CMS Part C and D User Call

November 6, 2013 3:30 PM ET

Operator: Good day, ladies and gentlemen, and welcome to your CMS Employer Group Waiver Plans Conference. At this time, all participants will be in a listen only mode and if time permits, there will be a question-and-answer session and instructions will be given at that time. If anyone should require audio assistance, you can press * then 0 in an audio operator will assist you. And as a reminder, today's conference is being recorded.

I would like to turn the conference over to your host, Latonya Dunlow. Latonya, please go ahead.

Latonya Dunlow: Good afternoon, everyone. Thank you all for joining today's CMS Part C and D user call. We'll move forward with today's presentation; Employer's Group Waiver Plans, and I'll turn the call over to Kathryn.

Kathryn Jansak: Hi, thank you. Hi. My name is Kathryn Jansak on behalf of the Centers for Medicare and Medicaid Services, CMS, I would like to welcome employers and unions to our call as well as the regular stakeholders who usually call in. I'd like to note that there are PowerPoint slides for this presentation. The're posted on our part the website and afterwards on the same website, we'll be posting the transcript and a recording, so you can reach that too. The easiest way to reach that is to go on CMS.gov and there's a search box there and you just put in, if you put in EGWP, you should be able to locate it. And when you get into that webpage, it's in the top of the box.

Now, I'd like to begin the presentation.

Chris Bauer: Now, wait a sec. Just to be clear, in the search box, you type in EGWP and the results page that first hit that you have will take you to the page that's the presentation, it's located there.

Kathryn Jansak: Thanks. Okay, CMS is a federal agency that administers Part C Medicare Advantage Health Care Plans and Medicare part B drug benefits. And there's been a growing (inaudible) enrollment and a monitoring presence, so we've been asked by the stakeholders to talk directly to the employers and unions that are associated with EGWPs. And today, we're going to give you a general framework of the landscape in which EGWPs operate. This is a high-level overview, high-level overview, and we're not going to explore the details of every slide, but you'll have the slides for your convenience and also will be taking Q&As after the presentation.

Moving on to Slide 2, just a brief overview that we're going to be covering four main topics: Key Policies is first. That's EGWIP basics. Waivers are part two,

where we discuss what CMS waives. Part three has to do with CMS monitoring. We monitor all Part C and D plans, which includes EGWPs. Likewise, part four will concern Medicare Start Ratings, which again apply to all plans, as well as EGWPs. And there's a separate attachment which won't be a part of this presentation, just enclose some enrollment numbers and star ratings measures.

To begin a presentation, I would like to introduce my colleague, Marty Abeln. He is a Team Lead who works on Part C EGWP matters and he'll be starting on Key Policies. Marty?

Marty Abeln: Thank you, Kathryn. What I'm going to just do, very briefly, is in this – what I'm going to be covering in summarizing for you is Slides 4 through 6. It's called Key Policies. That it, basically, is just going to give you the basics, the very basics, of what the EGWP program, what the EGWP program is and I think the way to think about it is employer group plans are a subset of Medicare Advantage and description drug plans, Part C and D plans, that are typically offered to individuals. Well, EGWPs, both C and D, are offered exclusively to employers and union groups and offered exclusively to their Medicare eligible employees, retirees, and spouses. So instead of being the larger MA or PDP plans that are open to the general public, the general Medicare public, they're only offered through employers and unions.

What makes it possible for these plans to exist is that the Congress passed sections 1857(i) of the Social Security Act that gave CMS the authority to waive or modify Part C and D regulatory requirements that would otherwise discourage employers and unions from offering EGWPs. So we have this unique 1857(i) authority that let us take the individual Part C and D plans and make changes to them, waivers we call them, that were based on making the plans more functional for employers and unions.

Currently, nearly all Part C and D EGWPs are offered through contracts with PDPs or MAOs, so the MAOs and the PDPs that also administer individual plans will contact employers and say to you, "We can offer a PDP or an employer for you." They operate, we, CMS, directly interacts with the MAOs and the PDPs whom we have the contract with and your points of contact are typically – that is the employer – would typically be the MA or the PDP.

There is a possibility, although I don't believe we have any right now or a very limited number, for an employer or a union to contract directly with CMS, but, they would have to follow all the rules and it can be administratively burdensome. And typically the reason employers who choose to offer Medicare coverage through EGWPs do so because the flexibility of the waivers allows these plans to tailor the coverage. I mean they have to cover the basic PDP requirements; they have to cover A and B; but for some supplemental benefits in some designs, because of waivers, they can somewhat tailor the package to suit their employer or union members.

And in Slide 6, we emphasize, which will emphasize repeatedly, that these waivers do not include waving important rights and protections for beneficiaries. We can talk about them a little later, what they entail, but they're mostly elements that make it easier, but they don't take away basic rights, because these

individuals are Medicare beneficiaries, just like any other Medicare beneficiary, except they're enrolled in a particular type of MA or PDP plan.

So you can look at the slides. They provide a little more detail and as Kathryn said, we're going to move through this quickly, so we have time for questions at the end but the slides give you a little more information and as you have questions, we can deal with those. So with that brief overview, I'm going to turn this over to Kathryn to go on with a couple other slides.

Kathryn Jansak: Okay, thank you, Marty. I'm just going to – Slides 7 and 8 concentrate on issues that are unique to the Part D drug benefit and the idea is that you cannot diminish the Part D benefit.

And just to give you a quick overview of how it works, basically EGWPs, like all Part D sponsors, create a formulary, which is a list of drugs, which is a drug list and they can make choices, but there are requirements and minimums that must be met for those drugs that are covered by the Part D benefit. So once they come up with their plan, their list of drugs, they submit the formulary to CMS, CMS checks it out, makes sure that the minimums are met. For instance, there's different classifications and generally, you need to provide two drugs within each classification and once this set, it's set for the year.

Now, if a plan wants to make a positive change and add drugs or make fewer restrictions, they do not need CMS permission to do that, but if they wish to make what is called the negative change to the plan for the year, they need to obtain CMS approval to do that and that means, for instance, if they wish to remove a drug from the formulary or move a drug to a different tier, a different level, where beneficiaries would have higher cost sharing. There's other kinds of restrictions but again, they're listed on the slide and that could be discussed at another time or off-line.

Now, the last thing I'd like to alert you on Slide 7 is that there's transition requirements. Basically when a bene – for instance, if a negative change is approved during the year and a beneficiary who is on a certain drug will either not have that drug or it will be available in a more restrictive way and basically, you have a need to provide notice and a refill, but again, that is not always mandatory – depends on the circumstances.

I'd like to turn to Slide 8 now. Slide 8 is about the concern that beneficiaries be able to choose within the network pharmacies. Basically, beneficiaries cannot be limited to just one pharmacy or just mail-order. Our concern is that beneficiaries are not receiving – we don't want them to receive drugs they do not want on the idea is to avoid unnecessary cost to the ben and to the program for unwanted or unnecessary drugs.

Now, the default for Part D sponsors for 2014 is to require that they obtained beneficiary consent before each mailing; however, EGWPs, if they meet certain requirements, can use automatic delivery so long as they obtain beneficiary consent once a year. And there's some requirements there; for instance, they can't make beneficiaries except automatic delivery as they would need to refund any unwanted medication.

Now were going to move to Slide 9, which is on supplemental benefits. There's a recent change in the regulation about revising the definition of part D supplemental benefits to exclude coverage offered through EGWPs other than the basic Part D plan coverage. And basically, the bottom line is that it means that starting in 2014, the Medicare component of EGWP plans is limited to defined standard benefit. EGWPs can no longer offer enhanced alternative plans.

