medicare Advantage Milestone	Description	Potential State Activities	Resources
Annual Notice of Change/Evidence of Coverage	All Medicare Advantage plans, including D-SNPs and FIDE SNPs, must send current enrollees an Annual Notice of Change (ANOC) for receipt by September 30. Plans are also required to send an Evidence of Coverage (EOC) document for receipt by December 31. The ANOC and EOC describe any changes in Medicare coverage, costs, or service area that will be effective in January of the coming year.	States may want to obtain copies of the ANOC/EOC sent to beneficiaries by the D-SNPs in their states so that they better understand the services that enrollees will be receiving. States can require D-SNPs to include a description of changes to Medicaid services in the notice.	• CMS *Medicare Marketing Guidelines*: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html. • CMS *Medicare Advantage Model Materials*: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html
LIS file sent	In September, CMS and SSA send a joint mailing to beneficiaries who will lose their LIS deemed status as of January 1. Also in September, CMS provides a Loss of Deemed Status file to states identifying residents who are being notified of their loss of deemed status.	States should use the information in this file to screen these individuals for eligibility for Medicaid or any of the Medicare Savings Programs, or to work with them to apply for LIS so that they do not lose prescription drug coverage.	• CMS *Sample Beneficiary Notice: Introduction to the Loss of Deemed Low Income Subsidy (Extra Help) Status Notice*: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/11198.pdf
October			
Non-renewal notification letters due to current enrollees	By October 1, all Medicare Advantage plans, including D-SNPs and FIDE SNPs, that will not renew their contract for the coming year must send personalized letters to current enrollees explaining their rights and options for Medicare coverage.	States should begin work with their non-renewing integrated D-SNPs and FIDE SNPs well in advance of the October 1 deadline to include information in these letters about beneficiaries' access to Medicaid benefits.	• ICRC *Medicare Advantage D-SNP Non-Renewals, Service Area Changes, Terminations, and New Entries: CMS Requirements and State Options*: http://www.integratedcareresourcecenter.com/PDFs/ICRC_D-SNP_Entries_and_Departures_September_2017.pdf
Release of final Medicare Star ratings	CMS publishes final Star Ratings for Medicare Advantage Organizations in mid-October every year.	States contracting with D-SNPs can use the Star ratings to see how D-SNPs in the state are performing. Plans with a "low-performing icon" (LPI) may be terminated by CMS at the end of the contract year if performance does not improve. States can use this information during their Medicaid agency's contracting renegotiations with these plans and to prepare for anticipated D-SNP terminations.	• ICRC *Finding Health Plan Star Ratings*: http://www.integratedcareresourcecenter.com/PDFs/2016%2010%2020%20Integrated%20Care%20Update.pdf • CMS *2017 Medicare Part C and D Star Ratings Data*: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html • CMS *2017 Fact Sheet on Star Ratings*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-12.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Medicare Advantage Milestone	Description	Potential State Activities	Resources
November			
Notice of intent to apply (NOIA) from D-SNP applicants due to CMS	In November, D-SNPs must submit to CMS a Notice of Intent to Apply (NOIA) that outlines the D-SNP's operational plan for the contract year that begins a little over a year later (i.e., the November 2017 NOIAs will outline D-SNP plans for CY 2019). While CMS does not have a formal process to alert states to these changes, states can add language to their MIPPA contracts with D-SNPs requiring that plans submit a copy of the NOIA to the state and notify them of planned service area additions, expansions, and reductions as soon as possible, but no later than the point when they notify CMS.	States with D-SNPs that will not renew their contracts for the upcoming contract year can work with these plans to transition enrollees. States may also wish to review their D-SNP and Medicaid LTSS contracting strategies in light of anticipated effects of the departure on other D-SNPs in the market.	• ICRC *Spotlight: Preview of 2017 D-SNP Entries and Departures*: http://www.integratedcareresourcecenter.com/PDFs/2016%2011%2022%20Spotlight%20DSNP%20Entries%20and%20Departures%20Preview.pdf

Exhibit 2. Additional Resources

Data Source	Frequency of Data	Description	Source
Report to the Congress: Medicaid Payment Policy	Annually	Provides analysis and recommendations to Congress from the Medicare Payment Advisory Commission (MedPAC) on issues critical to the Medicare program.	http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0
Report to Congress on Medicaid and CHIP	Annually	Provides analysis and recommendations to Congress from the Medicaid and CHIP Payment and Access Commission (MACPAC) on issues critical to these two programs.	https://www.macpac.gov/publication/march-2017-report-to-congress-on-medicaid-and-chip/

ENDNOTES

[1] MIPPA required all D-SNPs to have contracts with the states in which they operate. See: United States Code of Federal Regulations. 42 CFR §422.107. *Special Needs Plans and Dual Eligibles: Contracts with State Medicaid Agency*. Available at: https://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec422-107.

[2] Individuals interested in receiving ICRC emails may subscribe by visiting: http://www.integratedcareresourcecenter.com/subscribe.aspx.

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 by 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.