Frequently Asked Questions (FAQs)

2019 Fall Conference FAQ Document

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Please note: We received questions other than the ones listed in this document. Many of the questions were out of scope for the session and were not included in the list. If you feel that you still have an outstanding question, please email the appropriate contact.

Session 1 – IRE Transparency Initiative

Coretta Edmondson, Natasha Franklin, Kristie Werdein, and Katy Hanson

Session 1 – IRE Transparency Initiative

#	Question	Response
1	When will the new reports be provided?	The Enhanced Fact Sheets will be available quarterly and the Semi-Annual reports will be available twice per year. These reports will begin with data starting 1/1/20
2	How will Health Plans get these reports?	Health Plans will be delivered these reports electronically to the email address they have provided to the IRE for purposes of data receipt. Health Plans should contact the IRE prior to 1/1/2020 to provide the email address where they would like the reports delivered.
3	How can Health Plans provide the contact email address to the IRE?	Health plans should send the email address where they would like reports delivered to the IRE's main contact email box: For Part C, medicareappeal@maximus.com and for Part D medicarepartdappeals@maximus.com.
4	What can Health Plans do if they believe data in one of these reports is erroneous or if a Health Plan needs to request changes to other IRE data?	Plans should submit any requests for review of their data to the IRE's main contact email box: For Part C medicareappeal@maximus.com and for Part D medicarepartdappeals@maximus.com.
5	Besides these new reports, is there any other data/reporting available to Health Plans regarding their appeals data?	Yes. The Part C IRE hosts a website (www.medicareappeal.com) that houses Health Plan data surrounding appeals. The Part D IRE hosts a website as well, www.medicarepartdappeals.com Specifically, Health Plans can access data on appeal timeliness and overturn rates. We highly recommend that Health Plans monitor their contract data proactively on the website to avoid any delays or issues regarding reporting of this data for STAR rating purposes.
6	How often is the data updated on the www.medicareappeal.com and www.medicarepartdappeals.com websites?	The website data is refreshed daily, typically by 10am EST

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7	When will the new website database be available?	The website database will be available before 3/1/20. Please note that it will only include data from the launch date forward, so limited data will be available when the database first launches. Additional data will be added as the IRE closes out appeals.
8	When will the new Reconsideration Background Data Form (Part C) and the new Case File Transmittal form (Part D) be available?	The new Reconsideration Background Data form will be available on the www.medicareappeal.com website and the new Case File Transmittal Form will be available on the www.medicarepartdappeals.com website prior to the new website's launch.
9	Our Health Plan doesn't currently use the portal for case file submissions, but we would like to. How can we get access?	The Part C and Part D IRE's encourage Health Plans to use the portal for case file submissions. If you would like to set up your Health Plan in the portal, please contact MAXIMUS Federal Services at QICPortalsupport@maximus.com. There is also a user guide available online at https://qicappeals.cms.gov/qicportal/public/docs/portalUserGuide.pdf.
10	Will the reports and data base be available to the public or contractors for comparison and inclusion in Star rating databases?	The website database will be public facing and available to users without a password. The semi-annual reports are plan-specific and are not available to the public. Also, if you are asking if the reports and database will be available in HPMS, the answer is no.
11	Will the upcoming initiative include the ability for plan end users to export website search results/case data to Excel? This would be helpful for those reviewing the data at any given time throughout the year.	Yes, the plan will have to ability to export website search results/case data to excel.
12	IREs often rely on new or different information than was provided to the Part D plan by the prescriber at the outset. Can CMS require IREs to inform plans of the evidence on which they base their decisions?	The IRE's complete de novo reviews and explain how to they came to their decision in the decision rationale section of their letters. This would include stating that additional information was received, if that was the case. The IRE will not include specific medical record information as this is PHI. Appellants may request a copy of their case file via the FOIA process.

