CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Employer Group Waiver Plans

Part C & D Teleconference on EGWPs

November 6, 2013

Presentation Overview

I. Key Policies

II. Waivers

III. Monitoring

IV. Star Ratings and Past Performance

New Section

I. Key Policies

Employer/Union Sponsored Group Health Plans

- **EGWPs – Employer Group Waiver Plans: Waivers**
  - EGWPs are employer-only Medicare Advantage (MA) and/or Part D plans
  - EGWPs may take advantage of CMS waivers to provide Part C and/or Part D benefits to Medicare beneficiaries
- **EGHPs – Employer Group Health Plans: Individual plans, no waivers**
  - Employer plans offered through **individual** MA and/or Part D plans
  - These plans do not qualify for waivers available to employer-only MA and Part D plans
- Both must be employment-based (e.g., no association membership)

Two EGWP Categories

Two basic categories of EGWPs:

- **"800 series" EGWPs** – plans offered by third parties (Part D sponsors and MA organizations) to employer and union group sponsors. Employer contracts with a third party which bears the insurance risk and in turn functions as the plan sponsor. (Represents majority of EGWPs.)

- **Direct Contract EGWPs ("E contracts")** – plans offered by employers or unions that directly contract with CMS to become PDP sponsors or MA organizations for their members. Employer is self-insured.

Same Rights and Protections

- Providing all Medicare Part A and B services (for MA organizations) and meeting the "actuarially equivalent" test (for Part D sponsors) are not the only requirements for EGWP offerings
- EGWP enrollees have access to 1-800-MEDICARE and complaints will be entered into our complaints system (complaint tracking module or CTM)
- Beneficiaries in EGWPs are entitled to all rights and protections (e.g., Medicare benefits and grievance and appeals processes) that are available to enrollees in individual MA and Part D plans. For instance, EGWPs
  - Must furnish enrollees with an accurate Annual Notice of Changes/Evidence of Coverage (ANOC/EOC) document
  - Must inform enrollees of their right to appeal adverse coverage determinations

Same Rights and Protections (Con't.)

- EGWPs cannot diminish the Part D benefit
  - All formularies (drug lists) must meet CMS requirements including a minimum of covered Part D drugs
    - Part D sponsors, including EGWPs, create and submit formularies to CMS
  - Once CMS approves the formulary, Part D sponsors, including EGWPs, cannot make "negative changes" (that is, reduce the drug benefit) without CMS approval
    - CMS permission is required before removing drugs, increasing their cost-sharing, or restricting access (e.g., restricting amount available)
    - For midyear negative changes, depending on the nature of the change, beneficiaries may be entitled to stay on the drug for the rest of the plan year
  - Part D transition requirements apply
    - Initial supply
    - Notice

Same Rights and Protections (Con't.)

- Part D sponsors, including EGWPs, cannot limit the beneficiary choice of network pharmacy access
  - **Automatic delivery programs:** For 2014, in order to automatically deliver drug refills to an enrollee without obtaining enrollee permission for every delivery, EGWPs must meet certain requirements such as making the program voluntary for enrollees, refunding any unwanted medications, and obtaining enrollee permission every year
  - **Beneficiary choice of network pharmacy:** Part D sponsors, including EGWPs, cannot require an enrollee to get all his or her prescriptions filled at one particular pharmacy, including mail order pharmacies

Part D Supplemental Benefits

- Starting on January 1, 2014, the definition of Part D supplemental benefits in 42 CFR §423.100 excludes supplemental benefits offered through EGWPs
  - All benefits above the defined standard Medicare Part D benefit offered by employer group waiver plans are considered other, non-Medicare health coverage always paid after the coverage gap discount has been applied
  - 42 CFR §§423.100 and 423.2305 finalized in 4157-FC, April 12, 2012 (77 Fed Register 22072)
- This means EGWPs can no longer offer enhanced alternative plans starting in January 1, 2014 and the Medicare component of the EGWP plan is limited to be the defined standard benefit.

2013 EGWP Enrollment

- PDP EGWP enrollment doubled from 2012 to 2013
  - EGWP enrollment increased 103% from 2.2 to 4.5 million
    (Non-EGWP enrollment increased 2.7% from 17.8 to 18.2 million)
  - More Retiree Drug Subsidy (RDS) plans converting to EGWPs
- MA/MA-PD EGWP enrollment increased by a smaller proportion from 2012 to 2013
  - EGWP enrollment increased 4.5% from 1.26 to 1.32 million
    (Non-EGWP enrollment increased 9% from 10.9 to 11.9 million)

Enrollment and Eligibility

- Enrollees of EGWPs must qualify for Part C and D coverage
- In order for a beneficiary to be eligible to enroll in an EGWP, he or she must permanently reside in the defined EGWP area
- In order for a beneficiary to be eligible for a stand-alone EGWP prescription drug plan (PDP), he or she must be a retiree

Employer Plans Play an Important Role in Educating Their Members

- Member misunderstanding of how:
  - Medicare Part C and D coverage works
  - Enrollment occurs and relates to retiree benefits
- Results in serious consequences for the beneficiary
- Employers and unions need to communicate all benefits and requirements, including deadlines, to beneficiaries on time and in a clear manner

Employer Plans Play an Important Role in Educating Their Members (Con't.)

