Medicare Advantage & Prescription Drug Plan

SPRING CONFERENCE & WEBCAST

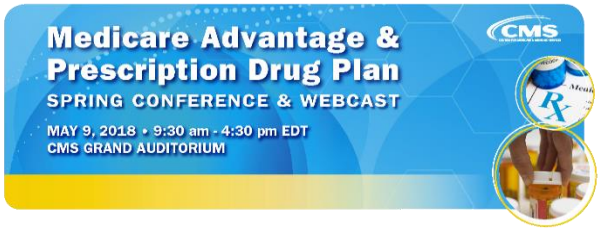
MAY 9, 2018 • 9:30 am - 4:30 pm EDT
CMS GRAND AUDITORIUM

Frequently Asked Questions (FAQs)

2018 Spring Conference FAQ Document

Table of Contents

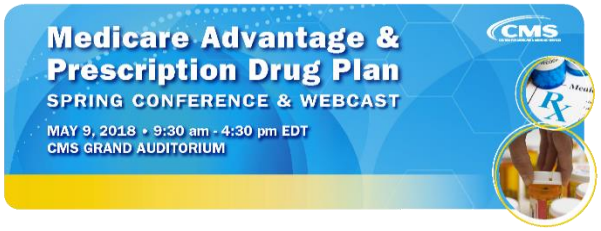
Please note: We received questions other than the ones listed in this document. Many of the questions were out of scope for the session and were not included in the list. If you feel that you still have an outstanding question, please email the appropriate contact.



Session 1 - Encounter Data
Shruti Rajan, Monica Reed-Asante

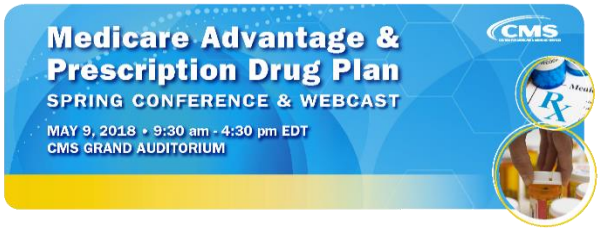
Session 1 - Encounter Data

#	Question	Response
1	I request clarification of when MAOs can submit a CRR when encounter data is captured in the medical record but a claim was not generated. The 4/9/2018 CMS memo Guidance for Chart Review Record (CRR) Submissions, states in part, ".MAOs should report items and services on an EDR, whether or not the items and services resulted in the creation of a claim from the provider to the MAO. Items or services provided to an enrollee under the plan must be reported on an EDR. A CRR should not be the only record with information about a healthcare item or service provided to a plan enrollee.."	While claims data are a primary source of data for many MAOs when they create encounter data records, clinical or administrative data may also be used as a source of data for EDRs.
2	Is there a HCC updated card or easy reference guide to reflect all current and new diagnosis codes that are approved?	The diagnoses to HCC mappings for risk adjustment eligible diagnoses are posted on the CMS Risk Adjustment Webpage: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html. .
3	Where can we find the April 2018 MOR review referenced in the presentation?	The April 2018 Webinar slides are located on the CSSC Operations Website: https://csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~User%20Group?open&expand=1&navmenu=Risk^Adjustment^Processing^System



Session 1 - Encounter Data
Shruti Rajan, Monica Reed-Asante

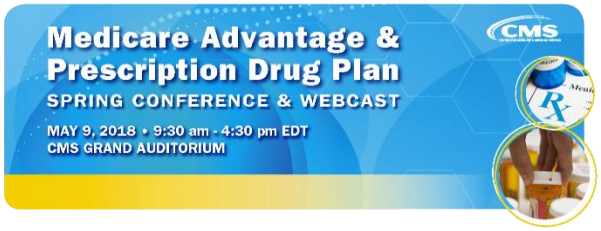
#	Question	Response
4	What source do you recommend for the most complete and accurate Medicare FFS and Medicare Advantage Data?	Can this inquiry be forwarded to the RA mailbox please -- Risk adjustment @cms.hhs.gov.



