

## TRANSCRIPT

### Day 1: Welcome, Keynote

*Love*

Good morning, everybody. I hope everybody had a nice Labor Day weekend. I'd like to welcome you to the CMS Annual Fall Enrollment Marketing and Compliance Conference for MA and PDP Plans. Let me begin by thanking you all for making the trip. We work hard to make our spring and fall conferences worth your while, worth your time and worth your travel, or virtual travel for the folks who are joining us on the web today. I have to admit, though, we work hard on this because we want to make it worth our time, as well, the CMS managers and staff. That's because these conferences really provide us with an excellent opportunity to communicate with you all in a relatively unfiltered way about particularly operational priorities in the MA and EDP programs.

So what I'd like to do today is give you all – or what we'd like to do today – is give you all the Agency's perspective on operational priorities as seen by the people at CMS who've been staffing these programs for a number of years. There's some pretty experienced folks that can be up here today on the Agency's behalf. I guess more importantly is they're likely to be staffing and managing these programs for years to come, so this really is the institutional perspective that you'll be getting, at least from the CMS staff, today about our priorities. The long-term perspective that these folks bring provides, I think, an authoritative view of where the program's been, where it is right now, and where we're heading in terms of near term priorities. You'll also hear from a few non-CMS speakers today including I think a very timely session later this morning on the topic of drug utilization control for opioid overuse among Medicare Part D beneficiaries.

And I think we should all be particularly looking forward to the 11:00 panel on best practices reviews from our five star clients. These plans have produced excellent results for the Medicare program for Medicare beneficiaries. And you'll hear from them shortly, but I did want to take a moment in my remarks to acknowledge this accomplishment and our five star plans today. I believe they're all represented here today. Health New England. I'm sorry. Five star plans for 2012. We've yet to announce the 2013 plans. Health New England. Martin's Point Generation. Group Health Cooperative of Puget Sound. Kaiser Foundation Health Plan. And Geisinger Health Plan. So those are our 2012 five star plans, and we look forward to hearing from them a little later this morning.

In reviewing today's agenda, I think you probably see that we're getting into some nuts and bolts of MA PDP operational priorities, the basic functions. Some of these basic functions do appear on today's agenda, but before getting into that, let me just make a couple of comments about the state of the Part C and D programs. And I think the headline here is that the MA programs remains, the current year and certainly looking forward, remains an attractive option for Medicare beneficiaries. Benefits, including supplemental benefits, are stable, which is certainly a very good thing from the beneficiary out-of-pocket perspective. Program enrollment is strong and projected to increase for

*FALL 2012 CMS CONFERENCE*

*Day 1: Welcome, Keynote - Love*

the 2013 contract year. And the current bid process went relatively smoothly. You'll hear more about that as well. And increased transparency from CMS, just in terms of the bid process, methodologies, processes, which we've been really making an effort to do lately, has been well received, at least some of the feedback we've heard from contractors, some of the folks in this room. So in some Medicare Part C and D continued to be robust programs, and we're projecting significant growth well into the foreseeable future. Despite that favorable outlook, however, there is always an opportunity for us to improve program management, both within CMS and as a result of our collaboration with all of you who ultimately are responsible for delivering these services on the Agency's behalf to Medicare beneficiaries.

Now I don't want to steal the thunder of any of our speakers today, but I would like to suggest a few themes for today's conference. The first theme is that we intend to recognize and celebrate excellence in the delivery of services to Medicare beneficiaries in the Part C and D programs. I've already mentioned the current five star plans. I should also note based on a preliminary review that we're likely to have additional five star plans in 2013 that you'll be hearing about soon enough. But beyond the significant incentive of the quality bonus payment, CMS will continue to look for additional operational leaders, those ones where we have discretionary authority to reward excellent performance. And one example of that is the five star special enrollment period will be in place for 2013, as it was for 2014, so if you're in a five star plan, you have the option of conducting year-round enrollment. And CMS will continue to promote five star plans in our coming initiatives to provide beneficiaries with personalized healthcare information and information to inform them of the best possible plan in their area.