- Examples of consequences of missed deadlines include:
  - Unintentional disenrollment from the employer or union plan (resulting in loss of retiree benefits) due to not receiving timely information about benefits or enrollment
  - Assessment of a Part D late enrollment penalty (LEP) due to not receiving information about maintaining creditable coverage or Part D for 63 days or more (LEP assessed monthly for as long as beneficiary has Part D coverage)
  - Disenrollment from the employer or union plan due to misunderstanding about the requirement to pay Part D-IRMAA (Income Related Monthly Adjustment Amount) directly to the government, if assessed.

Group Enrollment Mechanism - Requirements

- Required notification to beneficiary
  - Either plan or employer/union can send
  - Notice of enrollment and the effective date
  - Must send at least 21 days prior to the effective date of the group enrollment
  - Must give enrollees the information on how to opt out, and the opportunity to do so
  - Must include other requirements

Optional Mechanism For MA Group-Sponsored Plan Enrollment

- Employers and unions not limited to enrollment mechanisms outlined in Chapter 2 of the Managed Care Manual
- For MA plans only – not an option for PDPs or cost plans
- Requires an individual's active plan selection
  - Opt in, not opt out

Enrollment Request Mechanisms for Employer/Union Sponsored Coverage

- Data collection requirements
  - Employer or union must provide all the information required for organization to submit a complete enrollment request transaction to CMS
    - Includes Health Insurance Claim Number (HICN), residence information
- Data submission requirements
  - Timeliness requirements still apply
  - Must submit proper effective date as permitted in guidance

EGWP Special Enrollment Period

- Beneficiaries enroll in EGWPs during time periods specified by employer or union and may disenroll from EGWPs at any time
- EGWP Special Enrollment Period (SEP) for beneficiaries disenrolling from an EGWP to join an MA-PD or PDP
  - Always in effect for enrollees of EGWPs
  - Ends two months after loss of coverage or notification

Failure to Pay Plan Premiums for Individuals in EGWPs

- Employer group paying premiums for their members = no disenrollment for non-payment
- Issue between plan and employer group
- Individual paying premiums directly to plan = follow all rules for non-payment of premiums regardless of EGWP involvement

New Section

II. Waivers

EGWP Waivers 101

- All EGWPs must follow all Medicare Part C and D requirements unless explicitly waived or modified by CMS
  - E.g., see 42 CFR §423.458 finalized in 4157-FC, April 12, 2012 (77 Fed Register 22072)
- CMS will not approve waiver requests that restrict benefits or beneficiary protections

Waiver Parameters

- Waivers
  - Limited types of waivers have been granted
  - Apply to all EGWPs, except when noted
  - Are limited in scope as described
    - Descriptions available in CMS guidance including EGWP chapters in Managed Care Manual (Chapter 9) and Prescription Drug Benefit Manual (Chapter 12)
- Waiver requests
  - MAOs and Part D sponsors submit waiver requests to CMS which are considered and may be approved or disapproved
  - Required to include reason for request; how rule hinders design, offering, or enrollment in Medicare group coverage; and citations to related laws, rules, and guidance

Waivers are concentrated in certain areas

- **Enrollment:** Enrollment is not open to all Medicare beneficiaries but must be employment-based and limited to retirees in PDPs
- **Service Areas:** EGWP enrollment is limited to EGWP-approved service area, which is distinct from the individual-market approved service area
- **Marketing:** Prior CMS approval is not required; however, marketing documents must be created and CMS may request and review
- **Premiums:** Premiums can be subsidized; uniform premium requirement may be modified if certain criteria are met

Waivers are concentrated in certain areas (Con't.)

- **Part D Payment:** Part D direct subsidy is based on national average monthly bid amount rather than on a plan bid
- **Part D Bids:** EGWPs do not submit as much information to CMS as other Part D sponsors; but they are still required to create and upload an EGWP plan into HPMS
- **Part D Formulary:** EGWPs submit only the most restrictive base formulary which must meet all CMS requirements; once approved, CMS must still approve any negative change to the approved formulary benefits

Part C Resources

- **Guidance References**:

  Medicare Managed Care Manual Chapters

  - Chapter 2 – Medicare Advantage Enrollment and Disenrollment (*Updated August 2012*)

    http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/FINALMAEnrollmentandDisenrollmentGuidanceUpdateforCY2012-Revised872012forCY2013.pdf

  - Chapter 4 – Benefits and Beneficiary Protections (*Updated June 2012*)

    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

  - Chapter 9 – Part C - Employer/Union Sponsored Group Health Plans (*Updated June* 2013)

    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf

Part D Resources

- **Guidance References**:

  Prescription Drug Benefit Manual:

  http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

  - Chapter 2 PDP – Eligibility, Enrollment, and Disenrollment
  - Chapter 12 – Part D - Employer/Union Sponsored Group Health Plans

  Part D EGWP Website:

  http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartD-EGWP.html

  - Chapter 12 of the Prescription Drug Benefit Manual
  - List of and memos on waivers
  - Memo on supplemental benefits and coverage gap policies
  - EGWP presentation from 2012 Fall Part C and D Conference