Session 2 - Star Ratings Timeline
Liz Goldstein, Sarah Gaillot, Elizabeth Flow-Delwiche

Session 2 - Star Ratings Timeline

#	Questions	Response
1	Understanding that the Star Rating timeline will be discussed, are there changes to the Star Rating criterion that will also be discussed / reviewed and updates shared?	Key changes to the Star Ratings announced through the Call Letter and regulation will be discussed.
2	Why CMS count against the STARS plan rating overturned decisions for pharmacy redeterminations by Maximus and the ALJ when they received new information that the plan Sponsor did not received at the time the decision was made by the plan?	ALJ decisions are not included in the Part D appeals upheld measure. This measure is based on cases reviewed by the IRE (Maximus). Plans must have procedures in place for requesting and obtaining information necessary for making timely and appropriate decisions. The IRE's decision is based on the information gathered during its review process.
3	Which sectors or industry types of expertise is CMS/RAND seeking for the Technical Expert Panel, and how will stakeholders be notified of the TEP process and solicitation of subject matter experts?	CMS's current Part C & D Star Ratings contractor, RAND Corporation, established a small Technical Expert Panel (TEP) comprised of representatives across various stakeholder groups for RAND to obtain feedback on the Star Ratings framework, topic areas, methodology, and operational measures. RAND will analyze the suggestions from the TEP to provide feedback to CMS on potential future enhancements to the Star Ratings. The TEP includes industry representatives, beneficiary advocates, researchers and experts in evaluating quality of care.
4	Does CMS expect to use the findings from â œ€Scaled reductions for appeals IRE data completeness issues• for the 2019 Part C and D Star Ratings?	Yes, we do plan on using scaled reductions for the appeals measures for the 2019 Star Ratings.
5	Reference pg. 18 of the session handout: Extensive details were verbalized regarding the process of measure approval and timeframes. Can you please provide these details again or outlined on an additional slide?	These details can be found on page 16534 of the Part C and D Final Rule (CMS -4182 F) published on April 16, 2018 in the Federal Register (Vol 83, no. 73).



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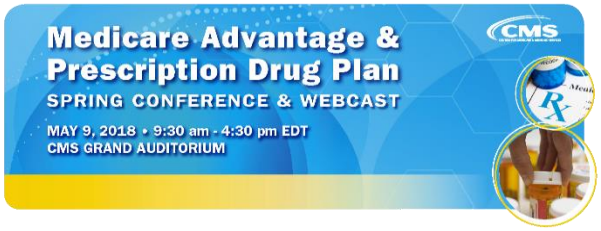
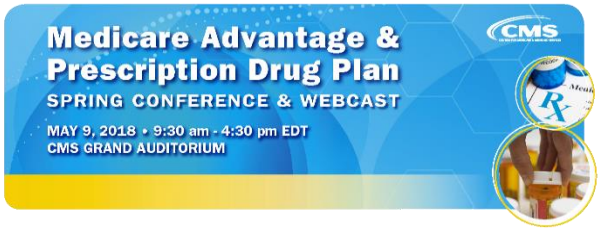
#	Questions	Response
6	Will plans receive results from the TMP in a timely fashion in order to address/rebut any reduction applied to the Star Ratings of the 4 IRE measures based on those results?	We anticipate sharing the results of any reductions by the first plan preview.
7	Please share if the TEP has been decided by the RAND corporation. If so, can you share the list of TEP members? If not, will CMS take a nomination process to create this TEP and how to get the information?	The TEP was selected by RAND and includes industry representatives, beneficiary advocates, researchers and experts in evaluating quality of care. We will publish a summary of the TEP proceedings for the public.



