

MEDICARE ADVANTAGE NEWS

News and Analysis of Medicare Advantage, Medicare Part D and Managed Medicaid

Contents

- 4** Jan. MA Enrollment Gain In CMS Data May Not Give Useful Insights
- 4** Table: MA, Cost, PACE, Demo and PDP Contract January Summary Report
- 5** MedPAC Adopts Recommendation to Limit Use of HRAs for MA Pay
- 7** United Agrees to Pay \$100,000 to Settle N.Y. AG's I-SNP Coercion Probe
- 8** News Briefs

Don't miss the valuable benefits for MAN subscribers at AISHealth.com — searchable archives, back issues, Hot Topics, postings from the editor, and more. Log in at www.AISHealth.com. If you need assistance, email customerserv@aishealth.com.

Managing Editor
James Gutman
jgutman@aishealth.com
Associate Editor
Lauren Clason
Executive Editor
Jill Brown

Calif. Delays by One Year Needed Decision On Whether to End Biggest Duals Demo

In a victory for the CMS-backed demonstration for Medicare-Medicaid dual eligibles, California Gov. Jerry Brown (D) said in his Jan. 7 budget message that the state will delay by one year a decision required by state law on whether to close its duals demo because of a lack of cost savings. Instead, California will focus this year on increasing participation in the care integration demo, the budget message said, as well as extending a controversial managed care organization (MCO) tax that helps fund it, and then decide by January 2017 whether to halt the demo effective January 2018.

Another key part of what will happen this year, Mari Cantwell, chief deputy director of the California Department of Health Care Services (DHCS), which oversees the state's demo, tells *MAN*, is getting data on cost-savings results so far. She says this includes duals who are able to move out of institutions because of the initiative — “we know that is happening” — or who are avoiding or delaying institutionalization. Some plans participating in Cal MediConnect, as the state's three-year Coordinated Care Initiative duals demo is called, already have such data, according to Cantwell, who cites early CCI entrant Health Plan of San Mateo as an example.

continued on p. 6

2016 Outlook

Expect More Regulation of MA as End of Administration Nears, Big Issues Remain

All of the signals — as well as the timing of the elections cycle — point to one thing about Medicare Advantage plan regulation this year. As Bruce Merlin Fried, managing partner in the Washington, D.C., office of the Dentons law firm, puts it, “We're going to see a heightened level of audit and regulatory scrutiny and enforcement in 2016.” He notes that CMS has been “ramping up oversight and enforcement activities” in MA for a while. And the fact that 2016 is not just a big election year but also the last full year of a two-term presidential administration makes now-or-never thinking more likely.

The “sum and substance” of all the overhanging factors is that CMS will be looking, even more than before, to “hold the [MA] industry accountable,” says Fried, who was the health plan overseer in CMS predecessor HCFA during the Clinton administration.

There are several areas in which enhanced MA regulatory scrutiny is likely, both Fried and other industry observers tell *MAN*. They include provider-network adequacy, risk scores, health risk assessments (HRAs), medication therapy management (MTM) and fraud, waste and abuse (FWA). Insurer consolidations that affect MA, including the big pending deals unveiled last summer (*MAN* 7/30/15, p. 5), also will get major scrutiny — albeit mainly from the Department of Justice and Federal Trade Commission rather than CMS — but all of the observers queried predict the deals will go through.

Perhaps the hottest area for MA organizations (MAOs) in 2016 is network adequacy. The more robust version of CMS's Network Management Module (*MAN* 5/21/15,

p. 1) is now operational, says Michael Adelberg, a former top CMS MA official who is senior director at FaegreBD Consulting, so the question is how CMS will use the NMM. By the time the final 2017 Call Letter is out April 4, he tells *MAN*, we'll know whether the agency will push ahead with a national provider database for use in assessing network access, or perhaps do something "less centralized" such as issuing specifications for MA plans to use in having their network information "machine readable."

Given that whatever CMS does on this issue will affect MAO application and bid intentions, the agency probably won't put out detailed regulations on network adequacy till mid-2016 and will make any changes effective for 2017, says Danielle Moon, an attorney and former top CMS Medicare plan contracts official who now is specialist leader in the life sciences and health care practice of consulting firm Deloitte. Moon notes that the MA network-adequacy audits CMS expects to conduct this year would be on a pilot basis and thus not used in enforcement, so any 2016 enforcement activity is more likely to involve accuracy of MAOs' provider directories.

