

# FALL 2012 CMS CONFERENCE



## TRANSCRIPT

### Day 1 01: Enrollment Updates

*Slade, Helphenstine*

How's everybody doing today? So, every year Randy Brauer gets up here and talks about the end of your MARx Guidance relating to rollovers and terminations. And this year he told me that I had the best seat in the house for this presentation. The Guidance hasn't come out yet. It usually comes out early September. So I'm sure everyone in this room has looked at it maybe once over the years, and it talks about the timelines/instructions for the end-of-year MARx activities. It talks about CMS-generated versus Plan-submitted rollovers and terminations. For this year, the CMS-generated rollovers and terminations – we'll be processing that December 6th and 7th, so it'll show up on the plans TRR on December 10th and 11th. And we process the rollover and terminations pursuant to the approved crosswalks in HPMS. And the scenarios this year for the rollovers and terminations are the same as it is for other years.

Now this is a deceptively simple slide, but so these scenarios or the concept is a whole PBP into another whole PBP – so it's one 2012 PBP into a 2013 PBP, multiple PBPs into a single PBP, etc., etc. And we sent that out in the end-of-the-year Memo which will be coming out shortly. So on your TRR that you'll get on December 10th and 11th, for the enrollments you'll receive a TRC 100 or a TRC 11 PBP change or Enrollment Accepted as Submitted with the enrollment source of D which is annual rollover. And this hopefully isn't news to folks, so I'm not going to spend too much time on it. We'd be throwing catch up after the presentation – with an effective date of January 1, 2013. The only kind of added thing that folks should really be looking at this year is we've automated the Segment ID Process, so you really want to pay attention on your Daily TRR to make sure that your beneficiaries are in the right segment. And if not, then you just need to submit a TC 77, which is a Segment ID Update.

For the CMS-generated Disenrollment, you'll receive a TRC 18 with an effective date of January 1, 2013. And we'll talk about Plan- submitted on the next slide. I have a few things to say about that. Plan Reports and System UI Availability – you know, we send out two letters on reassignment about the same time every year. Those haven't gone out yet, but they'll be coming out shortly. But effective Plans will be receiving their different reassignment files – like the loss of a low-income subsidy, the special TRR, etc., etc. – but that will be explained in the Reassignment Letters. The January Payment Report will be available December 20th. It's really important, as it always is, to review that to make sure all your folks are in the right PBP. So MARx UI will be in "read only" November 12th through the 15th and December 8th and 9th. So just take that into account if you have a lot of UI activity.

Plan-Submitted Rollovers and Terminations – so not every crosswalk exception requires that a Plan submit transactions. Plans need to pop onto HPMS, as they do every year, and check and see if you need to submit transactions. And inevitably, every year we get a few Plans that call us in January

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and wonder why their folks didn't roll over. And our first question usually is, "Were you required to submit a transaction?" and the phone usually gets quiet at that point. So be very mindful of whether you need to submit transactions or not. And in a lot of instances, you don't – in fact, most you don't.

So this year, Plans have to submit their plan-submitted transactions – if they have to submit transactions – October 9th by 5:00 p.m. Eastern Time. It's a 61 with an app date of October 1, 2012, and an Election Type of "X." And the Disenrollment is 51 -- everybody I'm sure knows this – with an Election Type of "X," effective date, 1/1/13' and a Disenrollment Reason Code of 92, which is Out of Service Area. So when you get your Daily TRR back after you submit your transactions – as we did last year and in past years – we want Plans to kind of analyze your transactions and submit a summary to your Regional Account Manager and the MAPD Help Desk. And I believe those are due October 12th, 2012. But wait for the Memo to come out, and I'm sure you'll read it very vigilantly.

And another kind of issue I think folks want to be mindful of is in past years we had an issue with short enrollments, where beneficiaries would sign up for November or December of a year and the MARx was putting an end date of December 31st on the enrollment. And folks, obviously, come January 1st were nowhere, so we had to do something. We did a fix for that. And so what is going to happen is that when you submit an enrollment for November 1st and December 1st, on the same Daily TRR you'll see enrollment for the November 1st or December 1st, well you'll also see the rollover transaction as well for the January 1, 2013. So you know, you want to make sure you see both of those on the Daily TRR. And if not, call the MAPD Help Desk because if something's not working right, we want to make sure it works right.