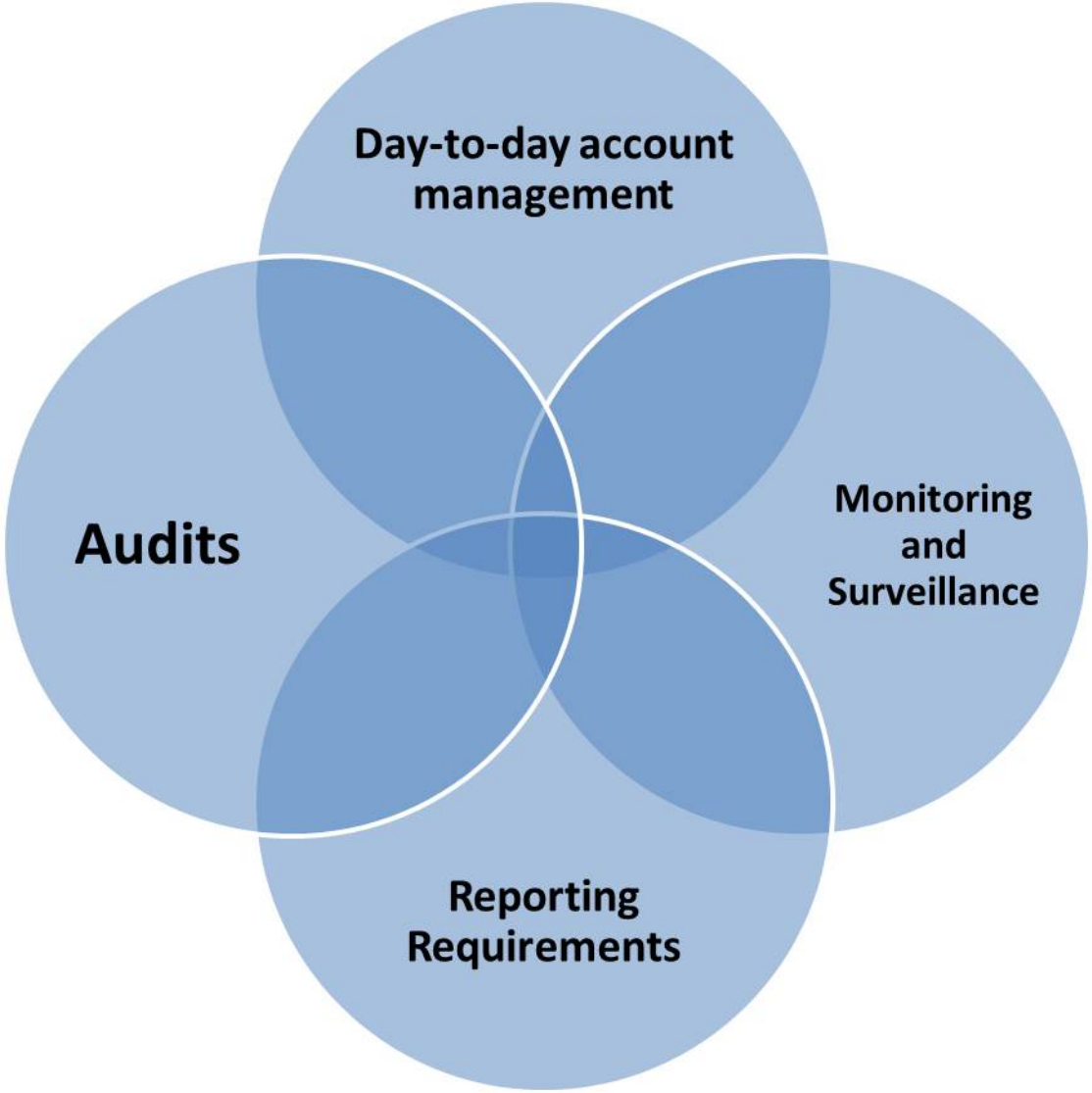
New Section

III. Monitoring

Monitoring of EGWPs

- To date, less focus by CMS on EGWPs
- Included in some monitoring and compliance activities, but not others
- Increased enrollment in EGWPs, rise in complaints, and further anticipated growth prompting us to turn more attention to this segment
- Will build on existing monitoring approaches

Monitoring and Compliance 101



Compliance Tools

Executive Conference Call/Meeting

Notice of Non-Compliance
- May include request for business plan

Warning Letter
- May include request for business plan

Various Suppressions and Exclusions:
- Medicare Plan Finder suppression
- Medicare & You Handbook exclusion
- On-line enrollment center exclusion
- Fewer formulary update windows
- No reassignments/auto-enrollees