She also points out that last November CMS revised regulations slightly so that MA provider directories would have to be updated only quarterly rather than

monthly, an apparent acknowledgment of the difficulty in getting accurate availability information quickly.

Difficulties notwithstanding, Fried expects to see "tightening of network adequacy" standards for MA plans in 2016, with CMS using a "data-driven approach" to assessing adequacy. He cautions that the standards will be applied to both new applicants and the annual submissions of existing MA plans and that if the data suggest access for members is inadequate, MAOs will be told to improve it or have their applications turned down. MAOs, however, he adds, still will be able to have narrow networks as long as the insurers can prove that the networks can serve additional members, calling this CMS stance a "more nuanced approach than before."

One factor in assessing adequacy, says John Gorman, executive chairman of Gorman Health Group, LLC, will be the model network-access standards developed by the National Association of Insurance Commissioners. CMS realizes that network access is substantially a state issue but wants to ensure that such aspects as waiting time for appointments are taken into account, he says.

More Scrutiny of Risk Scores Is Likely

If network adequacy likely is the biggest regulatory area for MA in 2016, risk scores — including how diagnoses used in risk adjustment are obtained and verified — are not far behind. With continued news articles and reports about alleged upcoding by MA firms, there will be increasing pressure on CMS to perform more audits of MA plans' risk-score practices, says Adelberg.

Some of this pressure is coming from Congress and consumer advocates, he says. And one result of it might be CMS returning to the concept, which it presented several years ago but hasn't yet used, of extrapolating the results of risk adjustment data validation (RADV) audits to the entire contracts of MAOs. Adelberg predicts CMS could start such extrapolation this year, as long as its methodology is "cautious," and would have support from Republicans as well as Democrats if it does.

Such cautious methodology presumably would entail that penalties against MAO contracts found to have overpayments would run less than the hundreds of millions of dollars discussed when RADV audit extrapolation first was proposed years ago.

Consultant Stephen Wood, a principal in Clear View Solutions, LLC, says the threat of using RADV extrapolation may cause enough anxiety to make MA plans more careful in their risk-score practices. The investment community, perhaps with that in mind, doesn't expect "dramatic things" on RADV extrapolation in an election year, Wood tells *MAN*.

One way CMS could attempt to get risk adjustment more accurate without RADV extrapolation is via use of

Medicare Advantage News (ISSN: 1089-6589) is published 24 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Copyright © 2016 by Atlantic Information Services, Inc. All rights reserved. On an occasional basis, it is okay to copy, fax or email an article or two from *MAN*. But unless you have AIS's permission, it violates federal law to make copies of, fax or email an entire issue, share your AISHealth.com subscriber password, or post newsletter content on any website or network. To obtain our quick permission to transmit or make a few copies, or post a few stories of *MAN* at no charge, please contact Eric Reckner (800-521-4323, ext. 3042, or ereckner@aishealth.com). Contact Bailey Sterrett (800-521-4323, ext. 3034, or bsterrett@aishealth.com) if you'd like to review our very reasonable rates for bulk or site licenses that will permit biweekly redistributions of entire issues. Contact Customer Service at 800-521-4323 or customerserv@aishealth.com.

Medicare Advantage News is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, James Gutman; Associate Editor, Lauren Clason; Executive Editor, Jill Brown; Publisher, Richard Behl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Director, Andrea Gudeon

Subscriptions to *MAN* include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *MAN* content and archives of past issues.

To order an annual subscription to **Medicare Advantage News** (\$636 bill me; \$586 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

the encounter data MA plans have been required to submit for several years. These encounter data will account for 10% of risk adjustment this year, CMS has said, and Gorman forecasts that the agency could propose a bigger percentage for 2017 in the draft Call Letter next month.

The other related issue that could resurface in the Call Letter is the use of home HRAs for obtaining diagnoses used in coding. CMS, of course, has proposed restrictions on HRAs for this purpose several times before but backed off each time in the face of numerous and varied objections ranging from the definition of HRAs to the difficulty of requiring patients to have clinical follow-up.

