Keynote Address

Demetrios Kouzoukas, Principal Deputy Administrator and Director, CM

Stacey Plizga: Please join me in welcoming our keynote speaker today, the Principal Deputy Administrator and Director for the Center for Medicare. Please welcome Demetrios Kouzoukas.

[Applause]

Demetrios Kouzoukas: Thank you.

Stacey Plizga: You're welcome.

Demetrios Kouzoukas: Hi, everyone. Good to see you all today. It's nice to join you and delighted to have you here today at the Audit and Enforcement Conference, particularly at this critical time for the Medicare Advantage and Part D programs. We've been on a bit of a journey, and I think started within the last year or so to really emphasize the program's potential and to try to unleash the potential of Medicare Advantage and Part D. It's a pleasure to talk about that some more with you today in the context of how CMS oversees plan compliance with our rules.

Our goal for today's conference is for each of you to understand where CMS is going and why when it comes to enforcement and to give you a bit of insight into our overall vision for the programs. These conference are critical to our efforts to ensure that people better understand our programs, our direction, and to provide you with an opportunity to ask us

questions. I hope it may help you better understand not only where we're coming from but how it first into a broader picture.

I'm going to spend a little bit of time recapping some of that for you today. Medicare Advantage and Part D play a critical role in the Agency's overall effort to transform our healthcare system. As the Secretary and the Administrator have said, this is an important evolution of changing the healthcare system from one that pays for procedures and sickness to one that better pays for value.

The question always arises then...what does "value" mean?

It's hard to disagree with the notion that we ought to pay for value; it's a word that can mean a lot of different things to different people. I think that for our leadership and for this Administration, we're saying that value means that patients are in the driver's seat. This concept is one that naturally lends itself to Medicare Advantage and Part D because in those programs, plans compete for patients and consumers...ultimately for their enrollment, as well as their loyalty, year to year. So it's important and natural in the work that plans do that they put patients in the driver's seat because inevitably they are. They get to choose every year whether to stay or not.

I think this is a goal that those of you who are gathered here in Baltimore and on the webcast understand quite naturally. As a result, Medicare Advantage and Part D are going to be at the forefront of this transformation or this evolution that I mentioned.

However, there's still work to be done. In order to continue making that progress, we have to move forward in several areas that many of you heard the administrator talk about in her keynote yesterday...including given consumer's greater control over their information through interoperable and accessible health IT, such as the blue button. This makes the patients more able to move between providers and plans and the like. Also encouraging transparency from payers, plans, and providers

and removing government burdens that impede the transformation I discussed. I'll touch a little bit more on the last two, transparency and burden reduction, today.

When we talk about transparency, we must emphasize that transparency includes accuracy and accountability. It's no secret that there are widespread problems with the accuracy and completeness of the information in plan's provider directories...including those in Medicare Advantage. For beneficiaries to make informed enrollment decisions, the accuracy of provider directors must improve. This is a challenge that I know is large and significant and very complex, but it's vital that we make progress on this front.

Yesterday many of you heard from our Office of Communications with reference to CMS' efforts to revamp Plan Finder and our Medicare and You handbook. You also heard the Administrator talk about the importance of improving beneficiary communications and empowering beneficiaries to make choices. All this can only be done with improved educational resources and materials that we put together.

As we ramp up these efforts on our end, the plan community has an important role to play as well. Plans have a duty to ensure that enrollees are making choices based on valid, reliable, up-to-date information; and that includes plan provider directories. With the increased focus and attention on Medicare Advantage, and the accuracy of information about options as well as information that's relevant to beneficiaries making decisions on both our parts, we think we can work towards that patient-driven healthcare vision much more effectively.

We know that patients or beneficiaries rely a great deal on knowing whether their provider is in the network when they're choosing a plan. So for our vision of a patient-driven healthcare system to succeed, it's important that they know whether their provider is in network or not when they're making that plan choice...understanding that there's always potential for changes of course as well.

It will come as no surprise, however, to anyone in this room that provider directories continue to show a number of errors. So we continue to stress the importance of these directors and wanted to give you a little bit of a sense of how that fits into the overall vision of why it's important to us. While CMS could mandate a solution, you understand your business better than we do. You know what's worked and what hasn't. We expect plans to work with providers to identify meaningful solutions to resolve this problem.

With that in mind, we want to hear what next steps you have taken to improve the accuracy of provider directories. We also want to hear what barriers exist that prevent you from achieving the desired results. What does a true solution look like, and how can CMS contribute to this challenge?

In terms of regulatory barriers to innovation, I'm pleased to also highlight many important changes that reduce administrative burdens and spur creativity and innovation and plan design for MA and Part D through their call letter, rate announcement, and final regulation released last month. It's a mouthful and the culmination of a lot of work. As you heard yesterday from the Administrator, the policy changes for 2019 include significant flexibility for plans to offer additional benefits that help enrollees lead healthier, more independent lives.

Underneath flexibility for 2019, plans can offer benefits that compensate for physical impairments, diminish the impact of injuries or health conditions, or reduce avoidable emergency reutilization. In addition, starting in 2019 supplemental benefits can be tailored to the needs of beneficiaries who meet the specific medical criteria. With this new flexibility, plans will be able to improve care and outcomes for beneficiaries with particular health conditions. These changes open up significant possibilities. We're excited about them and imagine that you are as well.

When you submit your bids on that first Monday in June, we encourage you to think boldly and creatively about how you can harness the power of these changes to really improve care and expand the types of benefits you are providing to enrollees. We want to work with you to ensure that these changes are meaningful and transformative. We encourage you to err on the side of including these benefits in your bids. As in the past, we will review your submissions and discuss without penalty or prejudice areas in need of modification or clarification.

