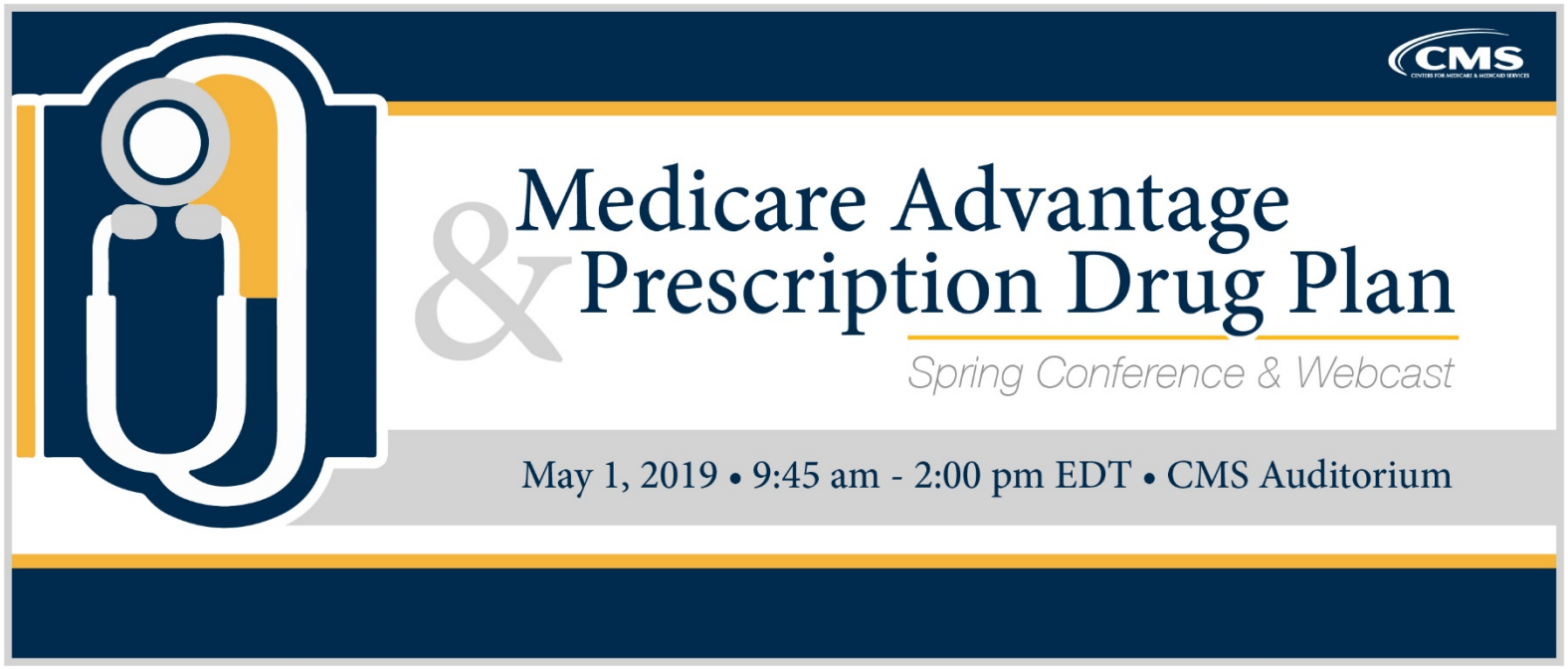

Frequently Asked Questions (FAQs)

2019 Spring Conference FAQ Document

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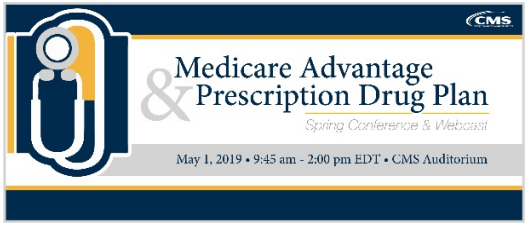
Please note: We received questions other than the ones listed in this document. Many of the questions were out of scope for the session and were not included in the list. If you feel that you still have an outstanding question, please email the appropriate contact.



Session 1 - All Payer Policy & Medicare Advantage Qualifying Payment Policy Arrangement Incentive (MAQI)

	Question	Response
		For more information about the Quality Payment Program and Other Payer Advance APMs, visit: https://qpp.cms.gov/about/resource-library For more information on the MAQI Demonstration, visit: https://innovation.cms.gov/initiatives/maqi/

Session 2 - eMedicare

Jon Booth

Session 2 - eMedicare

#	Questions	Response
1	The tool that helps users decide what type of Medicare coverage (original Medicare or Medicare advantage) is right for them: won't the results change based upon current diagnosis or health needs? How can this be addressed for the beneficiary?	This is correct. Results to change for beneficiaries based on factors like their health status. We do allow users to choose from "Good," "Poor," or "Excellent" health status, and we will continue to allow functionality like this in the redesigned Medicare Plan Finder.
2	We appreciate the efforts by CMS to improve the MPF. Regarding improvements to information about annual costs, will CMS share with plans information on how CMS calculates the plan and drug costs so that plans can better validate that the information is accurate? In this past, it's been somewhat of a black box on how the annual costs are calculated and why one plan is displayed ahead of another plan.	CMS is looking for opportunities to be more open and transparent about our methodologies with the redesigned Medicare Plan Finder. We don't have specific plans to report at this point, but this will be a part of our strategy for the rollout of the new tool and education to industry on the changes being made to MPF.
		For questions or more information, contact: Jon.Booth@cms.hhs.gov