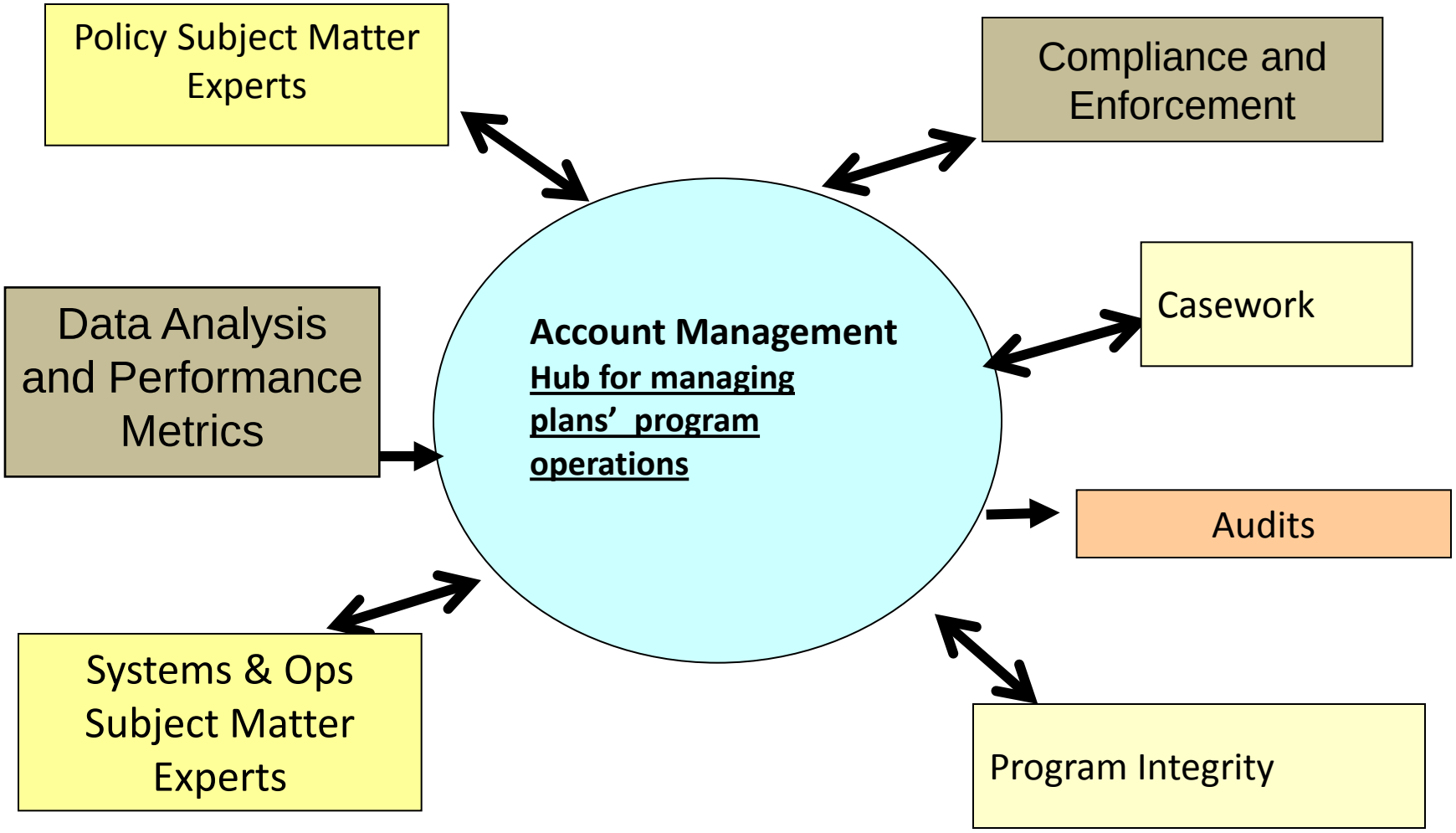
Request for Corrective Action Plan (CAP)

New Applications/SAE Denials

Audit Selection

Enforcement and Termination

Account Management



Reporting Requirements

- The intent of the Parts C and Part D Reporting Requirements is to:
  - Monitor health plan performance.
  - Hold plans accountable to stakeholders.
  - Help plans improve performance.
  - Provide data to Congress and interested federal agencies upon request.
- Unavailable through other sources or collection efforts
- More timely than other means of collecting this information

Reporting Requirements

- For 2013, there are 8 Part C reporting sections:

CY2013 Part C Reporting Sections	
Enrollment and Disenrollment	PFFS Provider Payment Dispute Resolution Process
Serious Reportable Adverse Events (SRAEs)	Special Needs Plan (SNPs) Care Management
Grievances	Employer/Union-Sponsored Group Health Plan Sponsors
Organization Determinations/Reconsiderations	Plan Oversight of Agents* -- N/A for EGWPs *The reporting section has been suspended for CY2013.

- EGWPs report on all, except plan oversight of agents.
- Four EGWP-reported sections undergo data validation
  - SRAEs, Grievances, Org Determinations/Reconsiderations, SNPs

Reporting Requirements

- **For 2013, there are 12 Part D reporting sections.**

CY2013 Part D Reporting Sections	
Enrollment and Disenrollment – N/A EGWPs	Coverage Determinations and Exceptions
Retail, Home Infusion, and Long-Term Care Pharmacy Access	Redeterminations – N/A EGWPs
Medication Therapy Management (MTM) Programs	Long-Term Care (LTC) Utilization – N/A EGWPs
Prompt Payment by Part D Sponsors	Fraud, Waste and Abuse Compliance Programs – N/A EGWPs
Grievances	Employer/Union-Sponsored Group Health Plan Sponsors
Pharmacy & Therapeutics (P&T) Committees/Provision of Part D Functions* -- N/A EGWPs	Plan Oversight of Agents* -- N/A EGWPs

*The reporting section has been suspended for CY2013.

- **EGWPs are required to report on 6 Part D sections and have their data undergo data validation for 3 of these sections.**
  - MTM, Grievances, Coverage Determinations/Exceptions

Reporting Requirements Unique to EGWPs

Employer Group Reported Data

- Employer Legal Name
- Employer DBA (“Doing Business As”) Name
- Employer Federal Tax ID
- Employer Address
- Type of Group Sponsor (Employer, Union, Trustees of a Fund)
- Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corp., Non-Profit, Church Group, Other)
- Type of Contract (Insured, Administrative Services Only, Other)
- Employer Plan Year Start Date
- Current Enrollment

Audit Approach

- **Audit/Review Activities**
  - Selection generally based on the following criteria: High Star plans, Low Performing Icons, High Risk plans, Plans not audited in last 3 years, Regional Office referrals and Ad Hoc audits.
  - Primary focus on outcomes (i.e., drug access, etc.), not policies and procedures. Selected samples target non-compliance.
  - Currently, EGWP enrollees included in sample upon referral; considering routinely including EGWP enrollees in samples in the future
  - EGWP-only contracts audited upon referral

