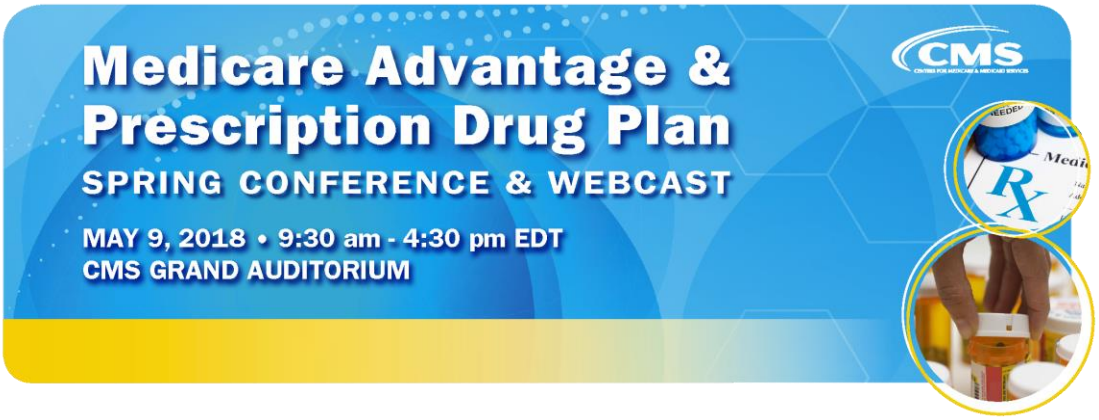

Open Q & A Session

Stacey Plizga, PRI

Stacey Plizga: All right. Well we have a couple minutes before we get started with our open Q&A session, so we are going to do a few trivia questions about CMS. So keep those phones out. It's just going to take us a second to bring them up. So while we're doing that, I will give you some of the information that I'm going to pass on to you at the end of the day.

So, for those of you who did not participate in polling today but would like to provide feedback regarding today's events, the link to the feedback survey, or the participant survey, will be emailed to you after this event so you can get it there. Or the QR codes that I told you were on the back of your badges, they're not. They're actually on little cards that were on the table and there's also some signs out there with the QR code. You can take a picture of it and it will take you directly to the survey.

Also – oh, you guys are answering! The first trivia question – I guess we'll go to that. In what year did a presidential health task force first recommend that the Medicare program cover outpatient prescription drugs? I'll give you a minute to send in your responses.

Hmm. We might all need a little history lesson on CMS. So the correct answer is B, in January of 1967, six months after Medicare implementation began, President Johnson required the Secretary of the Department of Health, Education, and Welfare, or HEW, to study adding outpatient prescription drugs to Medicare. In 1969, the task force made a

number of recommendations, including that drugs be added to the Medicare benefit package.

All right. Next question. When Medicare began, what sort of efforts did hospitals and nursing homes need to make to integrate their facilities for black and white patients?

Hmm. Give you a couple seconds to figure out. You can send in your responses as the speakers are gathering.

And the answer is, C. The Civil Rights Act, enacted in 1964, only one year before Medicare was enacted, prohibited recipients of federal funds from discriminating based on race, color, or national origin. The Secretary of HEW asked the Public Health Service to work with hospitals and with nursing homes to ensure that facilities were integrated prior to the launch of Medicare on July 1st, 1966.

Hmm. We'll have more questions tomorrow, so study up.

Okay, we are going to then move on to the open Q&A portion of our conference today. And basically what that means is we are going to bring up all of the speakers from all of the sessions today, session by session. We'll give you an opportunity to ask any questions that you may not have been able to answer or ask earlier. Also we will address any questions that came in from our virtual audience, so hang tight, we'll get to all the questions that came in.

So, I am going to ask our first session speakers from Encounter Data, so Shruti and Monica, if you could please come on up.

And I will give that to you guys. And I would like to at this time ask anyone in our in-house audience, if you have a question, to step to the microphone in the center aisle. Okay. And we do have one question. Please tell us your name and where you are from.

Open Q & A Session

Stacey Plizga, PRI

Howard Shapiro: Hi. Howard Shapiro from the Alliance Community Health Plans. In the past you've announced a transition schedule for the implementation of EDS data. I know 25% in 2019. And I don't recall from the notice if there are percentages for the succeeding years. Do you – do you have that transition schedule for the increasing percentage?

Monica Reed- Asante: So that's information that I actually don't have at this time. That's something that we would announce in the advance notice. We did discuss a transition schedule for the model in the advance notice, but again, we would do that in a future – in a future advance notice.