When we find something that works in this program, a best practice, we're going to let the MA PDP community know about it. I think you can see a push on much more information along those lines currently and in the near future. The five star plans were tremendously helpful to us earlier this year as we went out and did best practice reviews. We, within the Agency, were very careful to call them best practice reviews because we didn't want to reward the five star plans' accomplishment with an audit. And although I'm not sure any of the five star plans actually believed us when we came on site and said this is a best practice review rather than an audit because it sort of walked and quacked like an audit, so that was a fair interpretation, but that actually wasn't the case. We really were out there in different parts of the country trying to learn something from the plans who are really doing it right, absorb that information ourselves, and in turn share it with you all.

I was fortunate to spend the better part of a week in Seattle this past March with Group Health Cooperative, and it gave me a very good sense of what it takes to run a first-rate Medicare managed care plan. So you'll hear more about that shortly, but at the risk of stepping on Tawanda Holmes' lines, I'll announce that our compliance and oversight group has compiled insights from these best practice site visits and put together a white paper on best practices which will be available to you all shortly and Tawanda may have the delivery date for you on that when she comes up a little later on.

Another theme for today's conference is a perennial, and that is how to insure plans are adequately prepared for the upcoming AEP. Last year, earlier time frames coming out of the Affordable Care Act necessitated CMS giving plans additional flexibility as we got closer to the deadline to insure enrollments were timely and processed accurately. Now that we've been through this drill once,

however, CMS plans to adhere to those deadlines, and we hope that plans, those who did struggle a little bit toward the end of last year's AEP to meet those deadlines, have deployed adequate resources to not be in that situation again this year. In short, please be mindful of upcoming AEP deadlines and please take them as seriously as we do. There's a whole operational structure and series of sequences that are geared off those deadlines, so it's very important that folks pay attention to those beyond being required by statute.

Another theme I hope you recognize from today's conference is that CMS continues to put considerable effort into getting our black boxes out in the sunshine, our processes, methodologies, trying to increase the transparency of how and why we do things within the Agency relative to the Part C and D's programs. For example, we want people to understand, we want our partners, our contractors, to understand what the metrics are for establishing a five star plan, or any star rating, for that matter, one through five. We want you to understand how our audit protocols work, so when we're on site virtually or in person, your understanding of what we're trying to accomplish really does help the agency do its job, not to mention the fact that we're not sort of parallel processing and we're sharing a common objective.

I've already mentioned the best practices guide. In June you'll recall we sent out an HPMS memo outlining the Agency's quality strategy for Medicare Parts C and D, and that's obviously something that it was important for us to get out and you'll be hearing more about.

And for those of you who did have the pleasure, the non-five star plans, the non-best practice reviews, for those of you who did have the pleasure of interacting with our audit team over the past year or so, I hope you've noticed a difference in tone under Jerry Mulcahy's leadership. Jerry's the Director of our Program Compliance and Oversight Group, PCOG. And that brings me to yet another theme, and that is that CMS is putting significant effort and resources into developing our compliance and oversight auditing capacity. The capacity is data driven. It will be improvement oriented. And it will be professionally administered. Data driven because we intend to make compliance and oversight decisions, and enforcement decisions, based on what the numbers tell us rather than what a particular plan's narrative might be. Improvement oriented because, well, it's an article of faith for us at the Agency that our goal isn't to maintain the status quo as far as quality for plans, beneficiary satisfaction, all those things that go into your measures. Our goal is to work with you to improve the provision of services for Medicare beneficiaries. This reminds me of a comment attributed to former CMS Administrator Don Berwick, who was fielding a question, or a complaint, really, I guess it was, about the shifting nature of the sort of upward modification of the Agency's quality metrics. And his comment, I think which is a good sort of encapsulation of what the Agency perspective on this is, and replied to the complaint about shifting quality metrics, his comment was, "Of course we're changing the metrics. That's how you improve quality." And it really isn't a static enterprise. The systems, whether it's within the star system within the C and D side or other metric systems within the Agency's other lines of business, this is really so that we can help the program evolve in terms of quality, it's not so we can stand still.