Performance Areas Audited

- Formulary Administration, including transition
- Part C Organization Determinations, Appeals & Grievances
- Part D Coverage Determinations, Appeals & Grievances
- Compliance Program
- Special Needs Plan Model of Care

Data-Driven Monitoring

Essential tactic to systematically monitor these extraordinarily complex, large programs

766 contracts

524 legal entities

293 parent organizations

Sources of Data

CMS Systems and Administrative Data

- HPMS, MARx, other systems
- 4Rx, PDE, Formulary, Marketing, many others

Contracted Monitoring and Surveillance Projects

- Monitoring – generally implies conducted systematically across *all* contracts with large enough sample sizes to draw inferences
- Surveillance – activities to address specific program concern; may be short term in nature or apply to only a cohort of contracts

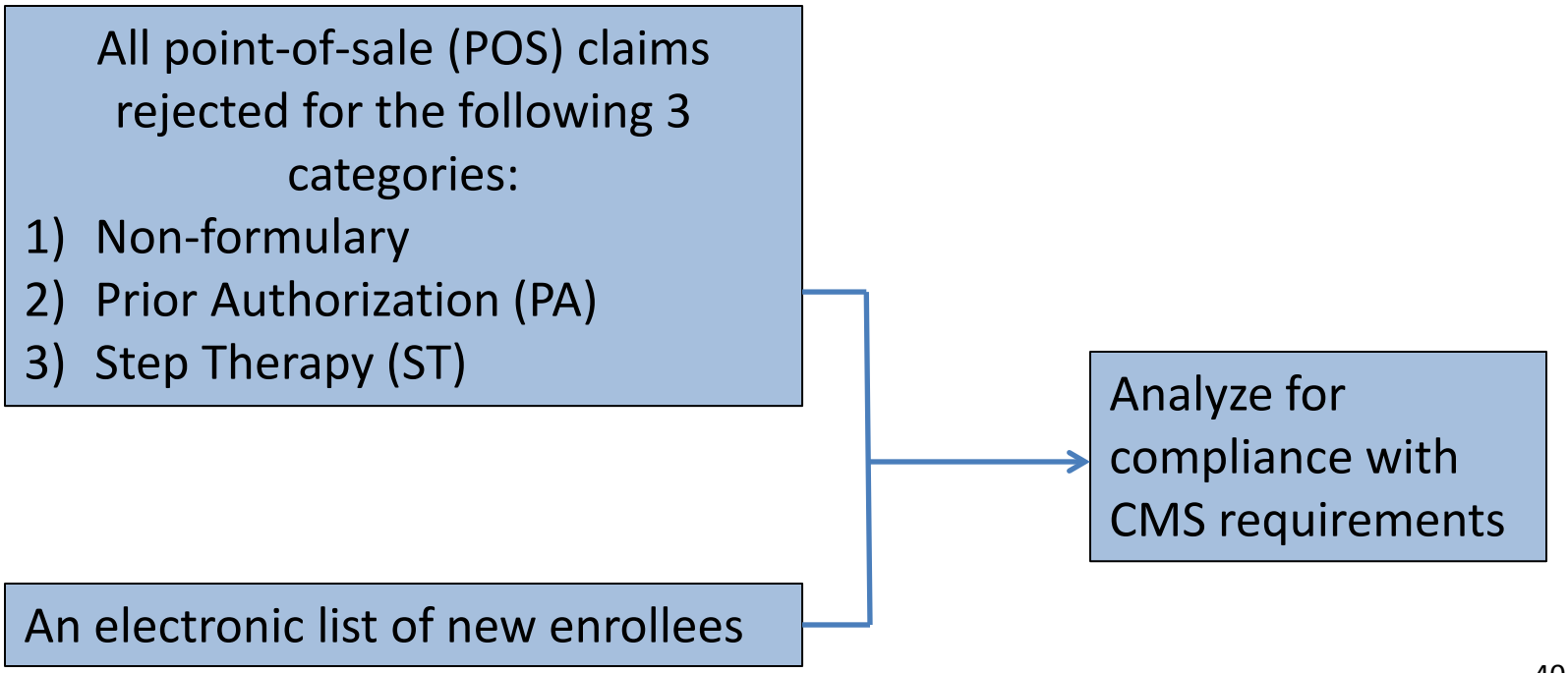
Extensive List of Monitoring Activities

- Call center monitoring for accuracy, hold times, interpreter availability
- Plan finder submissions and accuracy
- Protected class drugs on formularies
- LIS match rate
- BAE submissions
- MTM compliance
- Enrollment timeliness
- 4Rx data submission
- Outbound call verifications
- Formulary admin and transition process
- PDE submissions
- DIR submissions
- Submission and completeness of reporting requirements
- Bid accuracy
- Complaint levels
- Retroactive enrollment processing
- Mail order
- …and others

EGWPs already or will be included wherever applicable
Red text denotes already included