So MARx can accept enrollments for January of 2013 effective October 6, 2012. Now, this doesn't affect the October 15th AEP. This is for initial election periods and things like that. But I bring this up just because there may be instances where you receive an enrollment, but you can't submit it because it's not available -- MARx can't take it until October 6, 2012. So if you get an enrollment between October 1st and October 5th, just process it internally and on October 6th submit it to MARx. And if you submit it before October 6th, it will reject or fail because the contract information may not be available to MARx at that point. So it will look like there's not a 2013 Plan.

Oh, and Unsolicited Paper Applications – if you get those before October 15th, it's the same as past years. Submit the transaction to MARx October 15th, with an app date of October 15th.

All right, so this is hopefully some good news – not that what I just said wasn't good news. So we finally moved into the 21st Century. The monthly certification of enrollment and payment data we've put into HPMS. Now, I'm sure folks know that 45 days after your Monthly Payment Reports are available, your Plan has to certify that that information is correct. And it's a hard copy process at this point – print it out, sign it, send through the RPC. Well, we've put it in the MARx so that your COOs, CFO, or CEO can just pop into MARx and certify it. So the way this is being implemented is the certification for your July reports, which is due on Saturday, that's still the hard copy process. So do what you did last month. The HPMS process is for the August 22nd Payment Reports, and that certification is due October 6th. So if you send your hard copy certifications to RPC, they're probably going to send it back to you. So you need to make sure that you're doing it through HPMS. And we released guidance on how to do this on August 17th through HPMS.

So that's all I had. And I guess I'll turn it over to Patty to shed light on lots of good things. Okay, thanks a lot.

So I'm going to talk a little bit about our policy clarifications for 2013 regarding enrollment. We did issue an HPMS Memorandum on August 7th of this year, and we clarified some of the policies and adjusted some of the models for both Medicare Advantage and Prescription Drug Plans. The revised requirements are in effect for any enrollments that have an effective date of January 1, 2013, or later. And as usual, if Plans are able and want to implement them earlier, they're able to do so.

I do want to touch base a little bit. We did have a bit of a situation with our online – we posted the HPMS Memo, and then we posted the Guidance. And there were some inconsistencies. We just had a situation with the building of the PDF. And not all of our changes in HPMS transferred onto the file version that was marked as the actual Guidance. So that has been updated and went live yesterday. The file name has stayed the same on the site. So I want to make sure that everyone is aware. Please go back and download the new version. And when in doubt, follow the instruction on the HPMS Memo.

But I do want to thank those Plans that did reach out to us and indicate that there was a potential problem so we could find it.

So I do want to talk about a couple of things – really I'm going to outline some of the items that were in the HPMS Memo and then talk a little bit more about some regular updates at the end. So one of the items that we clarified is regarding SNP verification for eligibility. And we get asked the question fairly often about, "Is it incomplete? Is it complete? What is the enrollment request? Do we have the 21 days in order to verify eligibility?" And in our clarification, we've indicated that verification of SNP eligibility is a required element for an enrollment application – meaning that if you don't have that, the application is considered incomplete. And you do have the 21-day timeframe to go ahead and verify that eligibility. And then once you have the complete application, the seven days to submit it to CMS.

The other thing I do want to point out is that we do have Exhibit 5 for enrollment requests, which is the Request for Information. If the only thing the application is missing is the verification of SNP eligibility, you don't need to send that form to the beneficiary because clearly, if it's a dual SNP, you're typically checking with the State, although you could request the information if they have a Medicaid Award Notice or a Medicaid card. But for some of the others – obviously, institutional as well as chronic, there are other things that the beneficiary is not going to be able to provide to you, so it's a matter of going through your verification process.

The other point I want to raise is that this clarification of policy does not apply to chronic SNPs that have the preverification tool. If they're already using that process, those that come in because it's already under the preverification, they are already considered complete upon receipt.

So I do want to talk a little bit – we did modify the definition of involuntary disenrollment. We did this specifically because we kept getting asked over and over again specifically about out-of-area. If

the member called the Plan and said that they were moving, is that a voluntary disenrollment or involuntary disenrollment? So we really wanted to clarify the definition of involuntary disenrollment. The bottom line is, if the individual is no longer eligible to remain enrolled in the Plan, it's involuntary. So if the individual notifies you because they're moving out of area, they're no longer eligible to be in your Plan because they're out of the service area; therefore, that is an involuntary disenrollment.

And it's similar for other things – clearly, loss of B, loss of SNP eligibility, all of the other things we have outlined in Guidance. And you can read those. If any of the situations follow along on any of the involuntary disenrollment scenarios, then you would process it as such.