Next, we're going to move on to the enrollment slide and just to give you a – as we noted before there's been a lot of interest in EGWPs and one of the reasons is there's been a large increase in enrollment. For PDP Part D Plans, EGWP enrollment doubled from 2012 to 2013. For MA and MA-PD plans, EGWP enrollment increased by a smaller proportion.

With that, I'd like to turn over the rest of the series of slides on EGWP enrollment to Patty Helphenstine, who is the Director of the Division of Enrollment and Eligibility. Patty, thank you.

Patty Helphenstine: Hey, thanks a lot. So thank you all for joining us again and I'm going to go through some of the enrollment and eligibility rules and talk a little bit about what our expectations are. I do also want to point out that while we're talking about Employer Group Waiver Planned, what I'm going to address for enrollment and eligibility also apply to employer group health plans that are not seeking waiver of particular provisions or requirements. So it's important, as long as it's a plan that sponsored by the employer union, these rules are going to apply.

So we're on Slide 11, and it's important for all employers and union groups to remember that while you may want to have them as a member in your particular group, they still need to meet the regular eligibility requirements for both Medicare Advantage Part C, as well as Part D. And generally, that means that for Medicare advantage, your members will have both Part A and Part B and for Part D, they could have both or have either Medicare Part A or Part B. In addition, that member needs to be permanently residing in the planned service area and just as a quick reminder, permanent residence is not – we would not include, like, a snowbird summer home as a permanent residence. We're talking about the state an area of which there filing taxes and things of that sort. So it's important that they permanently reside in that plan service area.

One point to note is that for a stand-alone Employer Group Waiver Plan, if you're doing a stand-alone prescription drug plan, that member must be a retiree. For Medicare Advantage, that member could be a current employee or retiree.

So now I'm going to move to Slide 12 and I want to talk a little bit about the important role that employer plans and union plans, as well as the employers and unions themselves, play in educating their members. We find in here many times that this is the area for which all parties tend to have confusion, so I really want to try to hit this home. A lot of members don't understand how Medicare part C in part D coverage works. They don't understand how the employer's enrolling them. They don't understand if they choose not to go with the employer group enrollment how that might affect their retiree benefits. There's a lot of confusion and the results for the beneficiary could really be to get some serious

consequences, based on this misinformation, so it's important that those employers and unions, as well as the plans in which they contract with, are communicating both the benefits and all of the requirements to all of the members in a timely manner. We have timelines associated and requirements and the members need to understand, so they need to make sure that they're conveying it clearly.

Let's talk a little bit more about this on Slide 13. So we have some examples to talk about consequences based on untimely or and clear messaging and specifically, we have situations where perhaps the individual unintentionally disenrolls from the employer union plan and then they end up losing their retiree benefits. Or they can't get back in and they end up having gaps in coverage or whatever it might be, there are certain circumstances of which now, that beneficiary is disadvantaged.

Another particular consequence is plans, as well as the employer and union groups need to make sure that they are relaying information about the late enrollment penalty and about the importance of maintaining creditable coverage. If individuals have 63 days or more of a gap, they could potentially be assessed a penalty for Part D and they'll have that penalty monthly for as long as they have that coverage. So it's not a one-time payment; it's a long-term penalty.

In addition, if an employer or union group pays premiums on behalf of their members it's important that they know that if an individual does ask them a question has to pay the Part D IRMAA – which is an Income Related Monthly Adjustment Amount, it's basically if you make a higher income, you pay a little bit extra in your premium – that that must come directly from the member themselves to the federal government. Those individuals, if they do not pay timely and lapse out on their grace period, they will lose their coverage, be disenrolled from your plan, and potentially then be assessed late enrollment penalties and other issues.

Moving on to Slide 14, let's talk a little bit about the requirements, so that we can help make sure that you're providing the right information. Now, the notifications for enrollment, either the plan of the employer union group can send it, but it must go out and the notice must include both information about the enrollment, and it must provide the effective date of the coverage. That notice is required to be sent at least 21 days prior to that effective date. That gives, it basically gives individuals the opportunity to know it's coming, make a decision if it's right for them, and opt out if they want to opt out. And that is an important piece of this is that you have to give the individual the opportunity to opt out.

There's also some other requirements, such as you have to include the summary of benefits. You have to put in some information about the contractual agreement, but all of these are listed in our manuals. For note, it Section 40.1.6 of both Chapter 2 and Chapter 3, so we encourage you to become very familiar with those.

Okay, so we're going to move on, now, to Slide 15 and were going to talk a little bit about the optional mechanism for MA group-sponsored plans. The group enrollment mechanism that I was just talking about is really an option where the

plan, or I'm sorry, the employer group or the union group can pick the start date. They pick the plan, they pick the start date, they tell their members, "As of this date you're going to be in Plan A, and if you don't want it, you need to opt out."

The optional mechanism is only available for Medicare Advantage, it's not available solely for stand-alone PDP, but for Medicare Advantage, to have a second option where the employer or union can offer, let's say multiple plans, and their members then pick which one they want to go into, instead of opting out, there opting in and they're making the plan selection. In turn, you are then holding on and collecting all of that enrollment information and then you're going to submit it, in a group format, to the correct plan of what you're contracting and that's with that optional mechanism is all about.

Okay, moving on to Slide 16, I want to talk just a minute about data collection requirements and this I cannot emphasize enough. We've actually had instances where we're hearing of employers that are not following this and it's very severe violation, so we just really want to hit this home. And that point is that the employer or union, using the group enrollment mechanism, they must provide all of the information required so that the organization can submit a complete enrollment request. That means they have to have the name, primary residence, the real HICN, all of the elements that we outline in our chapters as required elements for enrollment, the employer is required for obtaining that information, making sure it's accurate, and then sending it to the plans.

It's also important to remember that all of our timeliness requirements are still, they still apply to employer group enrollment mechanisms and that the timing for when enrollments are effective is the same as it is for other enrollment. So if you're submitting it, you have up to a certain number of months that the enrollment can be effective, and then you can move on, but you cannot work outside of those guidelines.

Last but not least, we do have a special enrollment period for individuals that are currently enrolled in employer group health plans or waiver plan and those individuals have the opportunity to enroll in or just enroll from, at any time that they have that coverage going into employer group coverage or coming out of it. If they lose eligibility, they lose the membership, they also have up to two months in order to pick a new plan.

And last, but not least, I want to touch on failure to pay plan premiums for individuals in employer groups. There are two easy ways to remember this. If the employer group is paying for premiums, the plan may not disenroll for nonpayment. That becomes an issue between the employer and union on the plan in which their contracting to make sure the receiving payment. If the individual member is required to pay premiums directly to the plan, all of the normal rules regarding payment and nonpayment, disenrollment for nonpayment, do apply and that means individuals can lose their coverage.

At that time, that wraps up my slides and I'm going to turn it back over to Marty, who's going to present a waiver policy.

Marty Abeln: Okay, thank you. And I'll just mention a few things on waivers. Now I mentioned earlier that the EGWP program is based on waivers, under the 1857(i) authority. And what employer group plans are is they're plans – PDPs or MA plans – that have used certain waivers released by CMS. Now the waivers that are available are publicly available in Chapter 9 for Part C and Chapter 12 for Part D. Those are the only waivers – I mean if you have a question about, "Can I do something?" Or, "Does some rule apply to me?" If there's not an express waiver there that says that it is waived or somehow modified, then you have to follow the standard rules, and that's real important if there's any question about what waivers can be, or how much flexibility you have.