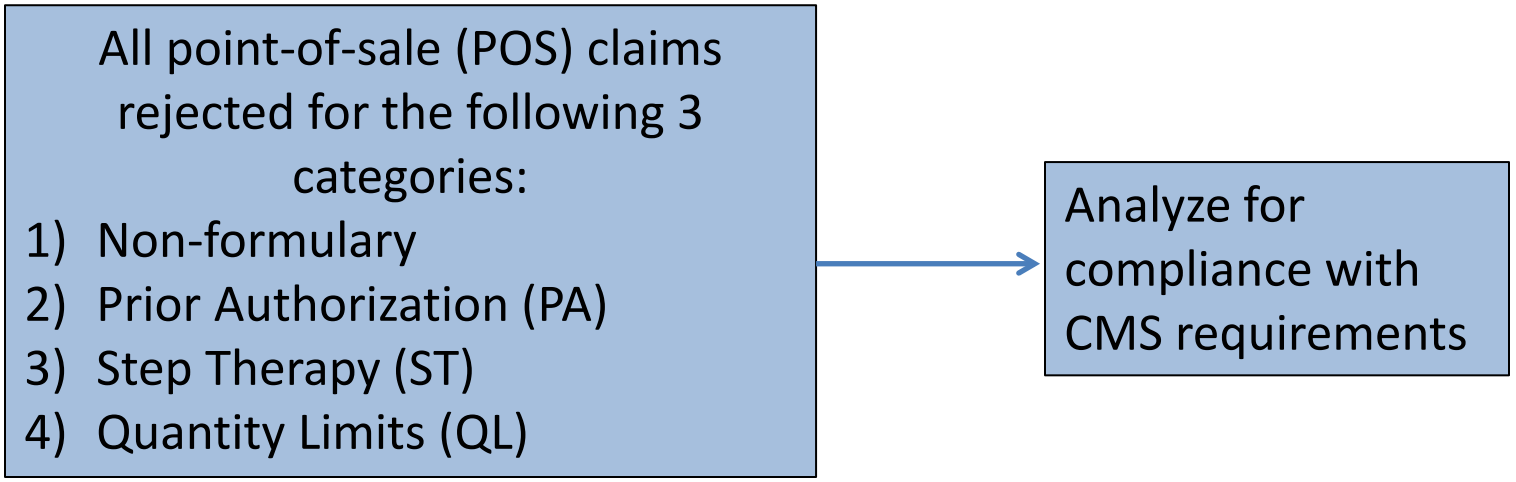
Example: Transition Monitoring Program Analysis (TMPA)

- To ensure Part D Sponsors adequately administer Medicare Part D formulary transition policies consistent with Part D requirements.



Example: Formulary Administration Analysis (FAA)

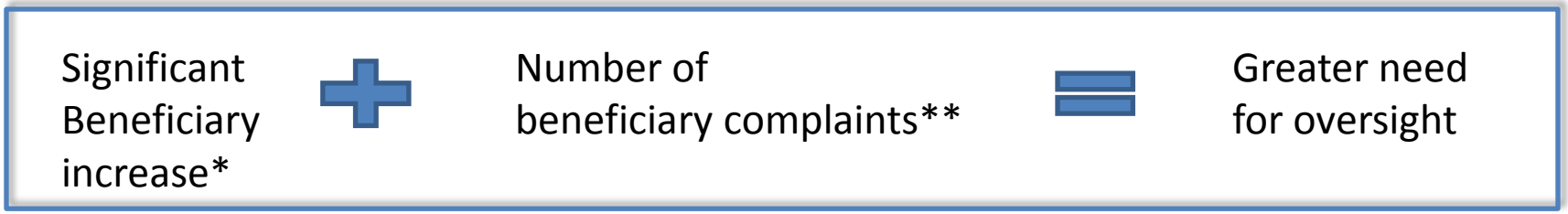
- To ensure Part D Sponsors are adjudicating Medicare Part D drug claims consistent with Part D requirements and marketed benefits.



New Monitoring Project Specific to EGWPs

Purpose: determine whether beneficiaries enrolled in EGWPs receive adequate Part C and D protection and study potential risks and vulnerabilities of the EGWP program.

Why Study EGWPs now?



***(2.2 million in February of 2012 to 4.4 million in February 2013)**

**Reporting serious access problems from beneficiaries who are not receiving the protections that are required under the Part D program (such as proper benefits administration, proper handling of grievances and poor handling of complaints)

EGWP Project Areas of Focus

- Grievances and complaints
- Formulary and benefits administration, including transition and True Out of Pocket Cost calculations
- Beneficiary appeals process for Part C and Part D
- Medication Therapy Management Programs
- Customer service call center timeliness and accuracy of answers, determine if beneficiaries are being referred to 1-800-MEDICARE
- Level playing field requirement (prohibiting mandatory use of mail order and requiring that if a 90-day supply is offered at mail, a 90-day supply must also be offered at retail)
- Other Part C and Part D beneficiary protections that have not been waived by CMS

New Section

IV. Star Ratings and Past Performance

Star Ratings

Star Ratings

- Measures quality and performance of Medicare health and drug plans.
- Available on Medicare Plan Finder website to aid Medicare beneficiaries in choosing a plan.
- Used to determine MA Quality Bonus Payments.
- MA EGWPs are eligible for Quality Bonus Payments.

Principles

- As the Star Ratings continue to evolve, we consider:
  - Six aims of the Institute of Medicine
    - Safe, effective, patient-centered, timely, efficient, and equitable
  - Three Part Aim & National Quality Strategy
    - Improve the individual experience of care
    - Improve the health of populations
    - Reduce the per capita costs of care for population

Accountability

- CMS' mission is oriented toward raising the importance of quality for Medicare.
- We are increasing the level of accountability for the care provided by physicians, hospitals, and other providers in the FFS program.
- Similarly, Parts C and D sponsors (including Employer groups) are accountable for the care provided by physicians, hospitals, and other providers to their enrollees.

Quality in MA and Part D

- Many Part C measures have existed since 1999 (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, HEDIS). In 2007, these measures were converted to stars and integrated with cost and benefit information on the Medicare Plan Finder.
- Part D ratings were first released in 2006 and focused on process measures and CAHPS. Today, measures include clinical and patient safety measures (e.g., Adherence, High Risk Medication).

