Keynote Address

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Demetrois Kouzoukas: You must have practiced on the pronunciation…got it right on the first try.

So delighted to be here today…I wanted to welcome each of you here and in the webcast. I understand there are 3,000 people, I'm told, on the webcast which is really exciting to CMS as we present our two-day conference for 2017. It's just a delight for me to be here, particularly to be on this side of the discussion. I've been out in the audience in years past and out on the webcast, and really have enjoyed the opportunity to sort of see CMS discuss its policies in this kind of setting. And now it's a real delight to be here on this side of the podium and help welcome you on behalf of the Administrator and the Agency to this conference, and encourage you to participate both today and invite you into an ongoing dialog. I'll talk a little bit more about that.

I also wanted to start by noting of course a very important Call Letter and Rate Announcement that we put out this year and the Request for Information that was in it that I hope many of you paid close attention to. I know we got a lot of great responses to that, and I want to summarize some of that for you today as we get started.

I thought I'd start by telling you a little bit about what we're hoping to accomplish in the Medicare Advantage Program. Much of that has been

discussed in the Call Letter and the Final Rate Announcement, but a few notes in terms of highlights and priorities. You'll see from having reviewed the Final Announcement and the Call Letter that we're focused on creating flexibility and innovation to encourage MA organizations and sponsors to develop new offerings. This is something that is very important to the Agency as we embark on new leadership at CMS and continue to help promote the MA program and ensure that it meets the needs of beneficiaries.

So you'll see a few specific policies that reflect that. For example, we're allowing differences in provider networks to constitute a meaningful difference in our review of benefit packages. You'll note an increase in the TBC, or total beneficiary cost, that allows MA plans more flexibility in how to design their benefits. You'll also notice that our overall approach and tone is one of encouraging plans to come in with offerings that are tailored to the populations that they serve.

The MA Program, as you know, perhaps those of you who work directly with beneficiaries best of all, provides beneficiaries with a valuable choice, one they might not otherwise have at all. So as I've worked with the CMS team on charting the direction of the MA Program and CMS's oversight of it, we've talked about what that vision is like and what we want to see come forward in the MA Program. I hope that you see in the Call Letter and the Rate Announcement, and in our ongoing policies, that the emphasis there is that we want the MA Program to reflect its original and true purpose, which is to provide an alternative to Medicare fee-for-service that reflects the needs of beneficiaries that aren't going to be met necessarily by the fee-for-service program.

So we hope to adopt policies that encourage that, and we're working hard to do that. It's not always sort of a simple, an overnight task; but we are exploring many of those things, including many of the ideas that came in, in the RFI to do that.

What I ask also of plans and others who are working the MA and Part D worlds is to take up that offer and to take advantage of the flexibilities that we offer and that we're going to try to make available,] and can actually put forward offerings that are different and varied and that that do meet the needs of varied constituents and beneficiaries, from the chronically ill to the active well who manage their own care, all of which have different needs. So that's sort of the overall direction.

We also look forward to partnering with you and building a relationship with those who administer the program…the actual plans and benefits that make an impact on our beneficiaries' lives. We have continued a process of asking for dialog and comments on various topics, and I'm delighted to see that there are additional steps in transparency that we're also undertaking. For example, we made our civil monitor a penalty methodology publically available, including changes based on comments; and we're also establishing a working group to identify critical issues in processing encounter data.

These are just a couple of examples but the overall point here is that in making sure that MA works and Part D works, we need to do that in conjunction with those who actually operate the plans and others who work with beneficiaries downstream as well and also with the beneficiary community. Our hope is to partner and dialog with the entire external world in terms of how we adopt our policies and to address the kind of operational impediments or obstacles that might be created by the rules at times or just by the fact of how or internal to individual organizations as well, sort the internal challenges and let us know as part of that dialog what we could or should be doing differently. We certainly won't hesitate to do the same, as you perhaps well know.

Also, I encourage you to continue the strategic conversations that many plans have been having with their account managers located in the regional office. It's a good opportunity to get sort of a broader perspective on plan performance.

I also encourage you, of course, to feel free to reach out to me; to my deputy, Cynthia Tudor,; or to any of the capable leaders I see assembled here today, many of whom you'll be hearing from in the MA and Part D programs here at CMS. I think that you'll find that they're a valuable resource for you, and it's been a real great experience for me to come in and be really honored to lead a team that knows the program so well and is also really committed to ensuring that it fulfills its purpose and that beneficiaries have made available to them all that's promised and all that can be made available in terms of opportunities as well.

Returning back to the Call Letter a bit, as I mentioned, CMS expects that the updated policies in the Call Letter and the Rate Announcement will provide additional flexibility. We have made changes that I mentioned, highlighted in that regard; but we also finalized policies and plans with respect to payments. As you know, after incorporating all the anticipated increases in coding intensity, CMS estimates that the average payment to plans will result in a total change of around 3%...2.95% to be precise.

With respect to encounter data, we received extensive comments from plans and other stakeholders. We were not surprised in that regard. We know it's an issue of great concern and that people are engaged actively in how to deal with the encounter data challenges. We decided to use an 85/15 blend of RAPS and encounter data in 2018 so that we have time to work with plans to address the technical and the operational issues and the kind of dialog that I laid out.