Session 3 - Medicare Advantage Benefit Flexibility (Supplemental Benefits and Uniformity)
Heather Kilbourne, Brandy Alston

Session 3 - Medicare Advantage Benefit Flexibility (Supplemental Benefits and Uniformity)

#	Question	Response
1	When will Telehealth services be allowable for all Medicare beneficiaries regardless of the number or type of diagnoses?	For CY2019, telehealth services are only available as they are under Original Medicare. However, MA plans are able to offer telehealth-like services as a supplemental benefit to all beneficiaries via the Remote Access Technology and Tele monitoring supplemental benefits as described in section 30.3 of chapter 4 of the Medicare Managed Care Manual which can be found at the following link: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.
2	In the final Call Letter, CMS redefines the primarily health-related benefits that insurers are allowed to include in their Medicare Advantage policies. Insurers will be permitted to provide care and devices that prevent or treat illness or injuries, compensate for physical impairments, address the psychological effects of illness or injuries, or reduce emergency medical care. Would this include pharmacist-provided health care services (e.g., services focused on safe and appropriate medication use; medication adherence for the elderly and other populations; medication reconciliation; wellness and prevention; chronic disease management services; and case management for beneficiaries with multiple medications that require complex medication dosing regimens)? How would CMS/MA insurers reimburse pharmacists for these services?	Pharmacists may furnish supplemental benefits for MA enrollees if they are licensed by the state, or in a manner that is consistent with state requirements, and meet any other applicable laws for the supplemental benefits they will be furnishing. MA regulations allow organizations and providers to negotiate the terms and conditions of payment in the contracts they enter into (see 42 CFR section 422.256(a) (2) (ii)).



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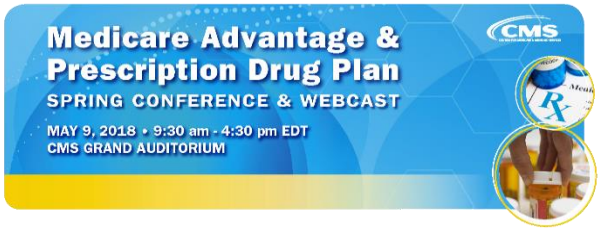
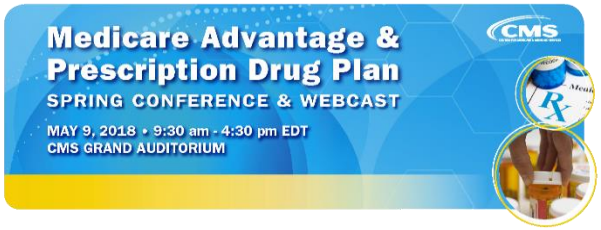
Heather Kilbourne, Brandy Alston

#	Question	Response
3	HMO POS mandatory MOOP limit in the 2019 call letter is $3401-$6700 for In-network services. Does the plan have flexibility to have a separate Out of Network MOOP of up to $10,000? Can the plan establish combined MOOP for in and out of network services of up to $10,000? This is CCP plan offering HMO POS product with limited POS services option.	Plans can establish either a plan benefit maximum or an enrollee maximum out of pocket (MOOP) limit for the POS supplemental benefit. To establish a combined MOOP limit that includes both the HMO in-network and the POS supplemental benefit, the plan must offer POS as a Mandatory benefit in Section C of the Plan Benefit Package. Once completing Section C with a Mandatory POS benefit, the Combined and Out-of-Network MOOP screens in Section D of the Plan Benefit Package will become enabled to complete data entry.
4	Can CMS provide additional guidance on how meals services will be handled given the new guidance related to supplemental benefits? Given the HPMS memo from 4/27 and today's presentation it is unclear, what flexibility is allowable for meal services?	Allowable meal service supplemental benefits are not changing for CY2019. Meal services are only allowed as described in section 30.3 of chapter 4 of the Medicare Managed Care Manual which can be found at the following link: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.
5	You mention transportation to the bank or for groceries are not permitted. But now you have banks, pharmacies, and food all in one. (IE; Walmart and Target) will this be a problem?	Transportation may be provided to pharmacies inside of stores like Walmart, Target, and Safeway as long as the purpose for the transportation is to go the pharmacy.
6	Will CMS provide examples of pharmacist-provided care services (MTM, DMST, etc.) that MA plans can offer as supplemental benefits? Also, how would these supplemental benefits be reimbursed? Do plans set the rates? If so, this may not provide enough incentive to ask these needed benefits?	Pharmacists may furnish supplemental benefits for MA enrollees if they are licensed by the state, or in a manner that is consistent with state requirements, and meet any other applicable laws for the supplemental benefits they will be furnishing. MA regulations allow organizations and providers to negotiate the terms and conditions of payment in the contracts they enter into (see 42 CFR section 422.256(a) (2) (ii)).