Howard Shapiro: Okay. Thank you.

Stacey Plizga: Okay, we will go to questions that we received from our virtual audience. And the first question here, where can we find the April 2018 Moore (sp) review referenced in the presentation?

Monica Reed-Asante: Yes, we covered that on the April 19th webinar. Those slides are posted on the CSSC website. So if you go to CSSCoperations.com, on the right-hand side there are those folders. If you click on Risk Adjustment Processing System and then User Group, the slides are available there. And there is a handy reference chart that identifies all the Moore record types for each of the payment years that we're doing the blends in.

Stacey Plizga: Okay. The next question. I request clarification of when MAOs can submit a CRR when encounter data is captured in the medical record but a claim was not generated. Before 9/2018 CMS memo guidance for chart review record, or CRR, submissions, states in part: MAOs should report items and services on an EDR whether or not the items and services resulted in the creation of a claim from the provider to the MAO. Items or services provided to an enrollee under the plan must be reported on an EDR. A CRR should not be the only record with information about a healthcare item or service provided to a plan enrollee.

Shruti Rajan: Okay. So the answer is that claims data are a primary source of data for many MAOs when they create an encounter data record. But clinical or administrative data may also be used as a source of data to create encounter data records. So those are legitimate sources.

Stacey Plizga: Okay. So we have another question. When will CMS post the Excel file with the mapping for 2019?

Monica Reed-Asante: Getting that question a lot lately. We are working on the crosswalk, the Excel file that has the mappings for all of the models for 2019. We did post the software, the 2019 software, and the mappings are in there. I know for some they like to have the Excel file, so we're working on that. And we anticipate releasing it hopefully in the next couple of weeks.

Oh, I should point out, though, that if you are looking for the mappings for the 2019 version of the model, we did release mappings with the advance notice. And since the version of the model – the clinical version of the model is the same, you can reference those mappings while we work on the – the full crosswalk.

Stacey Plizga: And the last question that we have here, can you clarify how the encounter data score will be supplemented with (inaudible) inpatient diagnosis?

Monica Reed-Asante: Yes. So we're going to supplement with (inaudible) inpatient provider types one and two. So inpatient principal and inpatient other. And so when we calculate the encounter database risk score, we'll take the diagnoses from encounter data, and then we'll also take the (inaudible) inpatient provider type 01/02 diagnoses as well as fee-for-service where applicable, and put them together to calculate the encounter database for a score.

Stacey Plizga: Okay. If there are no other questions from our in-house audience, then we will then move on to our next session. Thank you.

Which is Star Ratings timelines. So we have Liz Goldstein Sarah Gaillot, and Liz Flow Delwiche . So if there are any questions for this group, please step to the center mic.

Okay. Please tell us your name and where you're from.

Michelle Juhanson: Hi. I'm Michelle Juhanson from PerformRx. And this question I believe might be directed to Sarah. Number one, thank you guys. So I really appreciate that it's in the Final Rule, and that you're using the codified process. Number two, CMS has done an excellent job of being super transparent about the Star Ratings, and this has been a very long trajectory so we really appreciate it.

For the appeals – for the scale reductions for the IRE, and we did submit this question in writing. You're including two measures, appeals of auto forward and appeals upheld. Our understanding is that the appeals upheld measure only evaluates the consistency between the redetermination at the plan and the reconsideration at the IRE. The TMP audit only evaluates timeliness. And so if you were to use the TMP audit results to scale reduce the appeals auto – I mean the appeals upheld measure, we believe it would be technically unfair.

Liz Goldstein: So the reason – and this is similar to what we've done in the past. From the TMP data we can see how complete the data are in the IRE. And so the reason that we apply it to both appeals measures, if data is missing for, you know, not getting to the IRE, the upheld rate is also off because we're missing cases. So that's what we've done historically and that's what we were planning to do.

Michelle Juhanson: Okay. Would there be any opportunity for feedback or I guess maybe a little bit more of a feedback loop, because if a plan has never been – if the

plan is not aware that the IRE is having trouble, then if they're – if they're castigated for that, then it may be less than fair. But I definitely appreciate you sharing that.

Liz Goldestein: Right. So, yeah. So what we're really trying to get at with that adoption is that data are not getting to the IRE, so then we have no way of knowing, for those missing cases, would it be upheld or not.

Michelle Juhanson: Okay.

Liz Goldstein: So that's, you know, that's not a change we could make for this time. If, you know, we're getting feedback that it just be a reduction, for one, that would have to go through the call letter and regulatory process to, you know, propose an alternative. So we are open to hearing, you know, suggestions for modifying that, but would have to go through that process again like it did initially to, you know, implement it for both measures.