I also mentioned professionally administered as a key feat – administered as a key feature of our growing compliance and oversight capacity. And by that I mean when interacting with CMS audit staff or our contractors, a plan should expect professional, courteous and problem-solving attitude from the Agency. We won't pull any punches in our audits, however. We'll follow the data

wherever it leads, but our tactic won't be to simply tattle on plans. Instead we'll configure our findings in a way that is understandable and actionable to the plans being audited so they can also enter the problem-solving mode.

I tend to think of compliance and oversight as a spectrum ranging from failed plans on one side of the spectrum to high performing plans on the other. And moving along that spectrum we have different sorts of milestones. We have sticks starting at the one end, the low performing. You know sticks are – they can be, well, you can be removed from the program if you're a poor enough performer. That's something we've done before and unfortunately I'm sure that's something we'll have cause to do again. But as you move up the improvement scale, you get to civil money kind of things. You get to corrective action letters and progressively until you get to the other side of the scale, which are the five star plans, frankly, reaping carrots instead of sticks, whether it's the quality bonus payments, the special election period, or other operational levers we're able to find to recognize and reward five star clients.

So I'm going to pause for effect just a moment here, because there's one thing, if you don't remember anything else I say up here this morning, there's one thing I really do hope folks remember. And that is that CMS is far more interested in seeing plans move to the five star side of the spectrum than we are in identifying plans on the low performing side of the spectrum. Now that's not to say that we're going to let our guard down in identifying poor plans, monitoring and auditing. On the contrary, poor performing plans will receive greater attention going forward, that's really part of our beefed up compliance and oversight strategy. We'll be turning the heat up, quite frankly. The data is becoming more robust. We can understand operations on the ground better, and we're going to be pretty diligent about applying program requirements. But what we really want to see is significant movement to the high performing side of the spectrum. Sure, that's goods for plans because it means quality bonus payments, it means, I think, improved standing among your peers in the community. It's good for CMS staff because, you know, it's actually a lot more rewarding and fun to be managing a high performing federal program than it is to be managing a mediocre or poor one, so we definitely have some skin in the game as well. Most importantly, however, it's good for Medicare beneficiaries because they're going to be receiving access to better plans. They'll have the information they need to make the best choice among plans.

There are a few other important themes coming out of your agenda today. One I've already mentioned, the opioid over utilization. And just another word about this issue, the Medicare prescription drug program has been very active in what's really been a federal government-wide effort, federal government in consultation with state governments, I'm sure there's local government involvement that I'm not aware of, but this is a major initiative at a number of government levels. And beyond the sort of trust fund issues that all of us as stewards of the trust fund pay attention to, we also know that opioid overdose is now the second leading cause of unintentional death in the United States. So this is not just a fiscal issue or program management issue, it's a public health issue. And later this morning Cynthia Tudor will moderate a panel featuring representatives from CVS/Caremark, Humana and United Healthcare, and we all hope to learn a little bit more about improving drug utilization controls for the Part D opioids.

You'll also hear about the Agency's thinking regarding what detective of fraud, waste and abuse means in Part C and D programs. We have our colleagues from the Center for Program Integrity

*FALL 2012 CMS CONFERENCE*

*Day 1: Welcome, Keynote - Love*

will be stopping by this afternoon and providing a panel on that. And this is kind of a tricky issue because when we talk about program integrity, most of us, myself included, tend to think of that on the indemnity side, on the fee for service insurance side, or it's claims analysis or projection of claims analysis, and it's a much different thing when you're talking about capitated programs, so we'll all get a sense of that from the Center for Program Integrity folks later this afternoon. Well you can see we have a full agenda today, so I'm going to wrap up and let you all get down to business. Thank you again for joining us and have a great conference.