Brian Collender, specialist leader in the health actuarial practice at Deloitte, tells *MAN* he envisions a "40% chance" that the agency actually will adopt HRA restrictions for MA in this year's document. And Gorman, acknowledging he's predicted this before, forecasts that CMS finally in 2016 will "raise the bar" on HRAs in MA by requiring something like clinical follow-up or "another form of code verification."

He also predicts that "this will be the year of the medication review." Speaking of the concepts of MTM and comprehensive medication reviews (CMRs) via use of MTM, Gorman notes that CMS "has banged the drum on this for a long time." In 2016, he says, there will be a substantial number of audits of CMRs MA plans have done, and they will result in many plans getting only a one- or two-star rating on that scoring measure.

CMS is looking for ways to enhance the usage of MTM, says Deloitte's Moon, since the vast majority of MA plans just follow the minimum requirements. She tells *MAN* that the agency's pilot MTM audits, which it had hoped to conduct last year but instead will do in 2016, will look at concepts for potential enforcement steps, but there won't be enforcement actions until 2017.

The other big Part D regulatory issue — what CMS now calls "preferred cost sharing pharmacies" — also will get more attention, Collender says, with the agency checking to ensure that materials for beneficiaries exhibit clarity about which are the preferred pharmacies.

Another area in which more regulatory activity is likely for MA is the overall subject of FWA, says Washington, D.C., managed care attorney Mark Joffe, who has numerous MA clients. CMS is revising its program-audit program regarding FWA, he explains, and is particularly interested in how MA plans address such fraud issues as what to do when providers bill too high, including in cases when they coded too high. CMS wants to see what plans are doing to get the money back promptly for the government in these cases, Joffe tells *MAN*.

Contact Fried at bruce.fried@dentons.com, Adelberg at michael.adelberg@faegrebd.com, Moon at danmoon@deloitte.com, Gorman at jgorman@gormanhealthgroup.com, Wood at stephen.wood@clrvviewsolutions.com, Collender at bcollender@deloitte.com and Joffe at marksjoffe@gmail.com. ◇

Medicare Star Ratings: New Strategies to Match CMS's New Goals

AIS Virtual Conference: Thurs., Feb. 4, 2016 • 11 am - 5 pm ET

Get details of proven strategies to improve star-ratings performance in a changing environment ... and how to apply them to your plan. You'll hear valuable, practical intelligence on topics such as:

- How will MA plans and PDPs be affected by the potential enhancements CMS recently unveiled for the star ratings in 2017 and beyond?
- What strategies did Essence Healthcare employ to reach the five-star MA summit for the first time for 2016?
- What big obstacles are MA plans and PDPs facing on the Part D stars measures, on which average scores fell for 2016? What new tactics are they using to overcome those problems?
- How did the Regence plans, with the aid of their in-house pharmacy benefit manager, make significant gains in their pharmacy metrics using a cross-functional approach?

Visit www.AISHealth.com/marketplace/virtual for agenda and speaker information.

Register Today!

Jan. MA Enrollment Gain in CMS Data May Not Give Useful Insights

The biggest point about the January Medicare Advantage enrollment data that CMS released Jan. 15, according to consultants queried by *MAN*, is that they give a very incomplete picture about what happened in the 2016 MA Annual Election Period (AEP) that ended Dec. 7, 2015. Remembering how big a change there was between the January and February figures during the past three AEPs, the consultants were wary of drawing conclusions from what seems to be a relatively small MA enrollment gain reported for January compared with the December 2015 data (see table, below).

Specifically, the data, which reflect enrollments "accepted" by CMS through Dec. 4, showed that enrollments through this date in "prepaid contracts" — the vast majority of which is MA — amounted to 17,935,534, up from 17,761,121 in the December figures. The December data include enrollments accepted through Nov. 7. The MA subtotal itself climbed to 16,881,624 from 16,734,813, with the number in MA local Coordinated Care Plans (i.e., local HMOs and PPOs) rising to 15,337,796 from 15,210,201.