So one of the things we did in terms of again following up on requests from the Plans was to allow a new combination enrollment for the acknowledgement and the confirmation notice. And it permits PBP changes within the same organization. So it's really like a short form, and it allows that to again be processed. You don't have to send the acknowledgement and then later send the confirmation notice. So you can do the combo notice; and again, just make sure it's sent within seven calendar days of receiving the TRR of the accepted enrollment.

So let me talk just a little bit about failure to pay premiums. Again, this comes up fairly often about making sure that the policy for Plans that implement a failure to pay premiums disenrollment, that it's applied equally to all members. And we really want to clarify here. So in Section 50.3.1 – and this is talking Chapter 2 – but similarly for Chapter 3, the section on disenrollment for failure to pay premiums, we outline that someone has requested premium withhold they cannot be terminated for failure to pay premiums. However, the person is only considered in premium withhold if that request processes. So they are not in premium withhold if you get a feedback from CMS that the request has been rejected, if it failed, or if it was unsuccessful. If any of those three happens, the person's in direct billing status. And that could happen because the submission was after the monthly cutoff. It could happen for whatever reason. But when that happens, the individual is then in direct bill. And at that point, of course, they are responsible for paying the premiums directly to the Plan.

In the case whereby the request was after the monthly cutoff, we outlined in Section 40 – I think it's 40.4 – that the Plan then has to notify the individual that they're in Direct Bill status, that they have to continue to pay the Plan their premiums until the Premium Withhold Request does process. And that Premium Withhold will be prospective and not go back to the original date of their enrollment within that Plan. And if they do have a Failure to Pay Premium policy for disenrollment, they need to let them know that as well. So the big point of this is that if that happens, and even if someone's in Premium Withhold now because they've been submitted -- the request was sent a second time and started -- if they were in Direct Bill status and did not pay their premiums and you have this policy, those months count in your grace period.

So those individuals are not exempt from being disenrolled for failure to pay premiums because they needed to pay the premiums while they were in Direct Bill status.

Okay, so I'll talk a little bit about Good Cause. We adjusted the language a little bit in the Guidance to match the Good Cause Standard Operating Procedure that most of the Plans had received. And

what it basically states is that if you have an individual that's going through the Good Cause process and there is no Part D-IRMAA involvement, meaning that the individual only has to pay their Plan premiums – the past owed plus the three months within the three-month timeframe to be reinstated – upon full payment, the Plan is able to turn on access to services. So they have that ability to do that. That's what our SOP stated, and we just expanded it a bit in the Guidance itself so that it permits Plans to not have to wait for the TRR. However, we do have the three ways that services would be provided in the Good Cause reinstatement situation.

One is of course, again, if the Plan receives the full payment owed within the three-month timeframe, if they're contacted by the CMS caseworker indicating providing access to services, or if they do receive the notification of reinstatement on the Transaction Reply Report.

In cases where there is Part D-IRMAA involvement, the Plan can't automatically reinstate access to services upon receipt of their full payment because the individual has to pay both the amounts that they owe the Plan, and they have to pay the D-IRMAA amounts as well – meaning that we at CMS have to make sure that both have happened before reinstatement actually occurs. So in this case, the access to services is turned on when either they receive notification on the TRR of the reinstatement or if the Plan is contacted by the CMS caseworker.

One of the big things that we heard at the Spring Conference, for those of you that actually attended our Part D-IRMAA and Good Cause Session, there was a resounding request from everyone to really try to look at our model notices. And a lot of Plans had seen a great uptake in the number of CTM complaints that they had gotten because individuals were calling and generating CTMs when they thought perhaps they were disenrolled in error instead of calling the Plan first. So we definitely heard you, and we have modified our models to really allow and permit more communication between the disenrolled member and the Plan. Again, it's going to be Exhibits 20, 21, 21A; so it's all of the Exhibits for the Advance Notification of Disenrollment for Failure to Pay Plan Premiums, Confirmation of Disenrollment for Failure to Pay Premiums, and Disenrollment for D-IRMAA.

So again, we've added in that the individual can call the Plan if they think there's a mistake. That is number one up at the top. What we also have done is we've adjusted the language regarding the situations and why someone would call to request a Good Cause Reinstatement. It no longer lists out various scenarios. Instead it says, "I had an emergency, and I couldn't pay on time. What can I do?" So it really outlines for emergency and unusual situations, call us and request Good Cause. So that language has definitely been simplified, and we also adjusted and removed the MADP language – the Medicare Advantage Disenrollment Period language – regarding the enrollment periods, especially since if the individual is (inaudible) or being disenrolled, they can't use the MADP. They're no longer in an MA Plan.