Use of Star Ratings

- Displayed on Medicare Plan Finder website to aid consumers in choosing a plan
- Marketing advantages for plans with high performance (5 stars)
- Financial incentives created by the Affordable Care Act have further raised the stakes (Medicare Advantage Quality Bonus Payments)

Measure Changes

- Measure set reviewed each year; moving towards more outcome measures
- Measures moved from the Star Ratings on Medicare.gov to the display page on CMS.gov are still used for compliance and monitoring
- Refinements to the Star Ratings system ensure that high ratings represent excellence across a broad set of quality, operational, and clinical measures
- Proposed measure changes are announced in the annual Request for Comments and Call Letter

Review of Methodology for the Star Ratings

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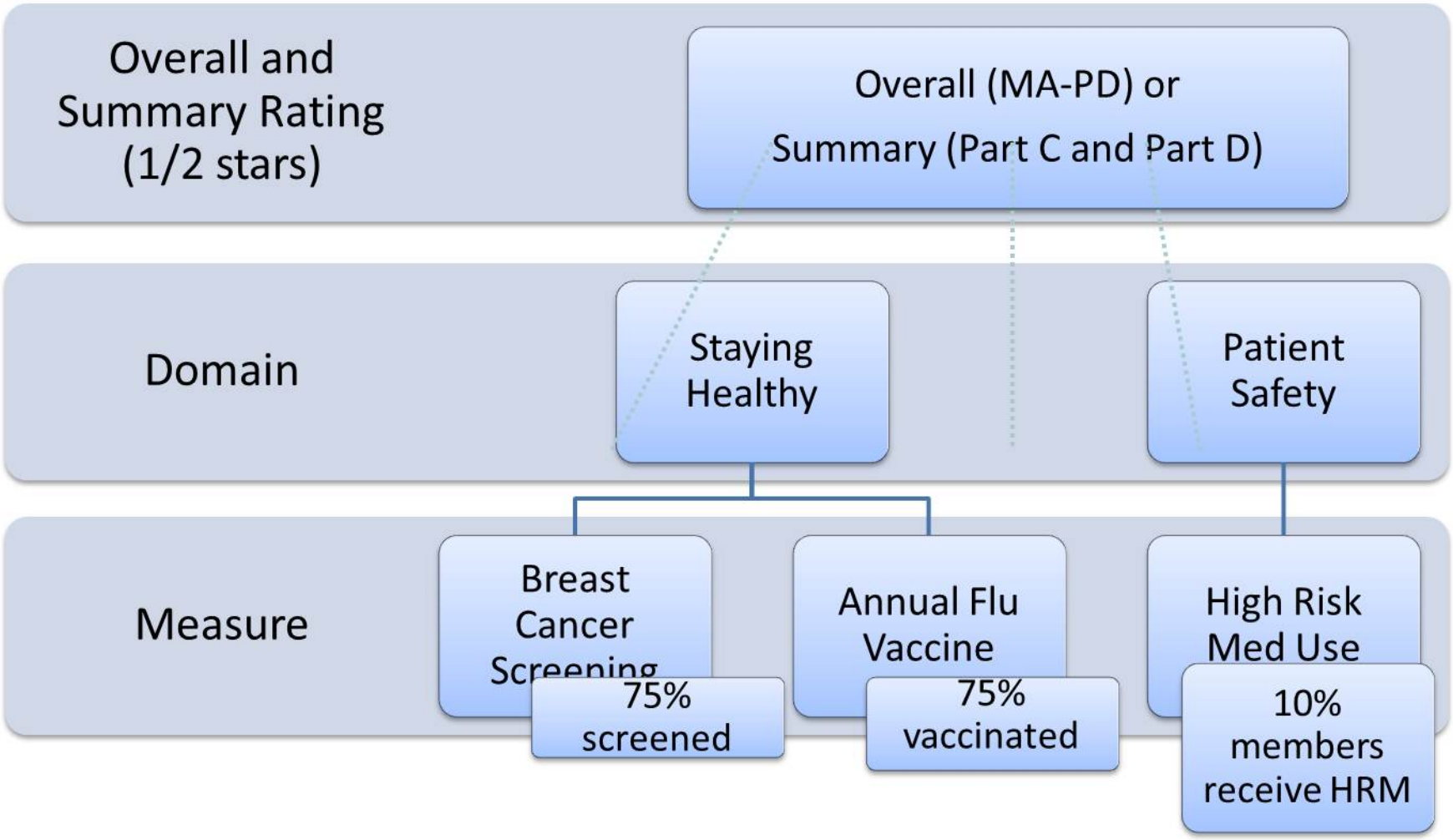
Star Ratings – 3 Levels of Stars