And as I mentioned earlier, CMS will not waive Medicare requirements and restrict benefits. Obviously, we're not going to limit Part A and B coverage, which has to be the same as any other MA plan, nor would we restrict Part D benefits. And also, on the MA side, we have cost-sharing limits on certain services. Chemotherapy, other sensitive services – those apply to EGWPs and we also have a protection on the MA side for a maximum out-of-pocket amount. All EGWPs should abide by those rules and, of course, beneficiaries and EGWPs have appeal rights. So if they don't believe they're entitle – or they've received a certain service benefit that the plan should be furnishing, then they have the right to an independent appeal to determine that.

And I just want to mention that in order to qualify for a waiver, because all the waivers out there are not necessarily applicable to every single MA or PDP, so you have to be mindful of reading the waiver and following the conditions of the waiver and make sure you comply with them if you want to use them. CMS is open from interested parties who want to submit waivers, waiver requests and basically what we look for is an explanation of why you want to wait something that hinders the offering of an EGWP Part D or Part C plan and obviously you want to be mindful that it doesn't take away important benefits, protections that these and really should have. So we look for an explanation, a rationale of why it's in the best interest of beneficiaries in the program to waive an existing requirement. It's something of a high bar before will approve a waiver, but if you think you have a good case for one, then you should submit it to CMS and, assuming it's approved, it gets published and released and is available to all other similarly situated Part C of Part D plans in the country.

So with that very brief overview of waiver policy, I'll turn it to Kathryn who, I think, will have a little more to add.

Kathryn Jansak: Yes, thank you Marty. Basically, you can see on Slide 22 that waivers are concentrated in certain areas and Patty's actually mentioned some of the enrollment ones. I'm not going to go into detail. Patty spoke about the service areas and that the waivers, as been mentioned, they're employment-based rather than being open to all Medicare beneficiaries. Also for marketing, I'll just mention that individual plans submit their marketing materials that are sent to beneficiaries before they're released. With CMS, that's not necessary but CMS may request and review those documents.

Also, moving on to Slide 23, we list a few of these Part D waivers and I would like to note that a waiver in an area does not mean that the entire area is waived.

For instance, the formulary. I mentioned that before. We do have a way for in the formulary. Most individual plans need to submit different plans for all their different – different formularies for all their different plans – and EGWPs certainly may have different formularies as well but for EGWPs, we only require that the EGWP submit what is called the most restrictive base formulary. Now, that base formulary must meet all the requirements that we discussed earlier; basically the beneficiary protections for their Part D benefit, but the restrictive base formulary must contain all the minimum that needs to be offered to all beneficiaries but it they don't have to submit every single formulary for every single plan, but what they do submit to us must be provided to all of their EGWP enrollees.

With that, we can move on to Slide 24. Slides 23 and 24 are just places where you can find – there's Part C resources and Part D resources. The resources here are more EGWP-specific. Obviously, there's other resources for other rules that are in the Part C and D program, but these are more EGWP-specific and at this point, we are ready to move on to Section III on Monitoring and I'd like to introduce Linda Gousis (ph) who is the Acting Deputy Director of the Division of Benefit Purchasing and Monitoring. Linda? Thanks.

Linda Gousis: Thanks, Kathryn. On Slide 27, when we talk about monitoring, we're talking about making sure that plans are in compliance with the Medicare Part C and D statutes, regulations, manual chapters and guidance, like HTMS memos. It's very important that health plans follow these rules so that beneficiaries get the benefits they are entitled to. In the past, we have been more focused on the individual market rather than EGWP plans. But we're starting to look more closely at EGWP compliance because of the increased enrollment into EGWPs over the past year and a rise in complaints.

So how do we do this monitoring? Let's look at Slide 28. The information we get about plans comes from four main buckets – day-to-day monitoring, day-to-day account management means that information that CMS obtains through your plans account manager by way of communication with the plans, beneficiary complaints, inquiries to 1-800-Medicare and information from advocates and federal, state, and local Congresspeople. Monitoring and surveillance means focused projects that look at a particular aspect of how all plans are performing. In contrast, audits are events where CMS looks at how a single plan is performing in multiple areas. I'll talk more about audits later in this call. The fourth bucket is reporting requirements, which is specific information that CMS collects from plans on a scheduled basis.

We synthesize all the information we get from these four buckets in order to understand how a plan is doing. Ultimately, we want to know if there are specific areas with a plan needs to work with their account manager or a CMS subject-matter expert to better understand a particular area of the program.

On Slide 29, you'll see a series of actions CMS may take a response to identifying noncompliance. That is (inaudible) follow CMS rules. At the top are our least-serious compliance tools and at the bottom are our most serious tools.

When we identify a compliance concern, we will work with the plan to research the issue and flesh out the extent of the problem. For first instances of noncompliance that had a significant beneficiary impact, involves a critical beneficiary right or protection, or a time sensitive plan administration issue, we may issue a formal letter called a Notice of Noncompliance to the plan. If the problem continues or if the compliance issue is particularly egregious, CMS may issue a warning letter or a request for a corrective action plan. It is only rarely that we have to use enforcement tools, like sanctions in civil monetary penalties.

Slide 30 shows all the information that funnels into each plans account manager and the resources they have available to them. Account managers are like Amazon.com for plans. If they don't have what you need, one of their resources does. Now, I'll move briefly to the topic of reporting requirements. Slide 31 discusses the purpose of reporting requirements. Please note that on slide 32, EGWPs report are nearly all of the same Part C elements as individual plans. Slide 33 discusses the Part D reporting requirements and look closely at Slide 34, which shows the reporting requirements that are unique to EGWPs. We need specific information about the employer.

Now, switching gears audits on Slide 35. In general, where more interested in the beneficiary experience. Our audits focus on the plan's outcomes, for example beneficiaries access to prescription drugs, rather than policies and procedures, but of course we look at those as well. Currently, EGWP enrollees are only included in the audit sample upon referral if there is a concern; however, we are considering routinely adding EGWP enrollees into samples in the future.

On Slide 36, you can see the performance areas we audit, like formulary administration, transition policy administration, and coverage determinations and appeals. Moving on to Slide 37, in order to monitor all plans on a specific topic, we gather data about plans during various times of the year. In some instances, plans supply the data directly to CMS, and in other instances, it is data gathered from our internal systems or by our contractors. We gather specific data points across all plans so we can compare plans to one another, determine plans that need established compliance thresholds, and determine outliers. On Slide 38, you can see the sources of some of the data we poll for our monitoring. On Slide 39 is a list of all of our monitoring activities. Those in red include EGWP plans. A few examples of monitoring projects that involve EGWP plans are making sure protected class drugs are in formularies; making sure PDE information is submitted; and monitoring complaint levels and mail order issues.

Now I'll turn it over to Lt. Cmdr. June Page (ph) who will discuss an example of the monitoring projects that EGWPs are involved in.

June Page: Thank you, Linda. As Linda mentioned, my name is June page and I'm a pharmacist on the Division of Formulary and Benefits team and I'm also the team lead for the Part D Transition. CMS announced an enhanced transition monitoring program analysis, which is commonly referred to as TMPA, that was piloted for the contract year 2012. The purpose of this monitoring effort is to ensure that Part D sponsors are adequately administering Medicare Part D formulary transition policies.

On Slide 40, it provides the methodology and data collection overview process for the TMPA. This project requests that Part D sponsors submit all point-of-sale claims rejected for the following three categories: non-formulary, prior authorization, and step therapy from January 1 to January 21. On to Slide 41 – in an effort to help ensure plan sponsors are adjudicating prescription drug claims properly, CMS also announced an enhanced formulary administration analysis, or commonly referred to as FAA. The purpose of this program is to evaluate whether Part D sponsors are appropriately adjudicating Medicare Part D drug claims consistent with Part D requirements and sponsors CMS approved benefits. This slide also provides the methodology and data collection overview process for FAA.

