Open Q&A Session

Stacey Plizga, PRI

Stacey Plizga: Okay. We will go ahead and start with the open Q&A session. And I would like to call up our first group of speakers, and that would be for session one, Auto-Forwarding Coverage Determination Cases to the Independent Review Entity -- Policy, Monitoring, and Compliance.

Okay. At this time, I would like to invite anybody from our in-house audience, if you have a question for this group, please step up to the microphone. And if there are none, I will go to the questions we received from our virtual audience. Okay. So, starting with the first question from our virtual audience, "If a case was denied due to lack of supporting statement, but the notice was not timely, do I still need to refer to the IRE if ultimately the IRE's decision would be the same as the plan sponsor?"

Amber Casserly: So, the answer to that is yes. So, even though the IRE would ultimately have the same response as the plan sponsor, they'll be doing a substantive review on the case.

Stacey Plizga: Okay. The second question, "For the thresholds listed for a CMP, the exclusions are written as 'and,' indicating that all three must be true, but was presented today as 'or,' meaning if any of the three exclusions apply, a contract is excluded."

Leila Zahara: That is correct. If any of the three exclusions apply, a contract is excluded.

Stacey Plizga: Okay. And we have one last questions here, "Regarding the example, yes, in this case, even though oral notification was made in a timely manner, the required written notification was made after the timeframes expired, and the case must be auto-forwarded to the IRE. If the oral notification was in approval, is the decision still valid or should an enrollee be called again to notify them that there is no decision and the decision will be made by the IRE?"

Amber Casserly: So, if the question is asking how should the beneficiary be notified once the case has been sent to the IRE, then the plan would send the model case -- the model notice that's in appendix six, notifying the beneficiary that the case files have been sent to the IRE.

Stacey Plizga: Okay. Last chance for any questions for this group. All right. Well, thank you very much. At this time, I would like to ask for the next group to come up for Summary of Benefits.

Okay. Anyone from our in-house audience, questions for Summary of Benefits? All right. Well, jumping right to our virtual audience questions, number one, "What is the expected penalty for plans who failed at following order of SB?"

Elizabeth Jacob: We are still considering levels of compliance. We are still doing our analysis.

Stacey Plizga: All right. The second question, "What HPMS code should be used for submitting the SB? To confirm, are plans prohibited from creating or using a benefit highlights in the addition to SBs?"

Elizabeth Jacob: So, the code that you should be using to submit is 1099. It's the same as the one that was used last year; the one before that was retired. And we would encourage you to only use the summary of benefits, but you are not prohibited from using a different document. That said, it was clear from the polling questions that a lot of you are still using a different

document. And our ultimate goal is to create or have guidance for you to create something that works for you so you don't have to use something else. So, we would solicit your feedback to let us know what's working with the guidance we sent, what's not working, and if you could send that in to our marketing mailbox at marketing@cms.hhs.gov, we would certainly appreciate that.

Stacey Plizga: Okay. And I have one last question here. "Would it be considered non-model to include a Medicare FFS Cost Sharing column and description in the summary of benefits, similar to the Medicare column that was included previously when CMS provided the summary of benefits printout through HPMS?"

Elizabeth Jacob: Okay. First and foremost, we have not provided a model for the SB. We provided a sample with a memo to help understand the SB memo. You can deviate from the sample as long as you follow our requirements.

Stacey Plizga: Okay. Last chance for questions for the Summary of Benefits. Okay. Well, thank you so much. We'll pull up our next group. Our next group, the title of the session was Supporting Access to Information for Individuals with Disabilities, or Section 504. We have Bridget and Kimberly. Okay. Any in-house questions? All right. We'll jump to the virtual questions. First one, is there guidance regarding having to provide beneficiaries everything that is requested?

Kimberly Snowden: Actually, there is. If a beneficiary makes a request for a fulfillment, you, at this time, are required to provide them with the information that they've requested in an accessible format. Of course, it's our recommendation to kind of work with the beneficiary, see what they need, and, as we communicated with you today, have that open line of communication and see what they're looking to receive from you in that accessible format, find out what their need is, what their requirement is, because there is a level of undue burden that can possibly be presented, but the requirement of undue burden is it's a really high marker for what undue burden is.

So, if you're looking at the policy of 504, which we talked about today, which is CFR 84, I know we've mentioned that today, it's in your presentation, they talk about that a lot. So, when you're taking that into consideration when you're fulfilling this request of what a beneficiary is specifically asking for, you need to really set that marker high when you're trying to fulfill the request. But when a beneficiary is actually requesting information from you, you really need to, you know, make sure that you're providing your program information in an accessible format, that way it's consumable information and the beneficiary understands it.

Stacey Plizga: Okay. The next question, "Are CMS materials available in alternate formats, for instance, braille or audio, for health plans to utilize?"