Michelle Juhanson: Okay. Thank you, Liz.

Liz Goldstein: Um hmm.

Howard Shapiro: Hi. Howard Shapiro again. It's not true that I get paid by the number of questions that I ask. But this is such a nice opportunity, and I appreciate it.

I have two questions. And one has to do with the effects of the provisions for the disaster areas. And that is, you know, with the removal of contracts from some of the ratings or the choice of 2018 versus 2019, depending on which is higher on individual measures, is that – have you modeled how that may be changing the cut points?

And then my second question, which is a separate one, a couple of us in the audience were surprised by your announcement that the weight for the patient satisfaction and access measures will be changed to two in

2021. That sounds like the kind of change that CMS traditionally has announced in the call letter or rule and would be open for comment. And so, you know, why the change now, and is there going to be an opportunity for comment on that?

Liz Goldstein: Okay, let me do the disaster one first. So that one, we have tried to model the impact looking at the contracts that were impacted by disasters, looking at how they've traditionally scored on Stars. We are not seeing that set of contracts that potentially have impact. We don't know until we get the data if they truly have impact. That their scores are, you know, very different. They're not, in particular, low-scoring contracts or high-scoring contracts, they're kind of randomly distributed. So we don't think it's going to have a big impact on cut points from what we've seen thus far, but, obviously, until we get data, you know, we won't be able to do the exact modeling. But we don't anticipate it to have a big, if any, effect.

In terms of the weight on the patient experience and access question as part of the 2019 regulation, we asked for feedback on increasing the weight of patient experience and access measures anywhere from a one – from 1.5, where it is today, to three. And so based on input through the reg, the proposed rule, we finalized a weight of two. In particular, representatives of beneficiary groups were very supportive of increasing the weight of beneficiary experience and access measures. They would like us to increase it to a weight of three, much higher, in the program. And I think really to the policies at CMS, we really are trying to make sure the beneficiary is put first, and, you know, listening to the beneficiary, in particular listening and including measures that are important from them, and looking at how they evaluate the care of plans, we think that's really critical. I know sometimes we get criticism that CAHP surveys, they say are subjective. But what they reflect is the opinion of beneficiaries. And it's their experience in the plan. So we think that's really important, and a lot of our stakeholders think that's really important also to listen to the beneficiaries.

Howard Shapiro: Thank you, Liz.

Stacey Plizga: Okay, thank you. We do have a question that came in from our virtual audience, and that is, which sectors or industry types of expertise is CMS RAND seeking for the technical expert panel, and how will the stakeholders be notified of the TEP process and solicitation of subject matter experts?

Liz Goldstein: So this we have gone through in the presentation. And the TEP is to give RAND, our CMV Star Ratings contractor, input into the Star Ratings program. And from that, they will provide us with recommendations. CMS was not involved in the selection of attendees of the TEP. We want to keep it independent from CMS. It's really a TEP for our contractor to make recommendations to us.

So they did choose representatives of the industry, researchers, quality experts, beneficiary advocates. So they have representatives from, you know, a broad spectrum, you know, of different folks. All the information from the TEP input received will be publicly shared as well as any recommendations that RAND makes to CMS, and, you know, CMS is proceeding or considering to proceed, we will solicit input like we, you know, traditionally do for the Star Ratings.

Stacey Plizga: Okay. Well, if there are no more questions from our in-house audience, I would like to thank the Star Ratings Timeline team for answering your questions today. Thank you.

Okay, next up we have Medicare Advantage Benefit Flexibility with Heather Kilbourne and Brandy Alston. So if you have a question for them, please step to the center aisle.

Please tell us who you are and your company, who you're with.

Diane Kortsch: Hi. Diane Kortsch with Anthem. I'm wondering if CMS can provide any additional guidance between the HPMS memo from 4/27 and then listening today. We're looking for some additional guidance on how meal – meal services will be handled, what type of flexibility might be allowable for those.

Heather Kilbourne: So with meals, our meals services have not expanded at all for CUI 2019. So the meals are the same as they are currently listed in Chapter Four. It's temporary right after a surgery for recovery. We also have the medical nutrition element. So everything that's in Chapter Four now is current for CUI 19. The meals are not part of the new primarily expanded definition.

Diane Kortsch: Thank you. That's helpful.

Heather Kilbourne: Sure.

Stacey Plizga: Okay, we will move to questions we got from our virtual audience. And the first question is, you mentioned transportation to the bank or for groceries are not permitted. But now you have banks, pharmacies, and food all in one. For example, Walmart or Target.