Session 3 - Medicare Advantage Benefit Flexibility (Supplemental Benefits and Uniformity)
Heather Kilbourne, Brandy Alston

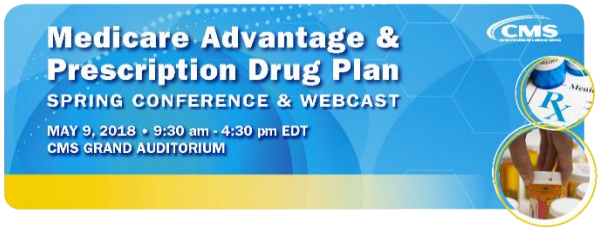
#	Question	Response
7	Does the Flexibility include Telehealth services?	For CY2019, telehealth services are only available as they are under Original Medicare. However, MA plans are able to offer telehealth-like services as a supplemental benefit to all beneficiaries via the Remote Access Technology and Tele monitoring supplemental benefits as described in section 30.3 of chapter 4 of the Medicare Managed Care Manual which can be found at the following link: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.



Session 4 - Talking to Beneficiaries about their Plan Choices
Erin Pressley, Jon Booth

Session 4 - Talking to Beneficiaries about their Plan Choices

#	Question	Response
1	How do we weigh the personal variables (income, health history, retirement assets, and risk tolerance) to guide them in the Advantage Plan direction or Medigap? Are there more Medigap options for each zip code than are listed on the Find a Medigap Plan search engine? Recently I have had people say they went with a broker that got them in a carrier's plan not listed on Medicare.gov for their zip code.	All of these variables should be taken into consideration by the consumer to determine what type of plan meets their needs and budget. We provide information in various educational resources like the "Medicare & You" handbook, the "Guide to Health Insurance" and Medicare.gov about these options and what the consumer should consider before making a choice. Since these considerations will vary by person, it's really up to each individual to determine what's financially feasible in relation to their health and needs. As for the Medigap data, it's captured from State Insurance Agency websites that are reviewed on a regular schedule, as well as data submitted quarterly to CMS by insurance companies. Therefore, depending on when a companies' policies were captured in a particular States' review, some policies may not be displayed on Plan Finder.
2	There isn't an exact category for my question. However, I need to ask and pursue the concern I have for seniors in regards to the PDP penalty. I have encountered clients that can't even afford a $0 premium payment plan just because the penalty won't allow them. It's the clients who aren't eligible for extra help but, food will come off their table due to these penalties. It's not fair when I hear them tell me nobody told them or they didn't know about it when they were new to Medicare. Is there going to be any changes on this deep concern for seniors?	We share this concern and want to make sure every person with Medicare has access to clear information so they can they best choice for their situation. We do provide information to consumers in various products when they enter Medicare about the choices they need to make and the consequences of waiting, like having to pay a Part B and/or Part D penalty. These products currently include the Medicare & You handbook and the Initial Enrollment Package. In addition, we continue to explore opportunities to educate consumers in other venues, including things like social media and email reminders, about the risks of waiting to make these important decisions.