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#	Question	Response
13	We greatly appreciate CMS' continuing efforts to improve transparency of the IRE clinical review process. Even though we understand that plan decisions upheld by the IRE is no longer a Star measure, we still have concerns about IRE overturns where the IRE receives new or different information than was available to the plan at the time of the plan's decision. Will the IRE be able to more clearly articulate that new/different information was received that influenced the change in the decision? Will information on these overturns be available in the searchable database? It would be extremely helpful if the plan could search by overturn reason, in addition to by case number, so that the plan can improve the consistency and accuracy of their future decision making based on the IRE reviews.	The IRE's complete de novo reviews and explain how to they came to their decision in the decision rationale section of their letters. The decision rationale in the letter will be searchable on the new website database for comparison. The site will not include actual appeal numbers and will be free of PHI/PII. The overturn reason will be considered for a future website enhancement as we continue to enhance the system of record (MAS).
14	Per § 50.7.2 of the Medicare Appeals & Grievances Guidance, "When a plan makes a fully favorable determination on a level 1 appeal less than 24 hours after the end of the adjudication timeframe, the plan should consider effectuating and notifying the enrollee of the favorable appeal decision (within the 24 hour period the appeal must be forwarded to the IRE) in lieu of forwarding the appeal to the IRE." a. How does this impact Stars measure C31 – Plan Makes Timely Decisions about Appeals?	Please direct any questions regarding TMP or the Stars measures to: PARTCDQA@cms.hhs.gov.

#	Question	Response
	b. Are there any plans to more closely coordinate the TMP results with the IRE reported timeliness to update this measure?	
15	For purposes of this question, assume all good faith attempts are appropriately documented by the plan. Based on the Audit program FAQs, the audit protocols, and the combined appeals and grievance guidance, there are several questions related to how the universes will be used to calculate timeliness and how to differentiate between successful oral notification and unsuccessful good faith efforts at oral notification when using the universe to assess timeliness. The "CMS Program Audit Frequently Asked Questions (FAQs) Medicare Parts C and D Oversight and Enforcement Group & Medicare-Medicaid Coordination Office document released February 2019, question and answer 4 on page 13 states: "4. Question: Should sponsoring organizations report the first or the last good faith effort in the "Date Oral Notification Provided to enrollee" and "Time Oral Notification Provided to enrollee" fields of the universe if several attempts are made to provide an enrollee with the outcome of his/her request? In some instances, the last attempt may exceed the allowed turn-around time for a case. Answer: If a sponsoring organization makes several good faith attempts to provide an enrollee (or authorized representative) with the outcome of his or her case but is not able to successfully reach the	Please direct all questions regarding protocols/universe submission to the audit mailbox: part_c_part_d_audit@cms.hhs.gov.

#	Question	Response
	enrollee or leave a voice mail, the sponsoring organization would enter the date of the last good faith attempt that was made within the applicable processing timeframe. If the only attempt to notify the enrollee was made after the applicable processing timeframe, the date and time should be entered as it occurred. Per the 2017 Part C ODAG Audit Process and Data Request (note the 2019 protocols are not yet published on cms.gov), EREC and SREC technical specifications state to populate the date of oral notification as follows: "Date oral notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no oral notification was provided." The combined A&G Guidance states: §10.5.4 – "If the plan successfully provides verbal notice and subsequent written notification is required, the plan must send written notice within 3 calendar days of the verbal notice. However, if a good faith effort was made but the plan is not able to provide verbal notice, written notice must be sent within the applicable timeframe." a. Does CMS plan to continue to use the ODAG universe layout to calculate timeliness for both program audits and TMP? i. If so, how will CMS and plans identify which universe records require written notification within the applicable timeframe and those which allow for written notification within 3 calendar days?	

#	Question	Response
	b. If so, should the plan populate the universe with the good faith attempt date or with NA when good faith efforts are unsuccessful? c. Does CMS plan to revise the universe record layout to accommodate good faith efforts?	
16	Per the 2017 Part C ODAG Audit Process and Data Request (note the 2019 protocols are not yet published on cms.gov), EREC and SREC technical specifications state to "submit cases based on the date the sponsor's decision was rendered or should have been rendered." a. Should plans use the "Date of sponsor decision" or the date of case resolution (due date for timely notification) to define the universe inclusion criteria?	Please direct all questions regarding protocols/universe submission to the audit mailbox: part_c_part_d_audit@cms.hhs.gov.
17	§10.5.2 of the Medicare Appeals & Grievances Guidance states: "Note: For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the appropriate department receives the request. Plan material should clearly state where pre- and post-service requests should be sent, thus ensuring requests are received at the correct location and giving the plan the greatest amount of time to process the request. Plan policy and procedures should clearly indicate how to route requests that are received in an incorrect location to the correct location as expeditiously as possible." Please	For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the department responsible for handling the request receives it.

