Open Q&A Session

Stacey Plizga, PRI

Stacey Plizga: Our next and last session of the day is what we call our Open Q&A Session. And during this time, we are going to have all of our speakers from today join us here on stage. And we will go through each session and give you one last opportunity to ask any questions that may have come up for you throughout the day. And at that time, too, for our viewing audience, we will address any of the questions that you've sent in to us via the Ask CMS Live survey. Any questions that we don't have time to respond to, we will actually prepare responses for those, and then those will be posted on the CTEO website at a later date, and you will receive an email when that information is posted.

So at this time, then, I would like to ask all of our speakers from today to join us here on stage and have a seat. And we will go through our questions with you.

Okay, so we will start with our first session of the day which included Richard Jensen and Sharon Andres. And we did receive a couple questions from our virtual audience, but I would like to open it up to anybody in our live audience first. And if you do have a question, please step to the microphone in the center of the room.

Okay, so we will go ahead and we'll jump to the questions we received from our virtual audience. And the first question is, and this is going to

Richard and Sharon, what if the plan doesn't have payment arrangements with providers that meet the APM?

(Inaudible.)

If you could speak at – there you go. It should be on.

Richard Jensen: Is this on now?

Stacey Plizga: Yes.

Richard Jensen: Um, could you repeat the question, please?

Stacey Plizga: Absolutely. The question is, what if the plan doesn't have any payment arrangements with providers that meet the APMs?

Richard Jensen: Well, the payment arrangement is either an APM or not. But I think what they're saying is if their providers are not involved in either APMs or Advanced APMs. This is – our discussion is not relevant in that sense because your, as I was saying during the presentation, your network is only going to be interested about getting Advanced APMs if – and becoming QPs because if they're at least significantly involved with Medicare Advanced APMs and therefore the All Payer.

For clinicians that are not in APMs, or Advanced APMs more specifically, they are going to be in the MIPS program and that's how they are going to be reimbursed under Part B.

Stacey Plizga: Okay. Thank you. The next question. If a provider is identified as submitting an inordinate amount of claims identified as improper payments, how does that affect their ability to be a Qualifying Participant in MIPS or Advanced APM?

Richard Jensen: I'm not a program integrity person.

Stacey Plizga: Okay.

Richard Jensen: That, in and of itself, I don't know what the relevance is per se. I mean, could you repeat what they said the – they're inappropriately?

Stacey Plizga: Sure. If a provider is identified as submitting an inordinate amount of claims identified as improper payments, how does that affect their ability to be a Qualifying Participant in MIPS or Advanced APM?

Richard Jensen: Um, I – I don't know. That's a program integration issue I'm not familiar with. They're going to be in trouble, but I can't tell you how.

Stacey Plizga: Okay.

Richard Jensen: There's nothing about our discussion to whether you're a MIPS – pardon me?

(Inaudible.)

Well that's certainly true. The claims wouldn't count towards their QP status, but they wouldn't count for any – any purpose whatsoever, it sounds like, so.

Stacey Plizga: Okay. We'll move on to the third question we received, and that is, please ca – sorry – please clarify the new gap on name-brand medicines.

Richard Jensen: That definitely has no relevance.

Stacey Plizga: Okay, so I'm not doing so well here today. All right. So any other questions for session one? If not, we're going to go ahead and move to session two to Jon Booth.

Okay, hopefully I'll do better this time. All right. Regarding the tool that helps users decide what type of Medicare coverage is right for them, won't the results change based upon current diagnosis or health needs, and how can this be addressed for the beneficiary?

Jon Booth: Yeah, it's a good question. They – they will change. And so one of the things that we built into the out-of-pocket cost calculator that we launched last year is the ability for people to select health status, so good, fair, or, you know, average, good, or poor. And then based on that they will see the – the projected costs change significantly. That's a model we're looking to refine and move forward. And I talked earlier in the day about using personalization, so we're looking to see if we could be able to actually identify some of that about a beneficiary knowing that they have, say, a chronic condition, we could maybe prefill that for them. So that's – that's sort of a future thing we're looking into. But we – yes, it does have a big impact on the – the potential out-of-pocket costs.

Stacey Plizga: All right. I got a good one. Moving on to the next one. We appreciate the efforts by CMS to improve the MPS. 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?

Jon Booth: Yeah. So one of the, you know, we talked earlier in the day about the part of the current Medicare Plan Finder platform is a proprietary engine, so it's not intellectual property that is CMS's. In the new tool, that – that pricing algorithm is something that we will own, and so we are looking to publish more information about that and to be more transparent about that moving forward. I will mention that a lot of the source of the drug information, the lists of the drugs and mapping commercial drugs to generics and those sorts of things, those are commercial data sources so that's not necessarily stuff we can release into the public. But the algorithm itself is something we do plan to – to publicize and make available, so people have a better insight into how that works than they do today.

Stacey Plizga: Okay. Any questions for Jon out there? Please step to the microphone.