The gains in some other measures on the CMS report also generally were on the small side. What CMS calls Medicare-Medicaid plans, which aren't included in the MA totals, showed membership of 382,705 in January, up from 371,367 in December, and stand-alone Medicare Prescription Drug Plans gained just to 24,323,724 from 24,269,249. MA Special Needs Plans, which can enroll qualified beneficiaries year round, had enrollment drop to 2,110,544 in January from 2,150,380 in December.

"My general sense is that it's pretty difficult to make conclusions" about the strength of the AEP based on the January data, says Tom Kornfield, a former CMS Medicare official who now is a vice president at consulting firm Avalere Health. He tells *MAN* that there was a big jump in MA enrollment between January and February CMS data last year because many enrollments even before Dec. 4 did not get recorded in time for the January report.

The difficulty, Kornfield explains, is that the enrollment files CMS publishes for Medicare are based on payments to the MA plans. The cutoff used for such payments is usually around the first of the month so that anything posted for payment after that is not included, he says. Sometimes even data from the end of the previ-

Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan (PDP) Contract Monthly Summary Report (Data as of January 2016)

Current Contract Summary:	Number of Contracts	Drug Plan Enrollment			Special Needs Plan Enrollment		Employer Plan Enrollees	
		MA-Only Enrollees	Drug Plan Enrollees	Total Enrollees	SNP Enrollees	Non-SNP Enrollees	Employer Plan Enrollees	Non-Employer Plan Enrollees
Total "Prepaid" Contracts¹	690	1,987,915	15,947,619	17,935,534	2,110,544	15,824,990	3,282,883	14,652,651
Local CCPs	464	1,415,217	13,922,579	15,337,796	1,877,608	13,460,188	3,099,632	12,238,164
PFFS	7	81,393	157,995	239,388	0	239,388	0	239,388
MSA	3	2,302	0	2,302	0	2,302	0	2,302
Regional PPOs	11	121,328	1,180,810	1,302,138	232,936	1,069,202	16,874	1,285,264
MA Subtotal	485	1,620,240	15,261,384	16,881,624	2,110,544	14,711,080	3,116,506	13,765,118
Medicare-Medicaid Plan	60	0	382,705	382,705	0	382,705	0	382,705
1876 Cost	16	317,430	269,229	586,659	0	586,659	166,377	420,282
1833 Cost (HCPP)	9	50,188	0	50,188	0	50,188	0	50,188
PACE	117	0	34,301	34,301	0	34,301	0	34,301
Pilot	3	57	0	57	0	57	0	57
Other Subtotal	205	367,675	686,235	1,053,910	0	1,053,910	166,377	887,533
Total PDPs	72	0	24,323,724	24,323,724	0	24,323,724	4,448,276	19,875,448
Employer/Union Only Direct Contract PDP	5	0	111,086	111,086	0	111,086	111,086	0
All Other PDP:	67	0	24,212,638	24,212,638	0	24,212,638	4,337,190	19,875,448
TOTAL	782	1,987,915	40,271,343	42,259,258	0	40,148,714	7,731,159	34,528,099

CCPs=Coordinated Care Plans; PFFS=Private Fee-for-Service; MSA=Medical Savings Account; PACE=Program of All-Inclusive Care for the Elderly.

¹Totals include beneficiaries enrolled in employer/union only group plans.

Note: Totals reflect enrollment as of the Jan. 1, 2016, payment. The January payment reflects enrollments accepted through Dec. 4, 2015.

SOURCE: CMS monthly enrollment summary report, released Jan. 15, 2016.

Subscribers who have not yet signed up for Web access — with searchable newsletter archives, Hot Topics, Recent Stories and more — should click the blue "Login" button at www.AISHealth.com, then follow the "Forgot your password?" link to receive further instructions.

ous month (i.e., November) are not included in the January report, according to Kornfield.

That said, he points out there may be specific reasons for one of the stronger enrollment increases shown in the January report, namely a rise in regional PPO enrollment to 1,302,138 this month from 1,259,523 last month. He theorizes that the regional PPOs may have gained in part because they often have “more expansive” provider networks than competitors and frequently are in areas not served by many other plans. Moreover, there were some regional PPO expansions for 2016, including in Ohio, he notes.