Now, I'll turn it over to Greg Bottiani (ph) who will now present on the new monitoring initiatives for EGWPs.

Greg Bottiani: Thank you, June. With respect to this project, and the first slide, 42, is the purpose and then Slide 43 is the topics. So historically, EGWPs have been excluded from much of our monitoring and oversight for various reasons. I think mostly because of the breadth of plan offerings in flexibility and benefit offerings just makes it difficult for CMS to include them in such projects as a call center monitoring where we ask plans specific questions.

So given the population growth and the increased number of beneficiary complaints reporting serious access problems with EGWPs, such as proper benefits administration, proper handling of grievances, and poor handling of complaints, we've decided to take a more active approach to monitoring and oversight. Over the next two years, we will be designing and implementing a monitoring program specifically for EGWPs.

Slide 43 shows areas that CMS will focus on during this project. One area to be studied is the practices of mail-order pharmacies. The level playing field requirements on this slide is part of that subset. For that mail-order piece, CMS will, in addition to the level playing field analysis, characterize the nature and volume of complaints concerning mail-order, evaluate mail order benefit offerings in formularies for these employers, the level of enhanced benefits in formularies and review beneficiary materials used by EGWPs concerning mail order to ensure that they accurately reflect benefits offered and program requirements.

The information gleaned from this two-year study may result in CMS issuing best practices memos, clarification, or updating of guidance or compliance actions. It really depends on what we learn.

And now I would like to introduce Liz Goldstein, Director of Consumer Assessment and Performance to present on star ratings.

Liz Goldstein: Thank you. So starting on Slide 46, the Star Ratings measure quality and performance of Medicare health and drug plans. They're available on our website to help consumers make decisions. There also used for our Medicare Advantage quality bonus payments system and I just wanted to note MA EGWPs are eligible for quality bonus payments.

On the next slide, list some of the principles we follow for the Star Ratings. I wanted to note that you have an appendix that includes all the measures that make up our Star Ratings. Our mission, on Slide 48 is really to improve the quality of care provided to Medicare beneficiaries, so Parts C and D sponsors, including employer groups, are accountable for the care provided to their enrollees and it is all the care provided – by physicians, hospitals, and other providers.

I wanted to give you a little background about our quality measures. On the Part C side, plans have been collecting data since 1999, so for a significant period of time. So this includes our CAHPS survey, which measures patient experiences. HEDIS, also, which are clinical measures. In 2007, these quality measures became part of the Star Rating System and are available on Medicare.gov with cost and benefit information. On the Part D side, ratings were first released in 2006 and initially, they focused more on process measures and are patient experience survey, our CAHPS survey, and today the measures also include clinical and patient safety measures.

Just to quickly note and we've noted about this already, the star ratings are used to make decisions for consumers, five-star contracts do have marketing advantages, so they can market year round, and again, they're included in the quality bonus payment system.

Each year, we look at the existing measures, review them for changes, look for new measures. We continue to refine the system we always have a series of public comment periods to get input into the rating system. So it starts out each fall with a request for comments, and then moves on to our draft call letter and final call letter.

I'm going to quickly – on Slide 53 – review the Star Rating System. There are three levels of stars, so at the bottom level, are the individual measures and for each individual measure, when we display it on the Medicare Plan Finder website on Medicare.gov, for the individual measures, we show both the numeric values and their star rating from 1 to 5. Those individual measures – and there are approximately 50 measures across C and D – are rolled up into nine domains or topic areas across C and D. So an example of a Part C is staying healthy and then those – we further roll everything up on the MA-PD side to an overall rating that summarizes how a contract does across all the measures. For NMA only contract, they would get a, their highest rating would summarize all the Part C measures and for a prescription drug plan, their rating would be summarizing all the Part D measures.

Just to note in the rating system, we weight outcome measures the highest. So they receive a weight of 3. Patient experience and access measures are also weighted a 1.5, which is greater than our process measures, which receive a weight of 1.

MA contracts – and this is Slide 55 – that include employer and none employer PBPs have always been required to collect and report measures from CAHPS, HEDIS, and our Medicare Health Outcomes Survey. So all this data has been

coming to us for many years. All prescription drug plans that include employer and non-employer PBPs have always been required to collect CAHPS information or our Patient Experience Survey and starting in 2012, all employer/union only direct contracts were required to meet the same reporting requirements as MA or PDP contracts.

I'm going to now pass it back to Linda for the next slide.

Linda Gousis: We'll actually have Michael Neuman talk about past performance.

Michael Neuman: Thank you, Linda. My name is Michael Neuman and I work in the Medicare Drug Benefit Group under the Department of Benefit Purchasing and Monitoring. Twice a year we conduct something known as past performance review. The past performance review is a systematic and comprehensive 14-month look back at all Medicare Part C and D plans' performance. The review is conducted once in the spring, which is used to make determinations regarding service area expansions in the approval of new Medicare contracts and once again in the fall as a precursor for the following spring to allow plants to know how they're doing. The next pass performance review coming up in the spring will include EGWPs.

Moving to Slide 57, the past performance review helps CMS identify performance outliers – that is plans that are performing very poorly compared to other plans. This slide shows some of the attributes of the past performance methodology. The draft methodology for next year will most likely be released later this month in the final methodology is usually published in January.

Moving along to Slide 58. On Slide 58, you can see the 11 categories that comprise past performance review. Slide 59 discusses when we compile those results, how we assign this point values for each dimension in each category. Usually, points in just one category are not enough to make a legal entity an outlier; however, points in multiple categories can move a legal entity into outlier status.

Moving to Slide 60, CMS uses past performance analysis and a variety of ways. One way is that it informs our decision-making for granting expansions are permitting new contract application. We urge organizations with the recent history of performance problems to focus on their current book of business and not expand until they are operating in full compliance. CMS has denied applications for EGWPs and EGWP service area expansions based on poor performance scores.

Now, I'll turn it over to Kathryn, who will wrap things up.

Kathryn Jansak: Thank you, Michael. I'd like to thank you and all the presenters. On this last slide, 61, is contact information. We have a mailbox for EGWP questions and we can vet them out to the experts but while we're on the line, let's – we would like to open it up to Q&A.

Chris Bauer: Before we start the Q&A, this is Chris Bauer, and the Director of Part D Policy. Like to take care of a couple housekeeping issues. First and foremost, if you

joined us late and you couldn't get your hands on the slides, you can – for this presentation – you can get the slides by going to our website CMS.gov and in the search box for this site type in E-G-W-P or as we like to call it EGWP, E-G-W-P and then on the results page that you'll see, the first link there will take you to the EGWP Policy Page and you'll see a link there that says "November 6th Presentation Slides" and there you would be able to get a copy of the slides. There's also an appendix there with some additional information related to a couple different areas that people talked about and give you some more enrollment numbers.

The purpose of this call was for us to get a chance to talk to some of the actual employers and unions that participate in this program. We do have a typical monthly call that we have with Part D sponsors in some of their contractors, and so we'd like to give the priority to asking questions to these actual employers and/or unions. And if a Part D sponsor asks questions about the Part C and D program, if you are a Part D or C sponsor or contractor and have a kind of benefit design question, you can please send them to the EGWP policy e-mail box. We'll take a look at those questions and if it's necessary, we can have another usual Part C and D user call to address those questions or come up with some other guidance that will clear up any sort of questions that people are having.