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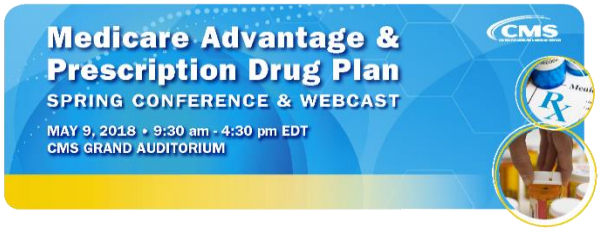
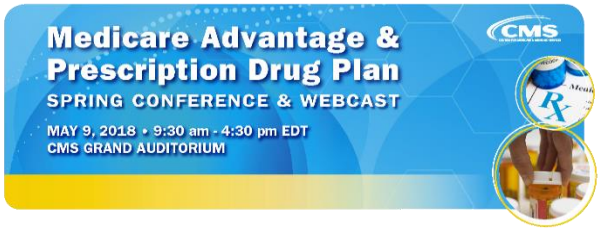
#	Question	Response
3	What is CMS doing to share information about plan choices/decisions with new beneficiaries who actively enroll with SSA, and don't get the IEP?	People who enroll in Medicare at SSA, usually because they are still working and aren't collecting Social Security benefits yet, always get a Medicare & You handbook in the mail. In addition, we're currently working on a welcome letter and decision booklet for this group of enrollees, similar to the information that comes in the IEP for their counterparts, that would be included in the envelope with their Medicare card (right now this mailing only includes a card). Over the last few months, we've also been partnering with SSA to better understand what the active enrollment process looks like for beneficiaries, and where they are opportunities to add plan choice messaging and highlight where decisions are needed.
4	What did CMS learn from changes made to Medicare.gov for last year's open enrollment?	Last year, we modified the Medicare Plan Finder to add back some data elements that were removed the prior year. We took that opportunity to conduct consumer testing and add the data back in a way that was more consumer-friendly with easier to understand terminology. We've incorporated consumer research into our development cycle so that as we begin building new features or improvements, we can verify that they meet the user's needs before we launch the tool rather than learning of problems after we launch them.
5	What are some recent website accomplishments and what have you learned from them?	We launched new features on MyMedicare.gov to allow beneficiaries to lookup their Medicare number and print a replacement Medicare card online. Previously, new cards could only be ordered and sent through the mail. That option still exists, but now users with a home printer can resolve their issue more quickly. Moving forward, we want to make sure that we make self-service a priority in addition to the other existing support channels. We also took the opportunity to streamline MyMedicare.gov, which now has a clean, easy-to-use homepage and account creation screen that is mobile optimized.



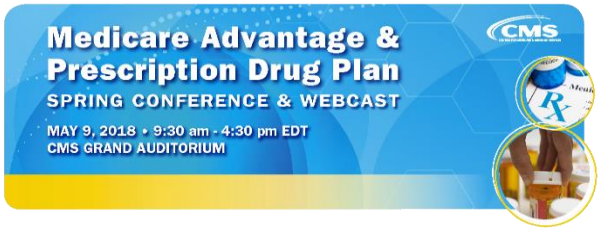
Session 4 - Talking to Beneficiaries about their Plan Choices
Erin Pressley, Jon Booth

#	Question	Response
6	Can Plans use the Medicare/CMS comparison chart (shown in the presentation) on our own websites as a downloadable tool for beneficiaries?	Yes. Please note that this chart will be updated for PY 2019.
7	Thank you for your presentation. It's very helpful to understand the process and the considerations CMS is taking on the effective sharing of information with beneficiaries and other decision-makers. Could you talk a little about the timing of release of Medicare & you handbook and other communications by CMS and the Plans. For example, Plans were prohibited from communicating or sharing information on service area reductions until the end of September, but the information was publicly available in the marketplace in the Medicare & you handbook. Plans, their contracted providers, specifically PCP's, and broker/agents, can receive a number of questions from beneficiaries and are unable to provide any helpful information that can result in member abrasion and confusion on options they have available as they enter the open enrollment period.	Thank you for your comments/questions. The Medicare & You handbook is mailed each fall to all people with Medicare. By law, we must mail the handbook at least 15 days prior to the start of the annual open enrollment period. This means handbooks with plan data are mailed in mid-September. Due to the time needed to print and mail more than 40 million handbooks, handbook content including plan data is finalized in the summer. CMS' current guidance allowing plans to provide information to their enrollees coincides with the release of the Medicare managed care landscape which captures the Medicare Advantage changes and choices for the following contract year. This information is typically released in mid- to late September, but may not be available at exactly the same time as the Medicare & You handbook. Given that there might be a slight gap when information is available, we will consider this as we update future guidance.
8	Have the new updates to the website tools updated to meet accessibility standards?	Yes, updates to the website tools are developed in line with Section 508 requirements and are tested with assistive technology.