Contact Kornfield at tkornfield@avalere.com. View the January CMS enrollment data at <http://tinyurl.com/jdteucx>. ♦

MedPAC Adopts Recommendation To Limit Use of HRAs for MA Pay

The Medicare Payment Advisory Commission (MedPAC) on Jan. 14 overwhelmingly adopted a staff proposal that would exclude for Medicare Advantage risk-adjusted payment purposes diagnoses obtained just from health risk adjustments (HRAs) without any evidence of clinical follow-up. It also would require two years of Medicare fee-for-service (FFS) and MA diagnostic data for risk adjustment instead of one year as now.

In addition, MedPAC unanimously adopted another recommendation that would abolish benchmark caps now limiting pay amounts to certain high-star-rated plans and would end double-bonus payments for certain disadvantaged urban counties with high MA penetration levels and below-average Medicare FFS costs.

The recommendations, which will be submitted to Congress in March, came after extensive discussion of the proposals both in last month’s MedPAC meeting and this month. In each case, MedPAC researchers brought to the meeting data suggesting that payments based on Hierarchical Condition Category (HCC) codes discovered only in home visits were soaring and that the double bonuses and benchmark caps were no longer needed, if they ever were.

The HRA recommendation proved to be the more controversial one at both MedPAC meetings, with the reservations expressed similar to those CMS heard when it proposed and later dropped — both in 2013 and 2014 — a similar proposal. But in the end, MedPAC Commissioner Warner Thomas of Ochsner Health System was the only vote against the recommendation among the 17 commissioners.

“This is too broad an approach,” he asserted, explaining that his concern “goes to [the] tone” of the rec-

ommendation because he wants to encourage that HRAs be done. Thomas stressed that he was not denying there is “some abuse” of HRA-based diagnoses by MA plans seeking to use them to get higher pay, but said evidence shows 64% of HRAs now result in follow-up by physicians, a higher percentage than previously. There should be more home-based care and HRA-based finding of diagnoses in Medicare FFS, he added.

While several other commissioners also praised the role of HRAs in MA and elsewhere, their comments focused on the fact that, as Commissioner Cori Uccello of the American Academy of Actuaries put it, “this is not disallowing HRAs,” just making them “more targeted.” And “if someone gets the [follow-up] care in the home, it counts,” pointed out MedPAC Executive Director Mark Miller, Ph.D.

HRA-Related Changes Could Save \$2 Billion

The potential importance of the recommendation, if it is accepted and adopted by Congress, is shown in the impact data presented at the meeting by MedPAC Senior Analyst Andrew Johnson, Ph.D. Making the changes, including use of two years of data and the application of an adjustment for the remaining difference in coding between FFS and MA, he said, would result in Medicare program reductions in spending of between \$750 million and \$2 billion a year.

A MedPAC analysis of MA encounter data for 2012, the first year in which plans had to submit them, found that 30% of HCCs stemming from HRAs showed no related treatment, and HRA-only HCCs accounted for \$2.3 billion in Medicare payments, Johnson said. In 2013, he reported, there was about a 50% increase in the number of HRAs administered and a 10% to 17% hike in the number of HRA-only HCCs.

If this MedPAC recommendation is adopted, the coding-intensity adjustment that CMS applies on MA payments under terms of the Affordable Care Act would be higher for high-coding plans and lower for low-coding ones while still meeting the statutory minimum adjustment now of about 5.7% for 2017, he told the commissioners. He added that evidence shows the coding-intensity impact in MA “is higher than 5.7%.”

The recommendation on benchmark caps and double-bonus counties also could have a big impact on specific plans, albeit not on the MA program overall, based on data presented at the meeting by MedPAC Principal Policy Analyst Scott Harrison, Ph.D. Eliminating the double bonuses would reduce Medicare spending by 0.6%, he said, while eliminating benchmark caps would boost it by 0.5%, according to Harrison.

He said MedPAC found that 63% of plans, covering 82% of MA enrollees, would see payments change by less

than 0.5%. Only 5% of plans, covering 2% of MA enrollees, would have payments decline 2% or more, he continued, while 3% of plans, covering 1% of MA enrollees, would get a payment increase of 2% or more. Payments overall would drop 0.1% for for-profit MA plans and 0.2% for not-for-profits, Harrison said.