I think there's a lot of information here. I know that we went through it very, very, very quickly. But we have some experts here that can answer your specific questions and if I was to summarize this whole presentation unlike one, one-and-a-half slides, what I would say is this program has been designed to help employers offer both health and drug benefits to their retirees. These sorts of plans have to meet the C and D requirements. You can build up from the base requirements, but you have to at least meet the requirements. You can't make, sort of, changes mid-year that diminish the benefit without CMS approval. For instance, you can say that you cannot want to cover hypertensive drugs. That would never be approved by CMS, either through waiver or any other mechanism. We do offer waivers to help you offer these plans. Those waivers are meant to not hinder the offering up that it will diminish the benefit. Program has been growing every year. We expect it to grow even more so in future years. As such, we're having a stronger compliance view and taking a look at these sorts of plans more in depth than we have in the past. So regular Part D sponsors are used to this sort of compliance review and our normal mechanisms for noncompliant and such. These players in the EGWP phase will have to get used to this and as we can kind of continue this.

And the other thing I'd like to say is one of the things we hear is there's a communication sometimes of sometimes of retirees not understanding their health plan and also part of the Medicare plan and all Medicare rights and protections still apply. They can still call 1-800-Medicare for complaints. The appeals process, they had the same access to appeals and (inaudible) is what regular Medicare beneficiaries do, and we want to make people, these sorts of Medicare eligible people also aware of these rights and protections. And then when your Part D sponsor is telling you, "Oh, we need this enrollment file, by such-and-such a day," if you're submitting it yourself or not going through the Part D sponsor or enrollment vendor, it's really important to meet these sorts of deadlines because they can have serious downward repercussions for not only

you offering the plan, but also for the particular beneficiary because they could have a financial impact that lasts, basically, forever.

And with that, now I'd like to open it up to questions. Thank you very much for participating in our call.

Operator: Okay, so at this time, ladies and gentlemen, if you do have a question or comment press the * followed with the 1 key, and you'll be placed into a question queue. So again, for any questions or comments, press the * followed with the 1 key at this time. And we do show a few questions coming in. Our first comes from Patrick McTie.

Patrick McTie: I'd like to go back to Slide 18, in terms of disenrollment for members, when the employer group is paying the premiums.

Kathryn Jansak: Sure, go ahead, what's your question?

Patrick McTie: Specifically, if the employer group is paying the premiums to the MA plan, but collecting the premiums either in part or in entirety from the retiree, and the retiree fails to make premium payments, what's our policy for disenrollment?

Kathryn Jansak: Okay, so if you have a contract with the plan to pay the premiums on behalf of your members, that's the contractual agreement you have with them. If the member is it paying you, as an employer, you determine the eligibility requirements for your particular membership group. So we don't outlining guidance how long any grace periods have to be anything of that sort, because it's really up to you. I mean, if –

Patrick McTie: Okay, so –

Kathryn Jansak: - I'm sorry?

Patrick McTie: - okay, my concern is retro – so let's say we give our members a 30 day grace period and they failed to make payment and so then we want to start termination process, which we understand from the MA plan, requires a 21 day letter be sent at that point in time before we can terminate them. So we can end at being two months into the plan and then appeared to be unable to retro terminate back to the date the member last paid.

Kathryn Jansak: Well, that's correct. I mean, disenrollments for nonpayment are never retroactive. The bottom line is is if you have a grace period of one month, well we have one on our side for the individuals, a minimum of a two-month grace period. So just like any other person that would lose eligibility to your group and you submit the disenrollment, the same process would apply. In this case, the individual is losing eligibility for your particular group because they're not meeting your payment policy. So it would be the same as though may be the – if you had someone that was a spouse and they are no longer covered as a spouse and you were, they lost all – it's the same exact process because it's your eligibility requirement, not our eligibility requirement, because you have the contract with the plan to pay the premium.

Patrick McTie: Where I really get down to, then, is if it takes, effectively, two months to actually terminate the member, then we have to eat the premium for those two months?

Kathryn Jansak: I would say, in this case, I would want to go back and take a look at the timing, because the 21-day advance notice has to do with the enrollment mechanism of when you're putting the individual into the plan. If they are being disenrolled for loss of eligibility, I need to double check my information. I don't want to say anything incorrect moving forward. So if you don't mind if you can provide or send your question again to the EGWP policy mailbox and I'll make sure I get that answer so that you can get a response.

Patrick McTie: So then, what I –

Kathryn Jansak: Okay, the address there is egwp_policy@cms.hhs.gov. Again, I'll read it one more time, and this is for any questions – egwp_policy@cms.hhs.gov and I guess we could take the next question, thank you.

Operator: Okay, thank you and we'll take our next question coming from Linda Kahn. Linda, please go ahead.

Linda Kahn: Yeah, both for fully-insured and self-insured plans, the question is is it possible for the plan to get access to the PDE or the MOR or the MMR files that are being filed by the insurance company? And more specifically, is it possible for the plan to get access to the CMS direct subsidies that are going back to the insurer, the donut hole discounts, the coinsured, the catastrophic reinsurance payments, the (inaudible) subsidies – how does the plan get access to the underlying information that the insurer is both submitting and the monies that are coming back from CMS to the insurer, so the plan can make sure that all of that information is accurate? And then finally how does the plan get access to the DIR information that's being submitted on behalf of the plan so that the plan can make sure that that information is accurate?

Tracey McCutcheon: This is Tracey McCutcheon (ph). We don't currently have any guidance that (inaudible) directly. We would expect that to be part of your contract with the sponsor.

Linda Kahn: Well, if the contract is in specific to it in the insurer will provide the information, then how is the plan sponsor supposed to make sure that the information is being submitted accurately on its behalf? I mean, presumably, CMS wants to make sure that the information is accurate and CMS makes the plan sponsor responsible for its accuracy and if the plan sponsor wants to find out if it's accurate, how does the plan sponsor go about doing that?

Tracey McCutcheon: So who is submitting the data, if not the plan sponsor?

Linda Kahn: Well, the insurance companies, just as a matter of practicality, the way the system works is insurance companies are almost always submitting the data on behalf of plan sponsors. The plan sponsors don't have access to gather the data; they don't get the data, frequently so they're not, they don't know what the data is. CMS is passing the money back to the insurers, not directly to the plan sponsors, so in order for the plan sponsors to know that it's being submitted accurately,

they would have to have some way that CMS would be able to provide that data to them as well. Just practically, that's the way the system is working.

Tracey McCutcheon: In our jargon, the sponsor is the insured entity, so it is generally the insurance company. They're one and the same. Are you talking about the –

Linda Kahn: Well, they may be one and the same, but the problem is the insurers are submitting all this information or the PBMs are submitting all of the information. So, you know, if you look at who you're getting information from, you're not getting it directly from plan sponsors; you're getting it from the PBMs or the insurers.

Tracey McCutcheon: Okay, well I would say that the insurer is the sponsor in our world, but the PBMs are another issue and I would point you to the recent MOR reg, which requires that plan sponsors have access to any of the dated necessary to do the MOR reporting. So I would look to that and that would be the authority to require that kind of information transfer between any plan sponsor and the PBM.

Linda Kahn: So this is an MOR reg?

Tracey McCutcheon: That's right.

Linda Kahn: And does that cover PDE files as well?

Tracey McCutcheon: Yes. Any information necessary to certify the MOR reports.

Linda Kahn: All right, thank you very much.

Kathryn Jansak: Thank you.

Operator: Okay, thank you. So we'll take our next question coming from William Kudenov.

William Kudenov; Thank you. Along Linda's line of questioning, this is about transparency. Well CMS provide access to the most current audit reports when an employer group's population has been targeted by audit and provide it to the plan sponsors, if you will? We would need to get some type of notification, because we require some time to do re-contracting if needed, so if you've identified in the service area that a plan sponsor's in violation, I think it's important that we know, so we can try to help hold them accountable.