Kimberly Snowden: So, CMS materials for utilization by plans, plans should have the responsibility of providing an accessible format when it's requested from their members or their potential members. So, if you receive a request to fulfill an accessible format, you should be fulfilling that. We receive requests to fulfill our materials in the accessible format. We work with our fulfillment contractors to fulfill those requests. And the expectation is that you will do the same.

Now, if you're having issues or if you're hitting roadblocks in any way, shape, or form, we recommend that you reach out to your account managers so we can have a conversation with you to find out what your hindrances are, what your current roadblocks are. As Randy had mentioned today, we want to work with you and understand what your challenges are meeting these requirements, but at the current, you know, situation stands is if you, you know, receive a request to fulfill these requests for individuals with disabilities, it's your requirement, regardless of what the program information is, to fulfill that request.

Stacey Plizga: Okay. Our next question, "Due to the cost associated with having documents in braille in stock, what does CMS consider a timely manner? Our organization has not received a request for braille documents."

Bridget Berardino: So, this is a complicated question, and I think as we talked about earlier today, a lot of the communications are -- a lot of the solutions are dependent on the communication that you are sending. For example, you don't have a request for something in braille but you get one, you have to have a process in place to fill that timely. You know, for example, here at CMS, we have instances where we have premium bills that we need to mail, we actually have put in a process in place where we issue those in braille or large print or an alternate format at the same time that the regular print premium bills are sent because there's such a timely manner in terms of EFT transmissions or bills that need to be paid.

So, you can't be in a situation where your ordering time for something in the alternate format puts the beneficiary in a position where they're not able to respond timely to that communication. So, one of the things that we've done internally is taken a look at all of our communications to determine some of those timely implications, so then we can make a decision about what we already have potentially on stock or what process we can automate to make sure those are done timely. And I think that's our recommendation to each of you is to look at those processes and establish that business process so you can do it, but I can't give you a standard timeframe because, again, everything that we all send has different implications, depending on the nature of the communication.

Stacey Plizga: Okay. Next question, "How do you suggest plans approach a request for large-print ID cards? ID cards have limited space to enlarge the font. Can we print a laminate -- print and laminate a large-print version of the ID card for the member?"

Bridget Berardino: This is a great question. And as you guys just heard, we're actually in the process of looking at our cards as well. We have had requests on the CMS side for braille Medicare cards. And, unfortunately, we're not in a position to provide that because that does not then help the card be used for its purpose when given to the provider. So, what we did is we actually provided a letter explaining the reason that we cannot provide the alternate format for the card, but the letter explains the content of the card

as well as the reasoning behind the material that's being sent in the alternate format that was requested.

So, again, that's kind of an example of why this is more of a communication about what it is that's -- what the communication is and what the person is requesting. We did find issues with mass producing cards in braille or large print. So, we had to come up with some creative solutions to try to get to what the communication is and make sure we're giving access to the program and services to the "bennies."

Stacey Plizga: Okay. "If a member requests a visual aid, such as large print or braille, once, do we have to send all materials from that point on in large print or, as slide 18 states, can we make these materials available as requested, as long as they are made available in a timely manner?"

Bridget Berardino: And I think that was one of the things we talked about this morning. I think the goal is to improve customer service and try to make an effort to identify beneficiaries that would like their communications in a particular format. We, on our side, have actually worked with the call center to ask the beneficiary, "If you call and ask for your Medicare handbook in a particular format, would you like all of your Medicare communications in that format?" And then we're actually recording that and trying to automate our processes in such a way so that we can produce that as normal operations. So, I think the goal is to improve our customer service so everyone that we serve and have that as the case. We recognize that there's some operational complexities. And, again, if there's specific things that we haven't considered, we'd be happy to have that conversation.

Stacey Plizga: Okay. And the last question that I have here from our online viewers, "Is the plan required to have online appointment systems or simply require providers have this as an option?"

Kimberly Snowden: As far as the requirement to have an online appointment system, no, it is not a requirement to have an online appointment system. If you have one,

you have one, that's up to you. That's an organizational choice. But if you do have that, then you need to make sure that it is accessible. You need to make sure that it's accessible for any individual, disabled, non-disabled. You just need to evaluate and look at it in your processes. So, that's just an organizational choice.

Stacey Plizga: Okay. That is -- oh, we do have one in-house question.

Linda Howard: Are there any -- are there any documentation requirements in terms of certifying, like, translations or alternate formats?

Kimberly Snowden: That's a great question.

Linda Howard: Do you have a great answer?

Kimberly Snowden: That's a great question. No, but what I'll tell you is we'll take it back and we'll look into that. So, that is -- that's a great question.