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	confirm the intent is for plans to continue to use the organization received date to determine timeliness rather than the date received in the A&G department.	
18	Are the fact sheets and semi-annual reports public for all contracts or can only the organization see the information?	The quarterly enhanced fact sheets will be public-facing. The semi-annual reports, however, are plan-specific and will only be available to the health plan directly- they will not be available to the public.
19	Will there be an opportunity for plans' Medical Director to have clinical discussion with the IRE clinician?	No- in order to maintain the IRE's neutrality, one on one discussions between the plan's Medical Director and the IRE's clinicians are not permitted. Health plans may request reopenings or clarifications through the normal process if there are questions regarding a clinical review.
20	We have requested the IRE reopen several overturn decision due to our stance that the IRE made an error in rendering an overturn decision. We had had several reopening in 2019 result in the IRE changing their decision and upholding the plans denial. Is there any quality monitoring done of the IRE decisions to ensure the best decision is made considering all submitted documentation? Having to reopen cases due to the IRE making an incorrect creates a negative experience for the members. Members are told something is approved by the IRE in error then after reopening the member is then told the service/item is denied.	The Centers for Medicare & Medicaid Services (CMS) conducts annual audits to assess if the IRE's performance is compliant with Federal Regulations, CMS rules, and the IRE Statement of Work.
21	Can plans assign multiple contacts to receive the IRE reports for both Part C and Part D?	The IRE prefers a single point of contact for reports. Plans may, however, send an email address contact that goes to a box that can be accessed by multiple individuals at the health plans.

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#	Question	Response
22	Given that plans will be asked to free text the condition on the updated forms for an IRE submission, there is a risk for inconsistency and a large number of condition types. Is CMS considering developing a set list of conditions?	Not at this time. We suggest that plans try to simplify the condition as much as possible and use layman's terms rather than ICD-9/10 language. An example would be back pain, plans should enter 'Back Pain' on the condition field, rather than "Pain of lumbar, acute, for less than 3 months". We also suggest that plans refrain from providing conditions that include NOS (not otherwise specified). If a layperson wants to use the site, it will be easier for them to navigate with more simple conditions listed.

Session 2 – New Medicare-Medicaid Integration Policies for D-SNPs for 2021

Julie Jones and Tobey Oliver

Session 2 – New Medicare-Medicaid Integration Policies for D-SNPs for 2021

#	Question	Response
1	Will CMS be conducting outreach to states regarding the new requirements?	Yes, CMS has been using various avenues to get information out to the states including through ICRC, the National Association of Medicaid Directors, as well as MMCO contacting states directly. However, we also urge plans to contact their states early to discuss the needed updates to their SMACs.
2	Will CMS be providing sample SMAC language to states that they can share with plans?	Yes, sample contract language to fulfill the notification requirement has been released through ICRC. We hope to provide additional sample contract language through ICRC in the late fall. You can find the link to their website on the last page of the presentation.
3	What do we do as an organization if we have been submitting evergreen contracts for some time and are having a hard time identifying the correct point of contact within the state to work with to update/revise the SMAC?	We would strongly encourage plans to reach out either through their AM or directly to MMCO so that we can work together to facilitate discussions between organizations offering D-SNPs and the states.
4	State policy in my state says that enrollment must be aligned between the D-SNP and an affiliated Medicaid MCO, but enrollment is never 100% aligned due to movement of members. Is my entity an applicable integrated plan?	Yes, it is still an applicable integrated plan. We recognize that that alignment may never be 100% but what matters is the state's policy.
5	What is an example of a Medicare service that could be continued, under the new regulations, while the plan-level appeal is pending?	Home Health