Linda Gousis: Thanks for that question, but unfortunately, we don't have anybody who can speak directly to that piece on the phone today, so can you please submit that to the EGWP policy mailbox?

William Kudenov: Okay, can I ask one more question, please?

Linda Gousis: Go for it.

William Kudenov: All right, so this actually has to do with the expanding of the audit for taking a look at EGWPs in general and I noticed in the call, a lot was talking about late

enrollment, eligibility, file information – is there a plan that's kind of – it feels like there's an undertone of a plan that CMS is kind of considering taking action against employers versus submitting information that may be missing. Is that what I'm hearing?

Chris Bauer: The compliance focus is more just an outgrowth that we haven't, that we are increasing our compliance, reviews in general, to this population because of growth and some other factors, but I wouldn't necessarily attributed to a particular – again, our jargon – Part C or D sponsor.

William Kudenov: So, if they're noticing a lot of late enrollments coming in and they're able to identify, "Hey, maybe it's like a particular employer group," I mean with that employer group go through that same level of sanctions as a health insurance company would?

Linda Gousis: Just one second.

Chris Bauer: So we have the authority to take action against a plan sponsor, and I'm trying to think along the lines of, you know, where some of this kind of audit information is available, again, I try to be careful in the language that I use because I think our terms are slightly different than your terms, that an employer or union could view – and that's not the case?

Unidentified Participant: Yeah, the audit reports are posted publicly now and we can, again, as I stated we don't have anyone from our audit team here, but these are all really good questions. But as already been stated, the target is not the employer. So the purpose of all of this is just to make sure that the sponsor or the insurance company is complying with all of our requirements and to the extent we identify a problem that involves the employer beneficiaries, that would be communicated back and that information, again, would be public on our website. But these are all good questions and so please do send them in and we'll make sure that our colleagues in the audit group get those (inaudible).

Chris Bauer: And we have varying levels of compliance actions. It's not like – and I'm just concerned that somebody's talking about re-contracting – we have lower level of compliance issues that don't rise to a major source of sanction where we apply a higher threshold. There's lots of little underlying things that we go back and ask a plan to fix if there's any data wrong and if it's not really hurting the beneficiary, more like the information reporting, it will be a lower level sort of compliance and it's something that we would just monitor. They would show up if they fixed it and we would be all moving on. It takes either a significant issue that harms the beneficiary or some other more significant thing for us to take a higher level, more significant, such as kicking somebody out of the Part C program, which is quite rare.

William Kudenov: Okay, thank you very much.

Kathryn Jansak: (Inaudible) ready for the next question?

Operator: Sure, so we'll take our next question coming from Michelle Cole.

Michelle Cole: Hi, thanks for taking my question. We need to know – we have a group coming on, and employer group, that is taking MA only plan through us, but they currently have a Part D stand-alone plan through Express Scripts and their wanting to continue that in 2014. We want to make sure that what we transmit won't disenroll them from their Part D stand-alone. And can I just verify as long as we're sending the employer group flag on the transmission file, that that will ensure that their part D won't be terminated.

Marty Abeln: So you're wanting enroll – they're in an MA only play and you want to enroll them in a stand-alone PDP?

Michelle Cole: Other way around. They're in a stand-alone PDP and they're coming with our company for the MA only side.

Patty Helphenstine: Okay, so this is Patty. Actually, they can't have both without a specific waiver approval. If you're enrolling them into the MA only, they will be disenroll from the stand-alone Part D plan.

Michelle Cole: Okay, so they're – oh, go ahead, sorry.

Patty Helphenstine: Yeah, I mean the laws very clear that individuals in an MA plan can't also be enrolled in a stand-alone PDP. So without a specific waiver approval, if that's even one of the items that's permitted, then they would not be able to maintain both.

Michelle Cole: Okay, because I'm reading in 20.1.8, which is the waiver that allows that. So are we needing to get approval from our regional plan for that waiver or – and it's also under 30.8.

Patty Helphenstine: I'm sorry, which section of the – oh, I see. Chapter 12. So –

Michelle Cole: Under 30.8 it talks about that as well.

Marty Abeln: That's right. I mean, in the past, it wasn't possible to enroll in it –

Michelle Cole: Right.

Marty Abeln: - because of the concerns about coordination. You had to enroll in a – you couldn't be enrolled in an MA only and a stand-alone PDP, but there is a waiver in place right now that does allow that to occur under certain conditions.

Michelle Cole: Okay, so does that mean that the waiver, we don't need an approval for the waiver?

Marty Abeln: As long as you abide by the conditions of the waiver, you don't have to have a specific approval for it.

Michelle Cole: Okay, so my next question –

Chris Bauer: I'm sorry to jump in but I think this is something that you'd want to talk with whoever your perspective Medicare partner is.

Michelle Cole: We did call our account manager. They sent us to the helpdesk. They said just (inaudible) the account manager, so I just thought, "Well, since you guys are the EGWP experts, (inaudible)."

Chris Bauer: And when you say account manager, you mean your account manager –

Michelle Cole: Regional –

Chris Bauer: - with the health insurer.

Michelle Cole: CMS – no with CMS.

Chris Bauer: With CMS.

Michelle Cole: I'm Regional Ten.

Chris Bauer: Oh, you're a sponsor?

Michelle Cole: Yes.

Chris Bauer: Oh. Why don't you –

Michelle Cole: So were trying to (inaudible) make sure we don't transmit something wrong.

Chris Bauer: Okay, yeah, so in this case, why don't you send your issue to the mailbox and we could take this offline and –

Michelle Cole: Okay.

Chris Bauer: - address it specifically.

Michelle Cole: Perfect. Thanks so much for your help.

Chris Bauer: Sure.

Kathryn Jansak: The next question, please.

Operator: Thank you. We'll take our next question coming from you, Cathy Windsield Jones. Please go ahead, Cathy.

Cathy Windsield Jones: Thank you. Just a quick question, now that we're in employer direct PDP, and now that we've got a star rating, are there plans to put that out on Medicare Plan Finder, because the past employer plans have not been out there?

Liz Goldstein: Right, traditionally, the employer only plans are not on Medicare Plan Finder, because the general population can't choose them. I'm not aware of efforts to change that at this time.

Cathy Windsield Jones: Okay, great. I just wanted to confirm that. Thank you.

Kathryn Jansak: Next question, please?

Operator: Okay, and our next question is from Elizabeth Loomis.

Elizabeth Loomis: Hi, I was wondering if there's anyone available that could explain the criteria to demonstrate that you can apply for a service area waiver for an EGWP. I know that it happens to the service area expansion process, but what would a plan actually file to demonstrate network adequacy.

Marty Abeln: Well, we don't require a specific filing. You're talking about an MA plan?

Elizabeth Loomis: It is. We have an MA-PD right now and looking for retirees that are outside of our service area. So we –

Marty Abeln: You can't enroll retirees that are outside of your service area.

Elizabeth Loomis: Well, you can if you have 51% of the group within your service area, 49% are outside, you can ask for a service area waiver. So were trying to understand what the criteria is to do that.

Marty Abeln: I'm not aware of that waiver. Your service area has to include is where you can enroll people. You can extend your service area under certain circumstances, but you always have to have a service area and that service area is the basis where people can enroll in your plan.

Elizabeth Loomis: Yeah, there's guidance in Chapter 9 about service area waivers for retirees that live outside of a given state.