Session 3 - Medicare Advantage Value Based Insurance Design Update

Gary Bacher and Laurie McWright

Session 3 - Medicare Advantage Value Based Insurance Design Update

#	Question	Response
1	I would like to know more about how access to telehealth will change in 2020 and 2021. Will we be able to use telehealth services in an urban setting and not just a rural setting? Can patients have a video supported visit from their home? Can we capture codes via telehealth?	Thank you for your question. All CMS guidelines for telehealth services still apply. The telehealth component of VBID allows for testing how telehealth services can augment in-person access to care. Please refer to the 2021 model RFA for requirements to participate in the VBID model.
2	For the 2021 model---is the idea that the MA plan would create a hospice provider network? Further negotiating costs and services? And maybe I missed it, how will the MA plan be reimbursed for the associated costs? You addressed it a bit, is it not fully understood just yet?	Thank you for the question. Overall, CMS will make network available over the coming months. Through the test of a MA carve-in, CMS will pay MA plans for covering hospice services for enrollees that elect hospice.
3	Laurie stated that annual limit for Rewards and Incentive programs will be upped to $600 and includes Part D benefits. Is this limited to rewards and incentive programs only for VBID programs/benefits, or does it cover all MA programs regardless of VBID participation?	Thank you for the question. The limit referenced applies to VBID model applications under the VBID model choosing to offer Rewards and Incentives. Please refer to all CMS guidelines, including but not limited to the Medicare Managed Care Manual, in designing any MA Reward and Incentive program.
4	How many plans submitted VBID applications for 2020?	Thank you for your question. Information on the model is available on the VBID model website, located at https://innovation.cms.gov/initiatives/vbid/.
		Please visit the VBID Model Website for more information and announcements: https://innovation.cms.gov/initiatives/vbid/ Please email all questions to: VBID@cms.hhs.gov

Session 5 - New Medicare-Medicaid Integration Policies in the CY 2020 C&D Final Rule

Vanessa Duran, Marna Metacalf Akbar, Paul Precht, Marc Steinberg, and Tobey Oliver

Session 5 - New Medicare-Medicaid Integration Policies in the CY 2020 C&D Final Rule

#	Question	Response
1	Final rule indicates that HIDE-SNPs can passively enroll. Will CMS issue guidance about how to do this?	The final rule updated to the language in the passive enrollment provision as HIDE SNP was previously not defined. However, no requirements for passive enrollment have sustainably changed. For more information on passive enrollment, please see enrollment and disenrollment guidance here: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf
2	Final rule indicates that the integration provisions do not apply to MMPs. Why not? MMPs meet the definition of a FIDE –only difference is they are demos. But CMS is extending the existing demos and expanding MMP demos into new states.	The statutory authority in the Bipartisan Budget Act of 2018 was specific to D-SNPs. MMP policy and operations will continue to be established in three-way contract agreements among CMS, health plans, and states.
3	Can a FIDE identify specific populations as high risk? If so does this require a separate product meaning identified as two separate DSNP types requiring separate contacts?	We clarify that FIDE SNPs are not subject to the requirement that they identify high risk populations as part of the notification requirement at 42 CFR 422.107(d). The notification requirement for high-risk individuals is applicable only to D-SNPs that are not FIDE SNPs or HIDE SNPs. A FIDE SNP has the ability to identify a group of its beneficiaries as high risk as part of its care coordination processes.
4	Will MA Plans who have Medicare and Medicaid members (who are not D-SNP, MMP) be able to use integrated letters for Appeals and Grievance for their dual eligible members?	No, the integrated notices will only apply to applicable integrated plans (see definition at 42 CFR 422.561). However, the current MA integrated denial notice (CMS-10003) does provide information for dual eligible individuals.

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#	Question	Response
5	What kinds of ongoing benefits do you consider to be subject to the continuation of benefits provisions for Medicare benefits? If a plan only authorizes a service (e.g., home health visits) for a limited number at a time will the continuation of benefits requirement apply & if so, how?	Any Medicare service provided on an ongoing basis could be subject to continuation of benefits. Home health services are a good example. In accord with 42 CFR 422.632(b) (4), the authorization for the service must not have expired at the time the appeal is made. Expiration of the authorization while the appeal is pending is not a factor for continuation of benefits under 42 CFR 422.632(c). This is the same policy as exists under Medicaid at 42 CFR 438.420(b) and (c).
6	You stated the unified appeal and grievance processes is only applicable to certain integrated plans. Are the applicable plans those where the beneficiary received DSNP and Medicaid from the same MCO or parent organization? What about beneficiaries who receive DSNP from one MCO and Medicaid from a different MCO? Can you provide the list of states and MCOs that ARE applicable?	Applicable integrated plans, as defined at 42 CFR 422.561, are those FIDE SNPs or HIDE SNPs with exclusively aligned enrollment (as defined at 42 CFR 422.2). This definition excludes plans that have some members who receive Medicaid benefits from an MCO with a different parent organization or from Medicaid FFS. Currently, exclusively aligned enrollment is required in the state Medicaid agency contract in only a few states: Idaho, Massachusetts, Minnesota, New Jersey, New York, and Wisconsin (certain D-SNPs only). D-SNPs can consult their state Medicaid agency contracts to ascertain whether the state in which they contract limit enrollment to full benefit dual eligibles who are receiving Medicaid benefits (including either behavioral health or LTSS) directly through the D-SNP or through a Medicaid MCO under the same parent organization.

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#	Question	Response
		For more information on: CMS-4185-F: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf Integrated Care Resource Center: https://www.integratedcareresourcecenter.com/ Questions on this presentation: MMCO_DSNPOperations@cms.hhs.gov