Session 2 – New Medicare-Medicaid Integration Policies for D-SNPs for 2021

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#	Question	Response
6	Will separate DSNP model materials be developed, separate from the SNP models for ANOC and EOC? These documents also apply to ISNP and CSNPs, but different requirements apply to DSNPs.	CMS will make available new language for plans implementing the unified appeals and grievance procedures in the D-SNP Evidence of Coverage model for CY 2021. We expect there will be opportunities for review and comment of the new model language.
7	Is there an expected date for the release of CMS model SMAC language which will support the HIDE or FIDE SMAC contract components through ICRC?	We expect that the Integrated Care Resource Center will issue sample SMAC language for all D-SNPs in November or December.
8	Will CMS be defining what is included in the CMS definition of "LTSS"? If so, what is the timeline for that? Or will this be deferred to the State? Consistent with the state policy as required by our State Medicaid Agency Contract (SMAC/MIPPA) with California's Department of Health Care Services (DHCS), our D-SNP plan covers LTC, CBAS and currently, MSSP under the Medicaid (Medi-Cal) wrap process. Will there be any new requirements from CMS besides these services?	Each state Medicaid agency has its own requirements for coverage of LTSS. We refer plans and others to the chart in our presentation comparing the attributes of FIDE SNPs and HIDE SNPs. A FIDE SNP must include at least 180 days of nursing facility and must cover LTSS services in the community. A HIDE SNP must cover LTSS if it doesn't meet the behavioral services coverage criterion. For both a FIDE and HIDE SNP, a carve-out by the state of a minimal scope of services is allowed. We welcome feedback on specific questions regarding carve-outs so that we can more specifically focus our technical assistance, which can include calls with plans.
9	What is included in the CMS definition of BH? Currently, consistent with the California state policy, DHCS requires mild-to-moderate, BHT and screening to be covered, under the Medicaid (Medi-Cal) wrap process. The County has financial and clinical oversight of Specialty Mental Health. Will there be any new requirements from besides these services?	Each state Medicaid agency has its own requirements for coverage of behavioral health services. We refer plans and others to the chart in our presentation comparing the attributes of FIDE SNPs and HIDE SNPs. A FIDE SNP that otherwise meets the nursing facility and LTSS coverage criteria does not need to cover behavioral health services if those services are carved out by the state. A HIDE SNP that doesn't otherwise meet the LTSS coverage criterion would have to cover behavioral health services. For both a FIDE and HIDE SNP, a carve-out by the state of a minimal scope of services is allowed. We welcome feedback on specific questions regarding carve-outs so that we

#	Question	Response
		can more specifically focus our technical assistance, which can include calls with plans.
10	Depending on which of the three integration criteria we pursue (notification process, HIDE, or FIDE SNP), will we be expecting a timeline from CMS/DHCS customized to each option? Or should we anticipate the timeline will be the same for all options?	CMS won't issue timelines specific to each integration option. The key dates provided in the October 7, 2019 HPMS memo apply to all D-SNPs regardless of which integration option they pursue. We urge each D-SNP to work closely with the states with which they contract to ensure they meet the CY 2021 SMAC requirements.
11	Data sharing with the State Medicaid Agency would be a new requirement for us to remain under our current D-SNP program (non-HIDE/non-FIDE SNP). Please clarify if the intent of the data sharing or notification requirement is to notify the State so that it can be pushed down to the member's Medi-Cal plan. Since CalOptima is a County Organized Health System (COHS) and the only Medi-Cal plan in Orange County, are there any specific notification process requirements that would apply to us given the Medi-Cal plan is one in the same as the D-SNP plan?	The notification requirement in 42 CFR 422.107(d) provides the state with flexibility to determine the entity that is notified of hospital and SNF admissions for a group of high-risk full-benefit dual eligible individuals. While that entity may be an MCO, it doesn't have to be. The state will need to consider which entities have the care coordination resources in place to help manage transitions for the state's selected group. For example, a state could designate Medicaid LTSS providers and/or care management agencies as the recipients of the notification.
12	For the unified appeals and grievances requirements for Plans with exclusively aligned enrollment, could CMS clarify whether the new notice template that is being developed (CMS Form 10716) also be used for Part D coverage determinations? Or is this only intended for Part C organization determinations (including Part B)?	The new notice template will be for Medicare Part C and Medicaid determinations only (including Part B). Part D procedures are not impacted by the integrated requirements.
13	Aside from the attestations and matrix that is submitted with the SMAC/MIPPA contract in July 2020, will CMS require for the D-SNP to submit the actual P&Ps during that	D-SNPs are not required to submit policies and procedures as part of the SMAC review. The documents that are required are described in the MA application and include the contract, any contract amendments, and matrixes and related items as described.

#	Question	Response
	submission? Or in advance of the submission for CMS review & approval prior to the submission?	
14	Please confirm that deeming rules would remain unchanged (6 months deeming, Medicare only benefits during deeming) for FIDE.	The recently codified integration and unified appeals and grievance requirements do no impact current deeming requirements.