Marty Abeln: Right, but you would have to extend your service area. You can't – that's just saying that waiver allows you to extend your service area outside of the state. Prior to that, you were limited to operating within the state, but you always – there's no waiver of the really basic requirement that you have to have a defined service area where you enroll people. You can have a national service area and you can enroll every, you know, you're EGWP or your retirees anywhere in the country, but you always have to – or you could have a service area that encompassed a region, multiple states, but you can never enroll people that are not residing in your service area. I think you might be –

Linda Anders: This is Linda Anders. I work on the Part D application and if I could just add into that, the service area waiver is actually in practice licensure waiver, so that your license in your domestic state and you don't have to be licensed in the other parts of your service area, outside of that, which is not true for non-EGWP plans. And this is the time of year when he would notify CMS that you're interested in expanding your service area. The notice of intent to apply was released last week. There is an option to expand the service area of your employer market only and it's a pretty quick application that is no submission of information. It's just clicking some attestations. You don't do any file uploads with that. And if you have questions, you can contact me at Linda.Anders@CMS.gov.

Marty Abeln: Let me add that when we say you don't have to submit the, you don't have to be licensed in other states – it doesn't mean that we can waive state licensure

requirements. It means that CMS doesn't require it, but if the state required it, you would have to comply with it.

Linda Anders: Correct.

Elizabeth Loomis: Yes, I think it was the semantic – I apologize. I didn't mean that we could just enroll outside of service area. I guess the question was how would a plan select either a region or a national service area expansion for those retirees that live outside of a state where we were licensed. That was probably a better way to phrase it. I apologize.

Marty Abeln: Okay, I mean did we answer your question?

Elizabeth Loomis: Yes, I mean if it's not an actual table, and MA or a facility table upload and you're just attesting that you will have adequate providers available, that's essentially what the waiver attestation is looking for, correct?

Marty Abeln: Correct.

Linda Anders: To expand only an employer of an exist – employer service area of an existing contract that already has employer approved.

Elizabeth Loomis: Right.

Linda Anders: On the Part D side is what I can speak to best. It's a series of attestations indicating that you are, in fact, expanding your service area and you can contact me if, after your reading through the notice of intent to apply, it doesn't make sense. So will walk you through it.

Elizabeth Loomis: Okay, perfect. Thank you.

Operator: Thank you. Our next question comes from Penny Baker:

Penny Baker: Hello. Thank you very much. We are a retiree organization that has a stand-alone Part D plan through a plan sponsor and we periodically run into issues where – and I guess I'm looking for a general philosophy – I've heard lots of discussion about is that CMS looks to make sure that the beneficiaries are given every possible, you know, all the right under the EGWP program, but what about being more liberal than CMS requires? And what I'm looking to specifically is some examples that I've seen where we had a retiree contact us with great difficulty, let's say forgetting their provider to go through a prior authorization process or a step therapy process, we, the employer group, want to request that they go ahead and be allowed to bypass that and yet, our plan sponsor, if you will, the PBM, is requiring that process to be in place, does not allow us to request an exception. Can you address kind of CMS's view in terms of being more generous? Thank you.

Judy Eber: This is Judy Eber (ph), so you are looking to make an across-the-board change where, for a particular medication, you didn't want to have a prior authorization apply?

Penny Baker: It's more of a on an individual case basis rather than going through the clinical exception or coverage review, because that presents some sort of difficulty.

Tracey McCutcheon: This is Tracey McCutcheon. That presents a uniform benefits issue for – so I think the devils in the details about whether or not there's a way in which you can help the PBM fulfill the prior authorization for the beneficiary so you can assist them in getting the information versus changing the benefit for that individual.

Judy Eber: Yeah, and this is Judy. I think the other thing you could do is look at the data that you have and if you have a particular medication where you're running into that a lot, I mean, you could consider not having whatever utilization management is on that medication for everybody would be another possibility. If it's a particular medication you run into a lot.

Penny Baker: All right, okay, thank you.

Kathryn Jansak: Thank you. Next question, please.

Operator: Okay, thank you and we'll take our next and final question at the moment from Donna Joyner.

Donna Joyner: Hi, I've got a EGWP disenrollment question. Can an ex-spouse be canceled retroactively to the first day of the month following the date of divorce, or must the 21 day notice he given to the ex-spouse prior to the disenrollment?

Kathryn Jansak: Okay, so thanks for asking your question. I am going to ask you to go ahead and submit that. I'm going to give you a slight answer now, but I'm going to ask you to submit it. In the meantime, since we've had all these other questions, I was actually able to go into the guidance and double check what our information is and you're correct. Disenrollments do require 21 days advance notice prior to the effective date. So that means if you have someone that – the bottom line is regardless of the situation, when the individual loses eligibility from the time you notify the plan, that individual has 21 days advance notice before the disenrolled. So retroactive is not really an option.

Donna Joyner: Okay, thank you.

Kathryn Jansak: Thanks. Did you say there's no more questions or anybody else? We do have some time?

Chris Bauer: We do have some time so we'll accept questions from any participant.

Operator: Okay, for any further questions, press the * followed up with the 1 key. And we have another question –

Chris Bauer: And while – oh, sorry, did you get somebody already/

Operator: Yeah, we do have one more question just (inaudible).

Chris Bauer: Okay, go ahead.

Operator: Patrick McTie.

Patrick McTie: I was the first question in regards to the similar issue on disenrollment. So since you've kind of provided some clarity and I have already submitted the e-mail, as well, but so specifically a the situation where we cannot retro terminate for a member, in our case it would be for nonpayment, then the employer group is forced to absorb the loss of a month or two of premium, which I assume (inaudible).

Kathryn Jansak: Yeah, I mean the employer group's required to continue to pay the premiums for the time the individual's enrolled in the plan.

Patrick McTie: So even though the – just to be clear – so the individual has failed to make premium payments, so for the two months that it takes to actually complete disenrollment, the employer has to absorb that cost of those two months of coverage that the individual has not paid for before they can terminate them?

Kathryn Jansak: Yep.

Patrick McTie: Okay.

Kathryn Jansak: And I – what I would recommend is that you take a look at what we offer in terms of how we have MA and PDP plans do their grace. And the timing of the notices because if you look at that, you might find that that might be a good means to half your grace. And perhaps provide the advance notice prior to the effective date of when everything sort of ends. You might be able to mirror that.

Patrick McTie: Oh, and where do I find that? Is that in the manual?

Kathryn Jansak: Yeah, so it's in the enrollment guidance and it would be in Section 50. Section 50's all the disenrollment information.

Patrick McTie: Section 50, thank you.

Kathryn Jansak: Mm-hmm. We do have more time for questions. It was opening up to the entire crowd.

Operator: Okay. So we do have one more, well, two more questions. Our next comes from Sally Knight.

Sally Knight: Yes ma'am. I have a question. Slide 20, in regards to the first bullet point where all EGWPs must follow Medicare Part C and D requirements unless explicitly waived or modified by CMS. Does that include the benefit limits for the co-pay structure?

Marty Abeln: Yes, it does. I mean are you talking about the cost-sharing limits that are established for chemotherapy and for certain other, I guess I'd call them sensitive benefits, that sicker beneficiaries need?

Sally Knight: Yes, sir.

Marty Abeln: Yeah, those definitely have not been waived. They're considered beneficiary protections and just like the maximum amount of part that is, so we wouldn't waive those.

Sally Knight: Okay, so where it says in that statement unless explicitly waived, so there's no waivers for that?

Marty Abeln: No, there's no waivers.

Chris Bauer: It's kind of like a Medicare Rule 101. We don't waive any to diminish the benefit our remote beneficiary protections and as Marty stated, we view this as a beneficiary protection.

Sally Knight: Okay, even if the employer group approves the plan?

Marty Abeln: If the employer group what?

Sally Knight: Even if the employer group agrees to the higher cost share?

Chris Bauer: No.