CMS will be working to ensure that our internal operations are working effectively so that we can process plan submissions accordingly, and we look forward to working with you as well to let us know what we need to be doing in that regard.

I also want to emphasize though that we do intend to ensure that encounter data is a fully robust system and that we have the ability to collect complete and accurate data with regard to encounters. So we

encourage you to actively participate. If you see that there are challenges in some of the discussions we'll be having, but also internally even if that's not part of your focus, to put resources and attention behind how to ensure that the encounter data system can work for your plan as well.

At the same time, I wanted to mention that for employer group plans we opted to pause a transition to a new payment methodology. This was in order to understand better the changes that we're making and the impact that they're having on beneficiaries. We intend to seek an understanding of those changes by engaging in discussions and outreach to people in the industry, as well as to others who are involved directly with the sale of employer plans. But I think at the end of the day, the plans know best and most closely exactly what the impact is on the kinds of offerings we're able to make. So please let us know, and not just anecdotally but with data, to the extent you can, what you're seeing as a result of the Employer Group Plans. We'll be engaged in our own fact finding; but if you can supplement that with direct information and data, that will be helpful to us as we consider what the best course is in the years ahead.

We also have been working on Star ratings. The Star Rating System, as you know, is very impactful certainly to payment and more broadly; and we're looking really at both C and D ratings. We're interested in improving the clinical measures that are included in Star ratings to ensure that beneficiaries have accurate information about how their plan performs on these indicators, but we also want to engage plans in discussions on ways that we can ensure the accuracy of the data used for Star ratings.

As a result of the continuing concern over the impact of audits on Star ratings and the overlap between the two, we discontinued the use of audit findings in the BAPP measure. We also are expanding CMS's monitoring efforts to include timeliness monitoring of all plans, including protocols from CMS's audit reviews. You'll be hearing a little bit more about this today. This timeliness monitoring will help us identify opportunities to

improve the processing of appeals, but it will also give us a better understanding of the options that we might have with regard to data integrity and how to consider the right data integrity policy as the program continues to evolve.

Finally, a critical area for MA and Part D programs is the effective processing of coverage requests. This is something that I know many people struggle with. These processes provide important protections for beneficiaries. We know that CMS audits routinely identify issues in how these requests are processed. So we want you all to obviously continue to focus on how to improve your operations with regard to that. At the same time, we're interested in ways that we can simplify the process and ensure a less complicated system for plans to follow, balancing that with the needs of beneficiaries to access care obviously.

So that's a little bit of where we're going in MA and Part D more broadly. I wanted to give you a little bit more context than the formal language the Call Letter and Rate Announcement give sometimes in terms of what's really important. It's a long document, has a lot in it, all of it very important; but these are the things that are sort of priorities for me and some of the other leadership as we continue to look at MA and Part D and guide it.

I wanted to also mention a little bit about MACRA and the Social Security Number Removal Initiative. This is something that is perhaps – it's not as deep in the policy sphere as some of the other things that we've talked about; but it's very important because it will be something that touches every Medicare beneficiary because they'll be getting new cards, as you know, and have a lot of questions about it. We're working hard on the A and B side to be able to anticipate those questions and some of the challenges that come as a result of the changes. We hope and expect that on the C and D side that you all are ready since you're often the first face that beneficiaries work with when they have a question to be in a position to help beneficiaries understand what the implications of the

changes are, and if there are things that we need to do to support that that you let us know as well.

As you know, the legislation requires that the new cards be mailed by April 2019. We're making changes to our IT systems. We're planning communication strategies. We expect that you're doing much of the same, so please let us know how it's going. If you feel that there are going to be challenges or issues, it's better for us to know earlier so that we can work with you and also make adjustments in some of our plans as well. So don't hesitate to do that.

We anticipate that we'll complete our system and process updates so that we can accept and return the new Medicare beneficiary identifier on April 1, 2018. It's an aggressive timeline; but a lot of work has been underway to make that happen, and I'm delighted that it seems like everything is on track.

We plan to engage in extensive outreach as well. Approximately 60 million beneficiaries, agents, advocacy groups, caregivers, will get information from us about the new card and instructing how the new card can be used, how to dispose of the old card. So those are sort of the major things that we're doing. I wanted you to have that as you consider your planning because obviously inevitably you do get questions as well.

So having wrapped up a little bit on the rate notice and the Call Letter, sort of the overall policy objectives, and some of our important work on the Social Security Number Initiative, I wanted to devote a little bit of time as well to the RFI, the Request for Information. It was something I was just really excited to get out there; and whenever I had an opportunity to talk to folks about what we were focused on, I kept sort of sending them back to the RFI. Send us what you have and make the submissions as serious and complete as possible.

I'm just delighted -- I got my first briefing on the contents of that with the team the other day -- to hear that there was such a robust discussion and good feedback in those comments. We received comments from over 130 people or organizations. As you may recall, we asked for ideas that will help CMS improve transparency, flexibility, program simplification, and innovation; and I think that the outside world delivered. So we have a lot of work underway to consider those comments, to categorize them, think about what they require in terms of subregulatory, regulatory, or statutory change to analyze the pros and cons of many of the individual suggestions.