Weighting of Star Ratings Measures

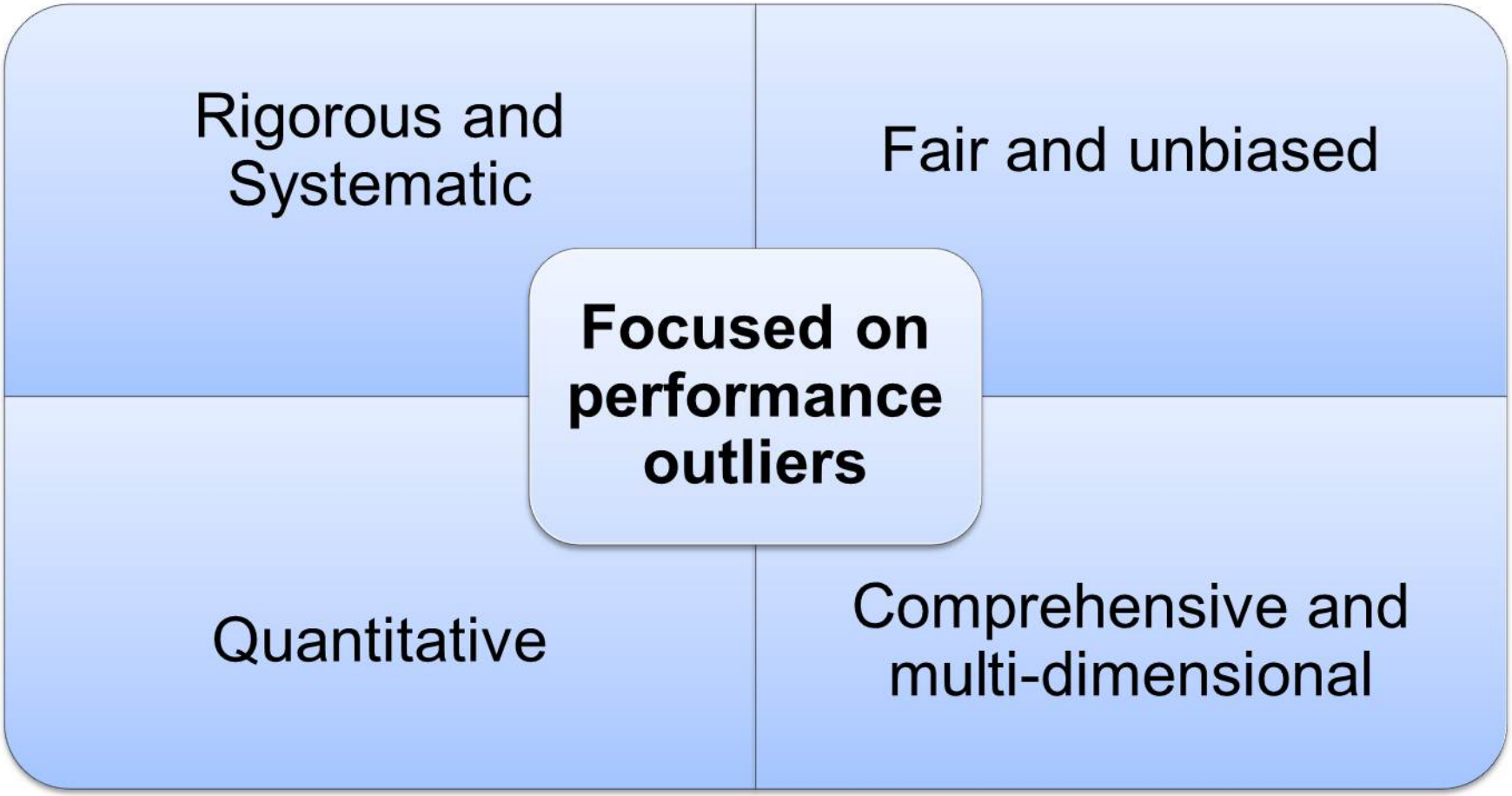
- Weight outcomes and intermediate outcomes 3x as much as process measures
- Weight patient experience and access measures 1.5x as much as process measures
- New measures are weighted 1 in the 1st year

Employers

- MA contracts that include employer and non-employer PBPs have always been required to collect and report to CMS quality measurement data from CAHPS, HEDIS, and Medicare Health Outcomes Survey (HOS) from all of their PBPs.
- All Prescription Drug Plans (PDPs) that include employer and non-employer PBPs have always been required to collect and report CAHPS to CMS for all of their PBPs.
- Starting in 2012, all Employer/Union Only Direct contracts were required to meet the same reporting requirements as MA or PDP contracts.

Past Performance

Annual Performance Review



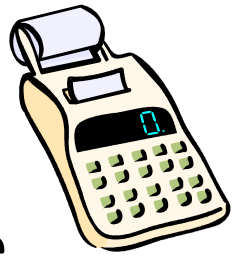
Eleven Performance Dimensions

Outliers or extreme poor performers identified in each category, based on the prior 14 months experience

- Compliance Letters
- Performance Metrics
- Multiple Ad Hoc CAPs
- Beneficiary Impact of Problems
- Financial Instability
- Performance Audits
- One-Third Financial Audits
- Exclusions
- Enforcement Actions
- Terminations/ Nonrenewals
- Open, Significant Problems

Compiling Results

- Point values assigned for each dimension
  - Point values vary depending on nature of problem and risk to program
- Analysis identifies overall performance outliers
  - Home in on sponsors with problems in multiple categories and/or in one or more particularly high risk area
  - Overall negative scores calculated at the contracting entity level
- Next version of methodology will note future inclusion of EGWPs



Uses of Past Performance

- Expansion/New Contract Application Denials
  - Organizations with a recent history of performance problems must focus on their current books of business and not expand until they are operating in full compliance
  - CMS has denied applications for EGWPs and EGWP service area expansions
- Medicare-Medicaid Duals Demonstration
  - State plan selection
  - Passive enrollment not allowed
- Identify high risk organizations
  - EGWPs could be referred for audit or enforcement actions
  - Currently organizations under an enrollment sanction may request permission to continue to enroll EGWP members. If evidence suggests poor performance in the EGWP, CMS would consider denying such requests
- Public Posting on CMS.gov

EGWP Contact Information

EGWP mailbox address:

EGWP_Policy@cms.hhs.gov