Session 3 – Updates from OFM Part C & D Improper Payment Activities

Chrissy Fowler and Carolyn Kapustij

Session 3 – Updates from OFM Part C & D Improper Payment Activities

#	Question	Response
1	How does the Part C Improper Payment Measure Relate to the contract- level Risk Adjustment Data Validation (RADV) audits?	They are separate activities, conducted in separate areas of the agency. OFM's activity is to report a program wide improper payment measure. The contract level RADV audits are a corrective action to address improper payments. Thus, the goals of the activities differ. The Center for Program Integrity (CPI) conducts the RADV contract-level audits for payment recovery.
2	How is encounter data used in the Part C measure?	As encounter data is a source of risk adjustment data, used for calculating risk scores, the HCCs resulting from encounter data are part of the validation and medical records will be requested to support them.
3	How can plans partner with CMS in the measurement process?	It is important that plans attend trainings, follow the medical record and prescription documentation instructions and deadlines, and ask questions! Obtaining accurate measures is vital for safeguarding taxpayer dollars and also allows the agency to identify potential issues with payments processes or policy.

Session 4 – One-Third Financial Audits Overview

Frank Chartier

Session 4 – One-Third Financial Audits Overview

#	Question	Response
1	What is the purpose of the One-Third Audits?	The purpose is to perform a review of internal controls as well as test the accuracy and allocation of Medicare Part C and D costs. The audit also includes a solvency review to evaluate the Plan's ability of bear the risk of potential financial losses.
2	How will a plan know that their Final Report or CAP submission is complete and has been accepted by CMS?	Your organization will be notified through HPMS when the review is completed and the audit has been closed.
3	Can CMS proactively communicate the yearly audit milestone timeline to the industry?	Please see presentation *"Session4_Chartier_One-Third_Financial_Audits_Overview_508"* (slide 13)
4	Can CMS provide Common Audit Findings for clients/PBMs to consider control points for audit findings and observations?	Please see presentation *"Session4_Chartier_One-Third_Financial_Audits_Overview_508"* (slides 14-16)
5	Fraud, Waste, Abuse (FWA) testing – CMS contracted auditors suggest taking proactive action based off of FWA Alert Memos such as barring Providers from our networks prior to being convicted. Legally, we cannot prohibit Providers from our networks solely based on indictments.	Please email the MAPD mailbox: MAPDAudits@cms.hhs.gov.
6	Transfer-IN/RelayHealth – Plans are given audit exceptions (Observations/Findings) in their Financial Audit exit reports based on Financial Information Reporting (FIR) that is outside of the plan/PBM's control. If a member's previous plan committed some error while submitting the transfer information to the FIR Transaction Facilitator (i.e., RelayHealth), then the accumulator information is not	Please email the MAPD mailbox: MAPDAudits@cms.hhs.gov.

Session 4 – One-Third Financial Audits Overview

Frank Chartier

#	Question	Response
	transmitted to the current plan of record. As a result, the TrOOP/Drug Spend accumulation dollar amounts are not properly being reported. This is not an issue with the current plan of record, but between the previous plan and RelayHealth, yet the current plan of record is being given audit exceptions.	

Session 5 – Communication Accessibility for Individuals with Disabilities

#	Question	Response
1	If a member asks that all correspondence be delivered in an alternate format (e.g., large print), should plans maintain this information and provide future correspondence in this accessible format?"	CMS encourages sponsors to adopt processes and mechanisms to provide continuing accommodations in the appropriate formats automatically after a member makes an initial request to receive information in an accessible format. This practice can save time and resources, as well as improve the beneficiary experience.

Session 6 – Plan Experience with the 2019 Opioid Safety Edits and the Drug Management Program

Adele Pietrantoni, Anne Kane, Johnathan Randle, Clay Rhodes, and Erin McKenna

Session 6 – Plan Experience with the 2019 Opioid Safety Edits and the Drug Management Program

#	Question	Response
1	Could you discuss the percentage of providers who work with plans on implementing tools to manage opioid utilization or overall engagement of providers with the drug management program?	Of qualifying beneficiaries for the DMP program ~ 50% of providers are engaged in tools to manage their patients, 33% of providers attest to appropriate treatment course with no changes, 17% actively changing/managing therapy.
2	What drove your decision to utilize the 200 MME edit? And what has been your experience using the 200 MME?	We decided on 200 MME because, at the time the edit was introduced, we (and the rest of the industry) were struggling with how to ensure access for patients based on medical necessity without further contributing to the challenges associated with opioid utilization. Based on our internal clinical analysis, the 200 MME threshold helps both us and the pharmacy identify potential high doses of opioids while ensuring continued access to opioid therapy. When the edit was put in, as with other edits, we did experience some disruption; however, we communicated with the pharmacies early and often to ensure that they were aware the edit would be implemented and to provide guidance on what to do in order to minimize patient disruption. As with DMP, frequent communication is pretty critical to success.
3	Can you tell me more about your physician detailing program?	Face to face in office visit with prescriber Topics include: • Non opioid treatment options for common pain conditions in a Medicare population and evidence based support • Safe prescribing habits for opioids • Substance use disorder -recognizing symptoms and developing plans • Discussion of X waiver training • Safe tapering – gradual and protocol based; includes patient level, expert recommended, talking points for providers • Leave behind materials including a CME self-study course