Heather Kilbourne: This is very true.

Stacey Plizga: Will this be a problem?

Heather Kilbourne: It should not be. So as long as you follow the guidelines that if the reason for going to the pharmacy that is within the Target or within the Walmart, that's the reason for the transportation is to go to the pharmacy, you should be good. So just remember it needs to be primarily health related, and the transportation needs to be for a covered supplemental benefit service, or Part D service, Part A service, Part B service. If the pharmacy happens, you know, you happen to pass food on the way there, that's okay, as long as you're going there for the pharmacy benefit. If someone picks something else up, we can't do anything about that. But you need to

– as long as they're there for the pharmacy. They can't go and not go to the pharmacy. If that helps at all.

Thank you.

Stacey Plizga: And we do have a question from one of our in-house guests.

Roberto Pando: Hello. Thanks again. I do have a question about the hospice benefit and benefit flexibility, but before that, my name is Roberto Pando. I'm from MCS Advantage. And coming from Puerto Rico, I had (inaudible) the CMS leadership administration that we're very appreciative of – of how the CMS team has been able to work really hard to adapt and manage the process with disaster areas. We have over 700,000 Medicare beneficiaries in the island. Almost 600,000 MA members. We're one of the largest (inaudible) populations, close to 300,000 people. And all those changes that are being done are very crucial for our healthcare system, so thank you again. We still have a lot of work to do, but we're very glad that we can work openly with the leadership.

Now to my questions about hospice and benefit flexibility. It doesn't – right now benefit flexibility and uniformity doesn't relate necessarily to hospice but it's a topic that has been around for a while. And in the spirit of continuity of care and integration of care, (inaudible) and others has recommended to congress to make amendments to law and integrate the hospice benefit to the Medicare Advantage program. Right now it's carved out, as you all know, and it does create a lot of burden in the – in the – in the care continuity between the MA program and the fee-for-service (inaudible).

My question is, in the work that you're doing after the BBA and with benefit flexibility, is the integration of the hospice benefit a topic, a priority, or something that the CMS leadership is discussing with congressional staff? And, if not, is – is the integration of the hospice benefit something that CMS could consider in highly penetrated areas. Like, for example, in

Puerto Rico we have 75% (inaudible). Is that something that could be considered as a demo project to integrate the hospice benefit into the MA program?

Heather Kilbourne: Thank you so much for that question and for all of your information. We really appreciate it.

For – in terms of hospice, I can't speak to demonstrations, but I can say that we appreciate all of your comments today and we will take everything under consideration. For benefit flexibility, we have expanded and provided the home palliative care – home-based palliative care for – not for hospice. But for now, and for CY19, hospice is still under original Medicare. But I can say that this is something that we've discussed and will continue to discuss and consider. And your comments today will definitely move – help provide some information for us for that. So we appreciate it.

Roberto Pando: Thank you.

Stacey Plizga: Okay. And I have one last question here from our virtual audience, and that is, does the flexibility include telehealth services?

Heather Kilbourne: So I – we had a similar question this morning. And with telehealth, the original Medicare telehealth has to be provided the way it is defined under original Medicare. But we do have remote access technology supplemental benefits, which is essentially an extension or an expansion of the original Medicare telehealth. That you are allowed to apply flexibility to. The current remote access technology benefit has not changed in any way. It's pretty expansive the way it is. It's just it has to be a supplemental benefit. If you wanted to apply uniformity to telehealth, you certainly can. Again, it would have to follow all of the requirements that Brandy discussed this morning and that is in the uniformity memo.

In terms of the new legislation on telehealth, that will be all forthcoming.

Open Q & A Session

Stacey Plizga, PRI

Stacey Plizga: Okay. If there are no more in-house questions, then please help me thank Heather and Brandy.

All right. Next up we have Erin Pressley and Jon Booth for talking to beneficiaries about their plan choices. If there are any in-house guests with questions, please move to the center aisle.

Okay. So there are not, so we will go to the questions that we received from our virtual audience. And the first question. What is CMS doing to share information about plan choices or decisions with new beneficiaries who actively enroll with SSA and don't get the IEP?

Erin Pressley: So that's a great question. I'll start and then, Jon, if you have anything to add. But we have, for some time, I think, been frustrated collectively that the beneficiaries who actively enroll in the Medicare program, that is they either walk into a Social Security district office and complete their enrollment, or they go online to SSA.gov and complete their enrollment, traditionally and today still only get a Medicare card in an envelope in the mail. They get no other information. And then about a month later they get a Medicare & You handbook. But they lose out on the additional information that we include in the IEP package for people who are automatically enrolled.