Session 4 - Talking to Beneficiaries about their Plan Choices
Erin Pressley, Jon Booth

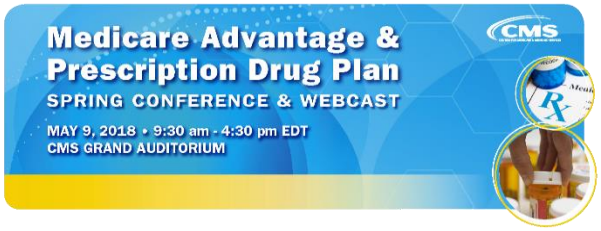
#	Question	Response
9	Beneficiary email addresses – CMS said that it is working to obtain email address via Medicare.gov and MyMedicare.gov – is this information passed onto MAO Plan Sponsors?	No, email information is not passed outside of CMS at this time.
10	Is CMS willing to share their "Shopping and enrollment process" research findings with plans? Can the study results be published?	We routinely review our research findings and periodically make summaries available online where we find that the topics are broad enough to be useful to others. Many times our research is specifically conducted for internal improvements to our communication products and is pertinent only to those products, but we are willing to share whatever we can.



Session 5 - CARA/Opioids
Lisa Thorpe, Michelle Ketcham, Gail Sexton, Sabrina Sparkman

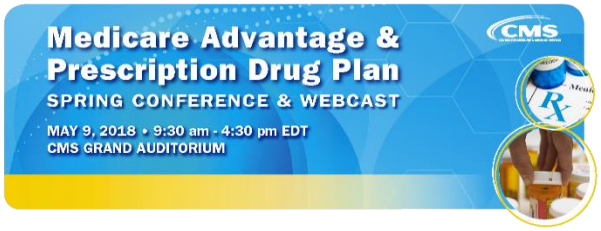
Session 5 - CARA/Opioids

#	Question	Response
1	Plan would appreciate information on when sub-regulatory guidance will be issued to implement changes for SEPs.	We expect to issue sub-regulatory guidance on the SEPs in summer 2018.
2	The reduction in Dual changes will help but the beneficiary needs to be informed of this change as well. I'm not sure of when this occurs but I'll use it going forward.	The changes in the duals/LIS SEP will be effective 1/1/2019. CMS is in the process of updating public facing and outreach materials to make beneficiaries aware of this change.
3	We would like to prohibit opioids from mail order for many reasons. But the bid tool allows mail order restrictions by tiers only. Most opioids are not above tier 3. What could be a workaround to implement this restriction? Member can still get their opioids at retail. For non-formulary opioid products and QL exceptions, we would like not to allow duration of therapy longer than 3 months (except for cancer, etc.) but the CMS audit protocol states "until end of plan year". Can CMS provide guidance? Thanks.	As noted in Chapter 5, section 50.2 of the PDBM, the inclusion of mail-order pharmacies in Part D plan networks is optional. Since network inclusion of mail-order pharmacies is optional, sponsors may designate a subset of formulary drugs (e.g., particular tiers or “maintenance drugs” only) for availability via network mail-order pharmacies. To be in compliance with the Medicare Marketing Guidelines, sponsors must use a symbol or abbreviation, as well as an explanation, to identify drugs that are available via mail order on their abridged and comprehensive formulary documents. We will take your question about non-formulary opioid exceptions into consideration.
4	When does CMS anticipate issuing detailed implementing instructions for its CARA Drug Management Program initiatives?	As noted in the presentation, we plan to release additional technical guidance in Fall 2018.
5	Will the drug management program beneficiary notices be model documents or instead developed by plans based on guidance of required content?	CMS will develop the notices and stakeholders will have an opportunity to comment before the final versions are released.