Even the unanimously adopted proposals on benchmark caps and double bonuses, though, drew some reservations from commissioners. Double-bonus counties, remarked Commissioner Craig Samitt, M.D., of Anthem, Inc., for instance, were designed to protect plans operating in disadvantaged areas, and removal of those extra bonuses "could create instability" and thus lead to access issues there. He suggested that, if the commission adopted the proposal, there be a "transition period" for plans that would suffer a 2% or greater impact as a result of the change.

MedPAC Chairman Francis (Jay) Crosson, M.D., right before the vote said that while there was no consensus for a transition period, it may make sense to require examination of the impact on plans that incur a 2% or greater impact.

There were no objections raised to abolishing benchmark caps, which now prevent numerous high-star-rated plans from getting their full stars bonuses. That's because such bonuses would result in their total pay being higher than it was prior to the ACA, and thus violate a provision of that law (*MAN 8/23/14, p. 5*).

View a transcript of the MedPAC meeting at www.medpac.gov/-public-meetings- ♦

Calif. Won't End Duals Demo in '17

continued from p. 1

But as the three-page section on CCI in Brown's budget makes clear, the financial results of the California initiative to date are not encouraging, albeit partly because of factors related to federal regulation rather than to matters under Cal MediConnect's control. To help pay for CalMediConnect's implementation, for instance, the budget noted, the feds allowed a 4% tax on MCOs through June 30, 2016. The budget notes, though, that the feds found the way California structured this tax on insurers in the Medi-Cal managed care program "is inconsistent with federal Medicaid regulations and will not be allowed to continue without major modifications."

While California lawmakers as of late last year had been unable to come up with a replacement for the tax, there may have been a breakthrough on that this month. *Kaiser Health News* reported Jan. 8 that Brown's administration appears to have reached a tentative agreement with some of the state's largest insurers on a new broad-

based health plan tax that would be offset with reductions in other taxes and could yield a resolution.

The tax is far from the only problem facing the CCI now, Brown's budget description emphasizes. Other problems, it points out, include that as of Nov. 1, 2015, about 69% of eligible duals had opted out or disenrolled from the demo, and the rate is about 83% among In-Home Supportive Services (IHSS) beneficiaries. And because of revised federal labor rules, IHSS providers have become entitled to overtime compensation, thereby "significantly" increasing the state's IHSS costs.

Those financial issues are of particular concern because of a bill requested by Brown and passed by the state legislature in 2013 (*MAN 6/27/13, p. 1*). Under that law, Brown's new budget points out, the state's director of finance must send to the legislature annually a determination of whether the CCI is cost-effective. "If the CCI is not cost-effective," the budget section notes, "the program would automatically cease operation in the following fiscal year," which would have been January 2017 had Brown invoked the provision in the current budget.

New Decision Time Will Be Next January

He apparently could have done this, especially since the section says that "if the managed care tax is not extended, the Budget projects net General Fund costs for the CCI of approximately \$130 million in 2016-17 and beyond." Instead, however, the budget says, "the Administration proposes to continue to implement the CCI in 2016" while retaining the option of deciding next January to drop it effective in January 2018.

"The governor's decision is an indication of continued support to have this program," maintains Cantwell.

The state stance drew cheers from demo participants. Martha Smith, chief duals program officer at Health Net, Inc., which serves Los Angeles and San Diego counties in Cal MediConnect, says the insurer is "encouraged by Gov. Brown's proposed budget and the continuation of the Coordinated Care Initiative through 2016." Smith tells *MAN* "we continue discussions with the administration in the expectation of finding a solution to continue the MCO tax."

She adds, "We believe the initiative deserves a long-term commitment from the state so it can continue delivering on its promise to improve care and lower costs."

Before there is any such long-term commitment, however, the state and its partners will need to find solutions to some continuing problems, including negative provider attitudes and actions regarding the duals demo and their influence in discouraging beneficiary enrollment (*MAN 7/30/15, p. 1*). Toward that end, Cantwell notes, Sarah Brooks, deputy director - health care delivery systems at DHCS, is working with participating

demo plans in California on “education at the provider level,” including sharing “more broadly” evidence turned up in surveys and focus groups that Cal MediConnect is improving care.