Stacey Plizga: Okay. That brings an end to the questions that we have for Bridget and Kimberly. So, next up I would like to ask the speakers from Medicare Advantage Organization Performance on CAHPS Measures to come on up. So, we have Liz and Sarah. Okay. Online questions received, the first one, "Are the MA PDP CAHPS results case-mix-adjusted?"

Liz Goldstein: Yes, the CAHPS results are case-mix-adjusted, you know, for factors that impact how someone responds to a survey. So, it's factors such as age, education, health status, dual LIS status. If you are interested in the factors and coefficients, it's in our Part C and D Star Ratings Technical Notes.

Stacey Plizga: Okay. "Can CMS share state-specific CAHPS score comparisons for other states, such as New York, et cetera?"

Liz Goldstein: So, the state comparisons, you know, for the state where you're located is in your plan reports that CMS produces, but I think we could put them up

also on our website, all of the state comparisons. So, we'll take that back to the team and, you know, put something up on our website.

Stacey Plizga: Okay. What is the methodology behind CAHPS scores that are shown as N/A in final CAHPS reporting due to low reliability?

Liz Goldstein: So, that is cases where there are not enough responses to have reliable performance, meaning we're picking up more noise than true performance. So, if you get down to the statistics, it's under a .6 reliability. But it's just that we feel like we're picking up more noise than true performance, so it becomes an N/A.

Stacey Plizga: Okay. And the last question from our viewing audience, "For plans that are still too small for a formal CAHPS survey to be conducted by an approved third party, can the plan still utilize the CAHPS questions to perform a proxy survey?"

Liz Goldstein: Yes, the CAHPS surveys are in the public domain, so you can go ahead and use the instrument and use it for quality improvement or for whatever, you know, purposes you would like.

Stacey Plizga: Okay. And those are all the questions that we have for Liz and Sarah. So, I would like, next, to ask Kerry, Jim, and Jeanette to come up for the Provider Directions Review Update. We've got someone waiting already. All right. Go ahead, please.

Travis Sutphin: Hello Travis Sutphin from EmblemHealth. For the broader directory updates, the requirement to indicate accepting new patients. Is that for both the paper directory and online, or just either/or?

Kerry Casey Both.

Travis Sutphin: Both. Okay. Second question, is CMS considering a national database so that providers only have to make one update, and then that information can be sent out to the plans where we can then update our information?

Kerry Casey: So, while we have heard that recommendation from plans before, and we're taking that under advisement, there have been no steps made to begin that process, but we do continue to hear that suggestion.

Travis Sutphin Thank you.

Stacey Plizga: Okay. Going to the questions received from our viewing audience, first one, "Are protocols going to be developed or distributed for the provider directory review, like the program audit protocols?"

Kerry Casey: So, what I would refer you to is our January 13th, 2017 report that we issued about the first-year review cycle. So, that contained some information about our methodology, particularly appendix one gives a lot of information about how the process was done, but we're not, at this time, looking to release some type of protocol.

Stacey Plizga: Okay. Next question, "Can CMS share selection methodology and call scripts so that plans may conduct their own audits, mirroring CMS techniques?"

Kerry Casey: So, again, I would refer you to that report that we released. And it is on the Medicare Managed Care Marketing website at cms.gov, a different page but the same place you'll go to find the Provider Directory Models and innocuous D models and things.

Stacey Plizga: Okay. "During the review process, does the contractor indicate that they are calling on behalf of CMS or is it a blind call?"

Jim Canavan: Absolutely, the contractor does identify themselves as a CMS contractor. And in situations where the provider's office may express concern or doubt, they have a letter from us that they then can fax to the provider's office.

Stacey Plizga: Okay. This next question has a couple parts to it. "Where and when are provider directories identified to compare to the monitoring calls? Are these pulled from the plan website? How soon before the call-start is the directory retrieved?"

Jim Canavan: The -- absolutely, they're pulled right off of the online provider directory. And when you receive your data file, we will have a field in there that identifies exactly the link where we took the provider directory information. It will also say what date we pulled the information off the online provider directory and the date that we made the call -- well, that the contractor made the call. And those are usually just within a couple of days, maybe a week, but not a significant period of time.

Stacey Plizga: Okay. That brings an end to the questions that I had for Carey and Jim. Thank you. All right. Before I bring up our next group, which would be Heather, Donna, Denise, and Dr. Worku for the Care Coordination and Medicare Advantage for the panel discussion, are there any questions from our in-house audience for this group? Okay.

And then we will move on to session seven, the Social Security Number -- I said I wasn't going to say that again, but I did -- Removal Initiative Updates for Amanda and Monica, are there any questions for Amanda or Monica from our in-house audience? Well, I guess we just wanted them to get some exercise, because I don't have any from our virtual audience, either. So sorry. They did a great job, no questions.

All right. So, we're back to a polling question, and that is would you like to evaluate the Q&A session? So, go ahead and give us your thoughts on this session. Give you a moment to do that.