Session 5 - CARA/Opioids
Lisa Thorpe, Michelle Ketcham, Gail Sexton, Sabrina Sparkman

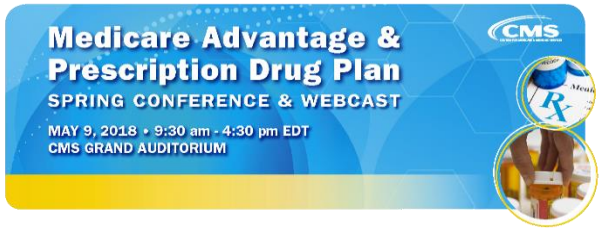
#	Question	Response
6	When deciding to expect all sponsors to implement a new, opioid care coordination edit at 90 MME per day, what stakeholders and feedback were relied upon in making this decision since the draft call letter did not reference a care coordination edit?	The care coordination edit involves a similar process for prescriber consultation and coordination as originally proposed with the hard edits but instead is attached to soft edits that plans already do (which can be resolved at point of sale by the pharmacist).



Session 7 - Network Adequacy Review Roundtable Discussion
Theresa Wachter, Kelley Ordonio, Christine Reinhard, Nyetta Patton

Session 7 - Network Adequacy Review Roundtable Discussion

#	Question	Response
1	How did CMS select contracts for the first triennial review cycle?	CMS pulled a random sample of contracts, including contracts that have never undergone a full network review in HPMS. We intend to review these particular contracts within the first two years of this initiative.
2	If an initial or SAE applicant is not meeting network adequacy requirements, will their application be denied?	No, as mentioned earlier, an application's approval is NOT contingent on the network review. We'd like to remind organizations of the opportunity to remove active counties from their proposed service area if they do identify network deficiencies through consultation or through the org-initiated upload. This can be done in June via the Service Area Reduction Module in HPMS, before service area verification, before the bid submission deadline, and before the formal network review.
3	When is the Service Area Expansion HSD submission due for CY 2019? Earlier guidance indicated sometime in June.	CMS has not yet announced the deadline for the June submission of Health Service Delivery (HSD) tables discussed in our January 10, 2018 HPMS memo. Organizations will receive a separate communication from HPMS with their HSD submission deadline.



Session 8 - The Da Vinci Project & Blue Button 2.0: Interoperability Initiatives in Medicare FFS and Medicare Advantage
Melanie Combs-Dyer, Allison Oelschlaeger

Session 8 - The Da Vinci Project & Blue Button 2.0: Interoperability Initiatives in Medicare FFS and Medicare Advantage

#	Question	Response
1	How can Medicare Advantage (MA) plans get involved in building a Documentation Requirement Lookup Service?	MA plans can either (1) reach out to HL7 to become a member of the Da Vinci project or (2) wait until the FHIR standards are posted to the public.
2	How would a Documentation Requirement Lookup Service be helpful to MA plans?	A Documentation Requirement Lookup Service could help MA plans to reduce provider burden, reduce improper payments and reduce appeals.
3	If a hospital system already has an EHR system that allows physicians to electronically communicate and share records with other physicians in their network, why should they care about the Da Vinci Team's provider to provider medical record exchange use case?	The provider to provider medical record exchange standards would allow physicians to electronically communicate and share records with other providers outside their network.
4	Can I participate in Da Vinci if I am not using Fast Healthcare Interoperability Resources (FHIR)?	No. The Da Vinci project is focused on developing and pilot testing FHIR standards.