Brooks says the steps being taken on this goal also involve development of “toolkits,” including one for providers, to answer questions about the demo. And DHCS and plans are working with foundations for providers, including ones focusing on ethnic groups, “drilling down in the data” to see where particular pockets of problems with providers are.

On the beneficiary side, part of the focus now is on streamlining processes by which duals who previously had opted out of Cal MediConnect can decide to opt in.

Such decision reversals by enrollees already are happening “in small numbers,” Brooks tells *MAN*. Cantwell points out that passive enrollment in Cal MediConnect now is “mostly over,” with late-starting Orange County the main exception, so DHCS is working with participating plans to make sure duals get information about easy enrollment processes available for them to get back in.

The CCI insurers themselves are unlikely to pull out, both California officials suggest, since there were about 116,000 duals already in the state’s demo when this month began, a figure high enough for the plans to want to continue. The California demo is by far the biggest in the 13-state CMS-backed initiative.

continued

United Agrees to Pay \$100,000 to Settle N.Y. AG’s I-SNP Coercion Probe

UnitedHealth Group and the New York state attorney general’s office reached a settlement Jan. 6 that bars United from requiring skilled nursing facilities (SNFs) seeking to contract with the company’s other health plans in the state to contract with United’s institutional Medicare Advantage Special Needs Plan (I-SNP). The agreement, the office of Attorney General Eric Schneiderman (D) said Jan. 7, followed SNF complaints that by requiring such I-SNP participation as a “condition for participating in its broader provider network,” United “was foreclosing competition from alternative I-SNP providers.”

As part of the settlement, United agreed to pay the state a \$100,000 penalty. The agreement specifically says the insurance giant “neither admits nor denies” the AG’s findings.

In the document, called an “Assurance of Discontinuance,” the AG’s office said it had “reviewed complaints from market participants, interviewed numerous SNF operators throughout New York State, and spoke with other health insurers that offer I-SNP insurance plans” there. It also obtained and “analyzed relevant market data.” The document noted that UnitedHealthcare is the largest MA health insurer “in several counties in New York, and has a significant market presence in many other counties,” aside from its managed Medicaid and long-term care plans and its “significant” share of the employer-based commercial market in the state.

The AG said that UnitedHealthcare “is by far the largest provider of I-SNP plans in New York,” with more than 10,000 covered lives and a market share “that approaches 70%.” Its competitors on the product, which is designed to keep as much care for

nursing-home patients as feasible in place and thus reduce hospital admissions, include ArchCare, Centerlight, Elderplan, Healthfirst and Independent Health, the document added.

The AG’s concern, according to the document, is that by using “its clout to induce certain SNFs to contract for the United I-SNP,” it is limiting rivals’ ability to compete on the product.

Under the settlement terms, United may not penalize a SNF for refusing to participate in the insurer’s I-SNP by offering the SNF “lower reimbursement rates than those offered to similarly situated SNFs who do not participate in United’s I-SNP,” even if they have not been asked to do so, and may not terminate or decline to renew contracts with non-I-SNP United plans on the basis of the SNF’s nonparticipation in the I-SNP. But United retains the freedom to “independently decide which SNFs to contract with for any of its plans” and may decline to enter or renew contracts with a SNF based just on “the business case for a non-I-SNP contract on a stand-alone basis.”

Asked what led to the settlement and what United may do differently as a result of it, company spokesperson Brad Lotterman replied with a prepared statement saying only that “we work with providers who will help the people we serve receive the high quality care they need to get and stay healthy, and we are pleased that the State recognizes that.”

View the New York settlement by visiting the Jan. 28 *From the Editor* entry at your subscriber-only Web page: www.aishealth.com/newsletters/medicareadvantagenews. Contact Lotterman at brad.lotterman@optum.com.

The IHSS situation is more complicated. The principal problem, as Cantwell explains it, is the state stands to bear the full costs of a 3.5% increase in annual overtime expenses for those services, with the entire amount being attributed to the CCI even though 51 of the 58 counties in California are not participating in it. She says state officials now are looking into options for changing that.

California is further along on the replacement for the Medi-Cal MCO tax, and Cantwell says the impact of the new tax being discussed would be to improve the cost-effectiveness of the CCI.