Matthew Dobson: Hi. Matt Dobson from Care First Blue Cross Blue Shield. You mentioned in your slides about better integrating Medigap into the Medicare Plan Finder. Do you have any specific on that?

Jon Booth: We don't have a lot at this point. Medigap data is something we've been doing a lot of – a lot of research on, and there's – the data is sort of collected manually today. We're talking with organizations that do collect that data. We know NAIC collects it, but the data NAIC collects is actually sort of one year behind the current year, and so that's not optimal for us to use in the tool. So, I don't know that we have a lot more to say at the moment, but we are beating the bushes to figure out as much as we can and getting good and timely sources of that data so that we can integrate it more into the tool. Thanks.

Stacey Plizga: Okay. Thank you, Jon. We are going to move on to our third session, and Laura McWright is with us here today to answer those questions. And if you have a question, our in-house audience, please step to the microphone. And if not, I will move forward with our virtual questions.

Okay, the first one I have here. 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, and can we capture codes via telehealth?

Laura McWright: Wow, lots of –

Yeah.

Lots of questions all at once. So, first, in fact the 2020 plan year, the telehealth network is an option as I described earlier today. It – it can be used not only in rural settings, but also underserved areas which could include the – the urban areas. In addition, see – going the –

Stacey Plizga: Can it be video supported from their home?

Laura McWright: Yeah, and so really we – we leave it to the plans in – in proposing a variety of interventions related to – to telehealth. And I think the – what we put our in our RFA as just general guidance was the idea that it be clinically appropriate for the specialty. And that it be supported by evidence out in – in – in the world that it makes sense. You know, the best examples are things like you're obviously not going to be telehealth when you're doing bunion surgery, or the idea of what you could – what you could see in a visit in a home, you know, what – what clinically makes sense there. And so we left it to the plans to propose interesting ways of using it.

Stacey Plizga: Okay. And the third part was can we capture codes via telehealth?

Laura McWright: Well, that – that's really a payment issue that would be between – that would be between the Medicare Advantage organization or plan with the providers. It's not - CMS wouldn't be directly involved in that.

Stacey Plizga: Okay. All right. Laura, the next question. For the 2021 model, is the idea that the MA plan would create a hospice provider network?

Laura McWright: As Gary described – that's a great question, and, you know, basically I think the concept that we're looking at is that there would be, as with all provider groups, that there would be an in-network contract with a set of hospice organizations but that it would also extend to the concept that there would be out-of-network coverage as well.

Stacey Plizga: Okay. And the second part of that question was, how will the MA plan be reimbursed for associated costs?

Laura McWright: Another great question. I was surprised that didn't come up this morning, actually.

So, in essence, the – the current rate book for MA organizations obviously does not include hospice because it's not, you know, it's not

carved in. And so we're looking at various strategies of how we might develop rates that would be inclusive of hospice. And, you know, just thinking about what's possible, you know, where the current methodology, including risk adjustment, etc., doesn't necessarily cover where we are now in terms of thinking about hospice. So, that's a work in progress and definitely more to come on those pieces.

Stacey Plizga: Okay. Next question. Laura stated that annual – the 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 and benefits or does it cover all MA programs regardless of VBID participation?

Laura McWright: Yeah, another great question. Yeah, that would just be related to VBID participants.

Stacey Plizga: And the last question I have here, how many plans submitted VBID applications for 2020?

Laura McWright: Thank you for that question, and right at the moment we're reviewing all the applications and the updated information we got last night, so we're not – not at liberty to – to be able to say a whole lot about that. But more to come, you know, in the future. And very excited to share all of the – all of the information.

Stacey Plizga: All right. And now we're going to move on to our last session of the day, so I would like to invite any of our in-house guests to step up to the microphone if you have any outstanding questions. And if not, I'll go to the question we received from our virtual audience. And that question is, can a FIDE identify specific populations as high risk? If so, does this require a separate product meaning identified as two separate D-SNP types requiring separate contacts?

Vanessa Duran: I'm going to take a stab at that based on what I think I understand about the question. So, it's the state determining what a high-risk enrollee is.

You know, Marna provided a couple of examples in her presentation about ways in which states might mine their data to, you know, or consistent with their goals, identify who is high risk. But then – then they would specify those – those high-risk populations in their contract.

But I just want to clarify that the FIDE SNPs are not required to report the SNF and hospital inpatient admission information. That's really for plans that are not FIDE or HIDE SNPs. So I just want to make sure that folks understand that.

Stacey Plizga: Okay. All right. Well, if there are no other questions from our in-house audience, those are all the ones I received from our webcast viewing audience, so I would like to thank all of our speakers today.

[applause]

You guys may head down if you would like. Although you're welcome to stay up here with me, that's fine, too. I'm okay with that.

All right, so one last time, to evaluate this session, so if you'd like to evaluate the open Q&A session, please go ahead, take out those phones, and enter A. Hit send, and follow the prompts please.