Session 6 – Plan Experience with the 2019 Opioid Safety Edits and the Drug Management Program

Adele Pietrantoni, Anne Kane, Johnathan Randle, Clay Rhodes, and Erin McKenna

#	Question	Response
4	Do you have information regarding PDE process?	Unfortunately there will not be a specific PDE session at this conference.
5	The at-risk beneficiary identification criteria are currently too restrictive. For example, limiting ARB status to only those who both exceed the MME limit and have 3+ prescribers and pharmacies means that only beneficiaries with an addiction are identified, not just those “at risk.” Would CMS consider expanding the at-risk beneficiary criteria, to be more inclusive?	We continually looks for ways to refine our approach and take into consideration stakeholder feedback during the process. Also, the SUPPORT Act of 2018 requires beneficiaries with a history of overdose to be included as potential at-risk beneficiaries under Part D drug management programs beginning 2021.
6	The process to “lock in” an at-risk beneficiary is similarly too restrictive. CMS should not require case management prior to imposing these limits. Would CMS consider loosening these standards to better protect beneficiaries?	To meet the requirements of CARA, under drug management programs, Part D sponsors clinical staff engage in case management for each potential at-risk beneficiary for the purpose of engaging in clinical contact with the prescribers of frequently abused drugs and verifying whether a potential at-risk beneficiary is an at-risk beneficiary. We have found demonstrable value from the case management approach to engage the beneficiaries’ prescribers to improve care coordination.
7	What changes are planned due to the law enacted last year (SUPPORT Act) which may make it even harder to identify members since it increases the time frame/number of appeals?	We have asked the inquirer for clarification on his question and we are awaiting his response.
8	What support (e.g. data source access) does CMS intend to provide Part D plans vis-à-vis reconciling claims for the new Part B opioid treatment provider opioid use disorder benefit for 2020?	We do not believe that a Part D plan will need data on OTP services. Our final regulation stated that in cases where a payment for drugs used as part of an OTP’s treatment plan is identified as being a duplicative payment because a claim for the same medications for the same beneficiary on the same date of service was paid under a different Medicare benefit, CMS will generally recoup the duplicative payment made to the OTP (See§ 410.67(d)(5)). We also stated that we expect Part D plans to administer MAT as they do now and will not

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#	Question	Response
		need additional data to reconcile Part D payments with the new OTP Part B benefit. This decision was made because the OTP would be in the best position to know whether or not the drug that is included as part of the beneficiary's treatment plan is furnished by the OTP or another provider.
9	We agree with the approach CMS has to provide further focus on at risk individuals' medication management. Our question is if CMS can further expand this program to lock at-risk individuals into a specific pharmacy, provider, and hospital in addition to case management provided by primary care. The state of Minnesota currently has a Restrictive Recipient model (MRRP) that includes these collaborations. Thank you.	CARA of 2016 provided the Part D program with the authority to allow so-called pharmacy and provider "lock-in" (referred to as coverage limitations) under drug management programs. CMS implemented drug management programs in 2019 through notice and comment rulemaking.
10	Based on the survey results that most were unaware of, what happened after the edit that limited the fill of over a 7 day supply in January? What is the general estimate of cash paying patients that bypassed the edit by not billing their insurance? Has any data been provided regarding the total # of prescriptions processed for Medicare patients regardless of payment method?	The intent of the survey was to create a thought provoking question for plans as a take away from the session. As Medicare Part D plans launched the 7 day edit earlier this year, we wanted plans to think about how it went for the plan and more importantly how it impacted the beneficiary. The panel discussion highlighted the various avenues for opioid access when the 7 day edit occurred such as (1) reduce the quantity and provide a 7 day first fill, (2) obtain a coverage exception, (3) pharmacy provided information of patient not meeting "opioid naïve" definition to name a few possible end results.