So I'm happy to say, and I should have said earlier, that we have been working with the Centers for Medicare over the last few months now to develop a companion booklet, a checklist of sorts of decisions that need to be made when you first enroll in Medicare, along with a cover letter and some additional information that will go into the envelope with the Medicare card to those beneficiaries who actively enroll in the Medicare programs. So that's a big win, I think, for all of us. And they will have similar information very soon to the information that is given to people who automatically enroll.

Jon Booth: I think the one other thing that I would say is that we are talking with SSA to make sure that they are aware of the web resources that we have online and other resources, things like 1-800-MEDICARE. And as we're making changes to those channels that they are looped in there so that they can use those as referral points and sort of make sure that people are aware of the information resources that we do have for those that are new to Medicare.

Stacey Plizga: All right. The next question we have. What did CMS learn from changes made to Medicare.gov for last year's Open Enrollment?

Jon Booth: So I think two things I would highlight. I think one is, you know, I talked about the Coverage Wizard earlier today. I think we found that that was useful to a set of users. It's not something everybody needed, but for those people that went through it, that was something that was helpful to them.

We did, as I mentioned, we've done the user research as part of our development starting last year, and that's been helpful so we sort of set that as a standard for all new development moving forward that we're going to incorporate that user research into our build.

So I think those would be the two big highlights for me, coming from last year.

Stacey Plizga: All right. Any additional questions?

Okay. So please help me thank Erin and Jon for taking the time to answer your questions.

Okay. So before I call up the next group for CARA opioids, I wanted to see if we have any in-house guests with questions.

No? Okay. So then I'm not going to call them up.

All right. And then also for the network adequacy review roundtable discussion, do we have anyone in-house with questions for them? Okay. If I could please have Theresa, Kelley, Christine, and Nyetta come up to address those questions.

Please let us know who you are and where you are from.

Anne Crawford: Thank you. Anne Crawford, ATTAC Consulting. And I was pleased to see some additions to the valid reasons for exception requests with the provider doesn't contract with any organization or they contract exclusively. And I was curious if you have some suggestions on what type of supporting documentation a health plan would put in so that that exception request would be granted.

Kelley Ordonio: So at this time I can't say that by submitting any information that it would be granted, but we do take all the information that you submit into consideration. At this point, if you are aware of providers that are not contracting with any organizations and you're able to provide any evidence or proof of that, whether it's emails or letters, any communication that you've received, we can take all those pieces into consideration.

Anne Crawford: Thank you.

Kelley Ordonio: Thank you.

Michael Adelberg: Hi. Mike Adelberg, Faegre Baker Daniels. In the event that a new applicant does – is unable to cure its network issues and is suppressed from Plan Finder this fall, will that new applicant still be able to enroll people through other means including agents, brokers, etc.?

Christine Reinhard: Yes, we will let you enroll other beneficiaries through other means. You will just be suppressed from Plan Finder.

Michael Adelberg: Thank you.

Stacey Plizga: Okay. We will go to questions from our virtual audience. And the first one, how did CMS select contracts for the first triennial review cycle?

Theresa Wachter: So CMS did a random sample for the selection. And we also made sure we included contracts that have never been reviewed in HPMS. And within the first two years of this initiative, we're going to review those specific contracts.

Stacey Plizga: All right. Thank you. And one last question here. If an initial or SAE applicant is not meeting network adequacy requirements, will their application be denied?

Kelley Ordonio: So this year the application determinations are separate and distinct from the network reviews. So there's two separate tracks for those determinations. So at this point, it's – your application deemed conditionally approved would move forward based on – and the network review is separate and distinct.

Stacey Plizga: Okay. And we have one last comment over here.

Nyetta Patton: Hi. During the polling, we noticed that some of you seemed a little bit confused about receiving information as to whether or not you were selected for the triennial review. Would you please check with your compliance officers if you don't happen to be that person. And most importantly, make sure you reach out to your account manager in your respective regional offices. Thank you.

Stacey Plizga: Okay. Please help me thank Theresa, Kelley, Christine, and Nyetta.

Open Q & A Session

Stacey Plizga, PRI

All right. And before I call up our last group I wanted to see if there are any in-house guests with questions for the Da Vinci project of for Blue Button 2.0. If you could step to the center.

And seeing none, we did not receive any questions from our virtual audience, so Melanie and Allison, thank you for staying to see if there were additional questions.