I thought I'd just share with you a little bit about what we heard so that you have a sense of what the broader community is talking about. I'd say the comments fall into three categories. One is to streamline and improve our oversight and management of plans. We had comments that suggest we reengineer the way we provide subregulatory guidance, the use of HPMS, notices, that we put more updates in the manuals more frequently rather than use HPMS; all of this would be designed to ensure plans have accurate, consistent, and up-to-date guidance. We'll be taking a look at the number and frequency of HPMS memos and how a more coordinated process could make everyone's life simpler and make the program easier to administer, both on our side and yours.

We also received comments around streamlining, improving, and coordinating the CMS appeals process, the CMS audit process, Star ratings changes and improvements. I think I talked a little bit about some of what we're thinking about in that area. We received comments around facilitating pricing and reimbursement, transparency, and fairness. We'll be looking at changes in Plan Finder, for example; but budgets are always a bit of a challenge, which is true of any organization. So thinking creatively too about ways that we might be able to improve the way that Plan Finder helps people make decisions.

We'd definitely welcome suggestions from the outside world as well on that. Many of you have your own websites and IT challenges and figuring out how to make things work better. If you have ideas for what you think would work well in Plan Finder, over and above what you've told us in the RFI, we welcome those as well.

Another area is a more general area in addition of the streamlining and improving oversight and management of plans is improving the beneficiary plan selection process, the marketing materials process, enrollment changes, and education. There where we received suggestions around developing more beneficiary-friendly materials in terms of the things that we put out, and I've been sitting down with our Office of Communications as well that puts out a lot of the Medicare materials, including the new Medicare Handbook and other items; and we've been talking about how we communicate MA and Part D options in those materials as well.

We also received suggestions around allowing paperless marketing and other beneficiary materials. We received suggestions around comparing MA options with fee-for-service. So these are all really fascinating ideas. I have really found it difficult to restrain myself from having meetings with the team run way over as we delve into some of these things; but I assure you, we're working diligently on a lot of these proposals.

Our focus is to improve the ability of the beneficiaries, obviously, in the Medicare Program; to identify the best options for them…whether that be an MA plan, a Part D plan, fee-for-service; select it; and then manage their care within it, in conjunction with their provider.

A third area, in addition to oversight and management of plans and beneficiary plan selection processes and the like, is innovating a program design to provide options in improving care and outcomes. There we received suggestions around modernizing the risk adjustment model, payment methodologies, and coding guidelines – obviously, an important

area. Some of those things may require statutory change and the like, but we're also looking at what we have the ability to do without that.

Expanding benefit flexibilities in MA around uniform benefits, meaningful differences, benchmark caps, telehealth, and network adequacy…you bunch all those together, and those are the pieces that I think result in the flexibility I talked about in terms of additional plan design and options. I do hope that the work we've done and will continue to do in that area does result in new options. So if there are reasons that you think we need to do something different or more, that beneficiaries have a demand that's not being met in the marketplace because of something that we're able to change, particularly about regulation or subregulatory guidance, please continue to have that discussion with us.

We also received ideas around providing greater flexibility in Part D to manage costs. These included ideas to change the number of drugs required per class, the transition benefit modifications, mid-year formulary changes, and specialty drug and high-cost drug management. We also received ideas, I think, falling into the general category around expanding Part D network flexibilities, addressing changes to any willing pharmacy rules, specialty pharmacy access, and mail order.

I think the other thing I was delighted to see is that we did receive comments from a broad variety of stakeholders…plans and beneficiary groups and vendors and others involved in the administration of the MA and Part D Programs. So I think I've given you a bit of a summary. What you haven't seen is sort of the variety of perspectives on many these things, and so that's part of the process I talked about in terms of analyzing what we might do with these.

Some of these ideas are ones that we think that we could and should adopt in the short term. Others are things that will require longer-term regulatory or maybe even statutory change, as I mentioned. My expectation and my hope is that we will look at the entire range of

options. We'll be not focusing only on sort of the low-hanging fruit, but some of the things that are harder to accomplish on our end as well. So that's the course we're engaged in.

I can't thank you all enough for the transformative ideas you've submitted. I look forward to working with you to provide the healthcare and value that Medicare Advantage and Part D beneficiaries can obtain in the MA and Part D programs.

I hope you have a great conference and a good day. I appreciate both your participation in this conference, but really in the program. At the end of the day, it's a delightful – it's a great opportunity for me to be part of this program in a different way than I have before and also to come back to government, having done some prior service as well with the perspective of experiences I've had in the interim.

So I look forward to putting those to work to make sure that the program operates as well as it can for our beneficiaries, and I'm looking forward to partner with you and guide the CMS team as we do so. Thanks again.

[Applause]

Stacey Plizga: Okay, our first session today consists of a panel of speakers who will provide participants with an understanding of CMS's auto forward policy for untimely cases and enforcement actions for non-compliance. Current guidance, upcoming enforcement actions, and common questions will be discussed by Amber Casserly, Gregory Bottiani, and Leila Zahama.