2019 is just the beginning though. We're also looking forward to 2020 and already starting the work that is necessary to make that a success as well. In 2020, plans and providers will have even more flexibility in how to deliver care. With the implementation of the Bipartisan Budget Act, MA plans will be able to provide telehealth services as a basic benefit in Medicare Advantage.

We also streamlined the review and approval process for materials that communicate health and drug plan information to beneficiaries, aligning it with what a reasonable person would consider when hearing the term "marketing." This, in turn, will reduce unnecessary burden when it comes to what is submitted for CMS review. We also added the concept of communications so stakeholders receive clear and concise guidance regarding our expectations on how non-marketing materials are produced and handled.

In preparation for the 2019 marketing season, we recently provided some highlights of proposed changes to the Marketing Guidelines, now called The Medication Communications and Market Guidelines, and sought your feedback. We specifically solicited comments on provider-based activities and whether the flexibility offered is broad enough to support and encourage new delivery channels. We also saw comments on flexibilities that enhance plans' ability to market competitively and foster fair comparisons while making sure beneficiaries have clear and reliable information.

We received over 300 comments, many of which were very positive and constructive. We expect that the changes made this year will lead to greater competition and greater value for beneficiaries. And where we don't make changes this year, we expect to have opportunities to continue encouraging competition and hope the feedback solicitation was the start of a longer internal and external process for dialog.

We received comments regarding the ability for providers to discuss plans with enrollees to ensure the plan meets beneficiary healthcare needs. With these changes, our aim coming up this year is to allow more in-depth discussions between providers and enrollees, as well as the sharing of materials in ways that better meet enrollees' healthcare needs...hence, our exploration of those topics in the comment solicitation.

We're also looking to find out how we can more clearly define the difference between plan communication and plan marketing, which would greatly increase flexibilities in how you communicate to beneficiaries. We're also looking to provide more concise information on which documents are required documents so you will more easily know whether these documents are marketing or communications, and how or whether they will need to be submitted. Our ultimate goal is to ensure that materials that require submission are those that truly benefit from the process.

The best part is that we feel confident that the changes we're making, if adopted, will allow us to maintain the needed beneficiary protections that have always driven Medicare Advantage and Part D marketing policies.

While we're on the topic of reducing burden, the regulation we issued also eliminated the requirement that Part C and Part D prescribes and providers enroll in Medicare...traditional Medicare, that is. Instead, we adopted a more efficient approach in which we will compile a list of prescribers and providers that are revoked or otherwise precluded from billing Medicare Advantage or Part D.

We also updated stop-loss protection requirements for physician incentive plans to better account for medical costs and utilization changes that have occurred since the final rule was published many years ago. We authorized more flexible actuarial equivalent arrangements to protect against financial loss and allowed non-risk patient equivalents...such as Medicare fee-for-service patients...to be included when determining the deductible. We clarified the substantial financial risk test and how it applies to intermediaries to negotiate rates on behalf of physician groups.

All this should allow more flexibility in negotiating and designing value-based arrangements between plans and providers to further the transformation I mentioned at the beginning of the discussion today with regard to patient-driven healthcare.

We also finalized policies responding to the president's call to end the scourge of the opioid epidemic. The policies provide Medicare with additional tools to combat opioid overprescribing and abuse, and to protect families and community across the nation. Several important policies we have put in place to fight this epidemic include:

Final rules for the lock-in programs for at-risk beneficiaries that limit access to opioids to one prescriber or one pharmacy.

For beneficiaries we consider at a high risk, we expect all sponsors to implement the real-time opioid care coordination safety edit based on the cumulative dosage threshold at the time of dispensing as a proactive step to engage both patients and prescribers about overdose risk and prevention.

We're also expanding the already successful over utilization monitoring system, and we're setting expectations for safety edits at the pharmacy counter to limit initial opioid prescription fills for acute pain to no more than a seven-day supply.

Now, with these changes in direction in mind, we return to the particular focus of today's conference…audit and enforcement. As many of you know, 2018 concludes the second cycle program audits. Already today you've heard about our updated data request documents that are posted for public comment through the pay for production and process. These improved audit tools for use in the audit cycle are the direct result of feedback we've received.

We heard suggestions for clarification around the classification of Parts C and D grievances and coverage requests and are pleased that we'll be presenting to you some examples today to promote compliance with our program requirements. We have also again released our annual Parts C and D Program Audit and Enforcement Results, highlight audit results and trends, as well as program areas where organizations continue to struggle with meeting CMS expectations.

We continue to look for ways to educate the plan community, to clarify our guidance where necessary, and to improve overall compliance. We continue to refine our audit processes to increase transparency, and we are committed to engaging with external stakeholders to ensure we are evaluating compliance with fairness and consistency. We are striving to reduce burden through regular updates to our process, our tools, and out guidance…including the recent regulatory change to streamline training requirements.

We are also exploring ways to increase transparency and provide beneficiaries with information on enforcement actions and plan performance. Medicare Advantage provides beneficiaries with a valuable choice, and the potential for Medicare Advantage and Part D has never been greater.

Thank you for joining us for today's conference. I hope you enjoy the afternoon sessions. I hope the information you receive today is valuable to you and that you will continue to provide us feedback as needed.

[Applause]

Kaye Rabel: Thank you, Demetrios, for sharing that valuable information with us today.

[Applause]

We will now be taking our lunch break, and we will begin sessions promptly this afternoon at 12:30 p.m. For our in-person guests, please visit the cafeteria located downstairs. If you preordered lunch, you can pick it up at the Jasmine Café, which is right outside of the cafeteria. Enjoy your lunch.