Marty Abeln: Well, I mean, remember it's a Medicare Advantage plan and it's not the employer's plan. The employer has some latitude to modify it in negotiations with and working with the MAO, but it's a Medicare Advantage plan.

Sally Knight: Okay, thank you.

Operator: Okay, thank you, and I'm showing another question next coming from Linda Kahn.

Linda Kahn: Yeah, a follow-up to my previous question. When data is submitted by insurance companies or PBM's, is it submitted under the actual plan sponsor, you know, a group number or something like that, or is it purely submitted using the HICN numbers? That is, the CMS get all files so that you can easily identify who the plan sponsor is? And if so, what is the identifier? Is it a group number?

Chris Bauer: Yeah, we have a, basically a submitter ID. I'm trying to – it's not exactly the terminology that we use.

Cynthia Tudor: So this is sensitive material, the data are supposed to be admitted by the plan. If the plan decides the PBM, in a Part D example, should submit the Part D data, basically the plan says these people will be submitting on my behalf.

Linda Kahn: Okay, but then if the plan has got an insurer submitting on their behalf, and the insurer submits, does the insurer have to submit using some number that identifies the plan?

Cynthia Tudor: Of course.

Chris Bauer: Yes.

Cynthia Tudor: Unless it's an employer plan, in which case they may not have a unique identifier.

Linda Kahn: So, the unique identifier would be labeled how? Is it called a group identifier, a PDP identifier, what is the label (inaudible).

Chris Bauer: So I think what we want to do with this is where not exactly sure where you're trying to go, so if you'd submit this, we can give you a more specific answer. We have Plan IDs for all of the Part C and D sponsors, the health insurers, and usually, data is submitted to us using that ID, so we can always tie it to, again, a Part C or D sponsor health insurer.

Linda Anders: Yeah, this is Linda Anders again. It sounds like you're confusing the terminology plan sponsor and if you are the employer buying a plan from one of the insurance companies that has a contract with us, it's the entity that we contract with that we refer to as the plan sponsor. So I think it's a terminology issue, but you can send – think about that when you're crafting your e-mail, so that we can best help you.

Chris Bauer: You know, sometimes even when we were designing this presentation, we realized that some of the terminology that we're so accustomed to using probably is a little complicated and is different, and has a different meaning from similar terms that you as an employer or union, you know, entity, sponsoring a C or D plan through a health insurer.

Linda Kahn: So, if I'm hearing you correctly, what you're saying is the health insurer is the plan sponsor and its representing the contracted employers.

Chris Bauer: Yes, that would be a very good way of describing it.

Linda Kahn: Okay, so then can you, is there a way to break out each of the contracted employers from the plan, you know, within the plan sponsor's data?

Chris Bauer: No, there is not.

(multiple speakers)

Linda Kahn: Other than by the numbers.

Cynthia Tudor: (inaudible) sponsor to. The sponsor would know but we wouldn't.

Chris Bauer: Yeah, as far as we – we receive data, you know, it kind of gets grouped with that sponsor. In the case of EGWPs, where they have multiple entities paying them to deliver health benefits. We don't have a mechanism in the way that the data is reported to us to differentiate those differing employers or union sponsors.

Cynthia Tudor: Correct. Right

Kathryn Jansak: Okay, does that answer your question enough for now? Please feel free to send in a question. Are there any more questions? We have just a little bit of time left.

Cynthia Tudor: If you send in that question, please make sure you sort of specify what you are and what entity, what the entity is doing for you because I think it's very difficult for us to answer some of these questions.

Operator: Okay, we do have a next question comes from Peggy Wilson.

Peggy Wilson: Good afternoon. We're a Medicare Advantage and PDP plan that we have 800 series PDP and I have some questions regarding the eligibility on some of these categories and I'm going to submit some of them to the mailbox, but in particular, for a standalone PDP where it's indicated that it must a retiree, we sometimes get some unique situations where both the husband and wife work for the same government – one's retired, one's not. Would that make a person ineligible if they were still working but there has been was retired?

Tracey McCutcheon: For a stand-alone PDP, yes.

Peggy Wilson: Okay, and I have a few other questions like that. I think I'll submit, because it gets kind of convoluted between, you know, if a person retired –

Chris Bauer: Yeah, probably – yeah, the more complicated questions probably are better handled through e-mail and phone conversations rather than this teleconference.

Peggy Wilson: Okay, thank you.

Chris Bauer: I do want to say we're running out of time and take care of a couple housekeeping issues before we ran out of time. Again, if you don't have the slides, they're available on our website. Go to CMS.gov. In the search box type E-G-W-P and the first link will get you there. If you found this helpful – we don't really have a good mechanism for communicating to employers/unions and so if you found this useful, please e-mail that e-mail box and tell us that you found it kind of helpful. If you think it would be worthwhile to have these sorts of calls and even topics for the call, send them to the mailbox and we can look at the feasibility of doing this more often.

And with that, I think we have time for another question or two.

Operator: Okay, just one moment. And our next question comes from Crenyse Briggs.

Crenyse Briggs: Hi, my question is fairly simple. It's from Slide 9, the Part D supplemental benefits. I would like to know if, it says starting on January 1, the supplemental benefits excludes those offered through EGWPs. Does that include the EGWP wrap programs, or is that something totally different?

Tracey McCutcheon: It's hard to answer the question. This is Tracey McCutcheon. Our requirements for 2014 are that the only component of an EGWP Part D plan that is a Medicare benefit is the defined standard benefit. I'm guessing that most employers and unions are offering something more than the standard, defined standard benefit to their retirees. The combination of those benefits will be the plan that you are offering. The defined standard portion of that benefit is what is Medicare and what will be subsidized by the government. It's up to the employer and union, in combination with the plan's sponsor to determine the structure of that plan,

whether it is a separate Medicare-defined standard benefit plan and a separate wrap plan or whether it is a co-administered benefit that is one plan that has those two components, the combination of the Medicare-defined standard benefit and the additional benefits, if you will, not using a Medicare term, that the employer or union is offering that would be treated, for purposes of PDE reporting, as OHI.

Crenyse Briggs: Okay, thank you.

Operator: Thank you, and we'll take our next question from William Kudenov.

William Kudenov: Actually, one of my questions was answered before, but along this particular line, are you saying that if we are providing any enhanced coverage beyond the CMS standard for Part D benefits that it could be even insofar as the delta between the co-insurance or whatever that co-insurance and a copay, that would be considered OHI?

Tracey McCutcheon: Correct.

William Kudenov: Wow.

Tracey McCutcheon: There are no longer any enhanced plans allowed in the Part D space. This is – as we explained in rulemaking and a lot of guidance, it's really the logical outgrowth of the coverage gap discount program and how we need to be able to ensure we know when the coverage gap begins and ends.

William Kudenov: So then – okay. So that means that all, whatever that delta is, none of that, I guess beyond – wouldn't apply to [troop]? That's a true statement then. Anything beyond wouldn't apply to [troop]. Is that a correct statement? Because if it's OHI, it's not a Part D it's not a Part B, it wouldn't be accumulated in the [troop] buckets.

Tracey McCutcheon: That's correct.

William Kudenov: Wow. Thank you.

Tracey McCutcheon: And I think we recently put out some additional PDE guidance on this, answering some of the, you know, complicated questions that may come up on how these PDE's would look.

Kathryn Jansak: Thank you. I think that's about, that concludes our call. We're very happy for the people who called in and we do, again, I would just say one more time the EGWP mailbox and again, we welcome suggestions for future calls. The address is egwp_policy@cms.hhs.gov and thank you again.

Operator: Okay, ladies and gentlemen, this does conclude your conference. You may now disconnect and you have a great day.