With all these factors in mind, DHCS is not focusing now on replacements for Cal MediConnect if the cost-effectiveness is not apparent by next January. Cantwell, however, points out that even if the initiative runs only through 2017, it would mark for California completion of the full three-year duration of the demo, leaving as unused only the two-year extension CMS offered last summer (*MAN* 7/30/15, p. 1). Other options for duals care integration after that, she tells *MAN*, could include

having duals enroll under Medi-Cal in insurers that also would operate MA Special Needs Plans for duals.

Plans participating in the CCI clearly would rather see the current initiative continue — if it can be improved. “We appreciate the inclusion of the CCI in Governor Brown’s budget proposal,” says, for instance, Lisa Rubino, senior vice president at demo participant Molina Healthcare, Inc. “Recent polls have shown that an overwhelming majority of enrollees are satisfied with the service provided by health plans serving them through the CCI.”

But Rubino also tells *MAN* that “the success of the program will depend on the number of enrollments — without enough members participating, the savings envisioned in the demonstration project are simply not achievable.”

Contact Cantwell and Brooks via spokesperson Anthony Cava at anthony.cava@dhcs.ca.gov, Smith at martha.smith@healthnet.com and Rubino at lisa.rubino@molinahealthcare.com. ◇

NEWS BRIEFS

◆ **CMS on Jan. 21 temporarily halted new enrollment in and marketing for Medicare Advantage and stand-alone Medicare Prescription Drug Plan (PDP) products of Cigna Corp. following an October audit.** The duration of the suspension is uncertain. CMS said it found severe deficiencies in coverage determinations — including for prescription drugs — and appeals and grievances, enough so that “Cigna’s conduct poses a serious threat to the health and safety of Medicare beneficiaries.” Violations included a failure to communicate with providers on clinical decisions in appeals, failure to provide complete and timely information in appeal decisions and failure to follow proper reconsideration processes, among others. The agency said it had repeatedly warned Cigna about violations in the past, and that the insurer has a “longstanding history of noncompliance.” Herb Fritch, the HealthSpring, Inc. founder who is president of Cigna-HealthSpring, said, “The findings in the audit are unacceptable and will be addressed in full partnership with CMS.... We have already started working to remedy them.” Cigna had nearly 544,000 MA and about 1.1 million PDP members as of Dec. 4. Visit <http://tinyurl.com/gpzzvx9>.

◆ **An Iowa Polk County judge on Jan. 22 ruled that the arguments of Aetna Inc. and WellCare Health Plans, Inc. on why they were unfairly shut out of**

the state’s new Medicaid managed care program are “unpersuasive.” Judge Robert Blink determined that the Iowa Department of Human Services operated within its parameters and had “particular reasoned actions” for selecting each insurer (*MAN* 12/17/15, p. 5). Blink said that Aetna and WellCare were each asking the court to “substitute its own judgment for that of DHS.” Aetna had alleged the bidding process was unfair, while WellCare’s initial selection by the state was overturned by an administrative law judge and later by the director of Iowa’s Department of Administrative Service on grounds of unethical bidding practices. Both companies still may make further appeals. Visit <http://tinyurl.com/zbjmsg3>.

◆ **CMS’s current risk-adjustment model for Medicare Advantage underpredicts costs for members with multiple chronic conditions by \$2.6 billion a year,** according to a new study conducted for the America’s Health Insurance Plans trade group by Avalere Health LLC. The report released Jan. 22 found that CMS substantially underpredicts expenses of care for beneficiaries with such conditions as chronic kidney disease, osteoarthritis, rheumatoid arthritis and Alzheimer’s disease and related conditions. View the report at <http://tinyurl.com/zolfets>.

Call Bailey Sterrett at 202-775-9008, ext. 3034 for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data...daily, weekly or whenever you need it.

**IF YOU DON'T ALREADY SUBSCRIBE TO THE NEWSLETTER,
HERE ARE THREE EASY WAYS TO SIGN UP:**

1. Return to any Web page that linked you to this issue
2. Go to the MarketPlace at www.AISHealth.com and click on "Newsletters."
3. Call Customer Service at 800-521-4323

**If you are a subscriber and want to provide regular access to
the newsletter — and other subscriber-only resources
at AISHealth.com — to others in your organization:**

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)