So all of that was done, and of course the grievance language was added in as well. We are really hopeful that that will help get rid of unnecessary CTMs. Of course individuals can still call us and we'll generate one. But hopefully, if they think they've been disenrolled in error, they're going to contact you first. And you can say whether or not it was appropriate or not appropriate and close it out yourselves, and it doesn't have to get to that level.

In addition, what we've also done is we've clarified for UI codes 713, if you get a TRC 713, which model you should be sending. So when we first started doing Good Cause reinstatements, we developed a reinstatement notice – a generic one specifically – and realizing there was another UI reinstatement code and a different notice – I think it was 30 – but it really didn't apply. So what we've done is we've clarified that the Reinstatement Notice should be 25a for Chapter 2, 22a for Chapter 3, and it does need to now include a little bit of information on Plan premiums. So, "Member, you've been reinstated. You now have access to services. Continue using your card or we'll send you a new card. And by the way, don't forget our Plan premium is this amount of money and you owe it." So that's a small little adjustment.

One thing that I do want to talk about though is we've received a couple reports for reinstatements for Good Cause, whereby some Plans are not receiving TRC 713's in the reinstatement process. They should be. What we found is that we had a system update; and in some cases, the disenrollment date isn't being removed. So instead, it's generating -- I think it's a 288 – which is cancel disenrollment. So hopefully I got the number right.

If you're doing a Good Cause Reinstatement and there was no D-IRMAA, hopefully you as the Plan have already turned on the services because you've received the full payment. But we do ask that for those that you're tracking as "good cause" and are looking for that follow-up TRC, please make sure you're sending them the Reinstatement Notice -- 25a or 22a. If there is an individual that has the D-IRMAA involvement, meaning they have pay both the Plan and CMS or the RRB for their Part D-IRMAA accounts, in those cases, the Plan will be contacted by the CMS caseworker to let them know, "Hey, we've processed this. Please make sure that they're getting the right notice."

Hopefully you are getting the 713s. It seems to be in certain cases, and we're working on adjusting that. But the point we want to make is we want to make sure the individual upon Reinstatement for Good Cause or any type of reinstatement, that they're getting the Reinstatement Notice telling them that they have access to services, that they can continue to see the providers. And that's really what we want to make sure gets relayed to the beneficiary.

Okay, so a couple other things that we have going on on our Part D-IRMAA side – and this is just a quick update -- and that is that we are making improvements to our internal premium payment processing. As you may recall, individuals that have Part D-IRMAA, they don't pay the Plan the Part D-IRMAA amounts; they pay the Federal Government. Most people have that taken out of their Social Security checks. But there are those that don't receive Social Security checks, so they're not big enough to take the amount of money. So we direct bill them – CMS does or the Railroad Retirement Board, depending on who they get their benefits from.

At CMS, we're making some improvements on our internal direct billing system and how we're processing those. So in the meantime, while those system enhancements are being made, we're temporarily suspending Part D-IRMAA disenrollments for non-payment until those improvements are complete.

The Railroad Retirement Board disenrollments are still occurring monthly. I will indicate that they are literally a handful each month. So the bottom line is, for the next couple months, Plans may not be receiving those TRCs. So if there is an individual whereby the Plan is also within their grace

period for non-payment of premiums and they on our end haven't been paying D-IRMAA, typically whichever disenrollment occurs first is the TRC and you all process it. In this case, you just won't be getting the TRCs from us. We are going to continue to rollover these individuals. So if they are within their grace period for non-payment of plan premiums, they'll likely hit the end of your grace period and be disenrolled for that particular reason.

We are in fact still continuing – we started a few months ago, I think we talked about it at the Technical Assistance Roadshow last month, that we are doing a monthly notice for anyone in direct billing status for Part D-IRMAA that is delinquent. So if their payment was not received on time and they're in what we call a Second Notice or Delinquent Notice Status, we are sending them a monthly letter to encourage their payment and let them know the importance and the need to pay this in order to keep their Part D coverage. So those will continue, even though we're temporarily suspending the disenrollments. Ideally, people will start paying, come current, and stay current. And then they never get into the situation where they potentially lose their Part D coverage for non-payment of IRMAA.

A couple other notes I did want to talk about. I know Tim mentioned about the 5-Star SEP. This is a reminder that if you have five stars in 2012 but are losing five stars in 2013, that the last day that you can accept enrollments and market under the 5-Star SEP opportunity is November 30th. And that's because the enrollments you would receive as of November 30th, the effective date would be December 1st. And that's the last month in which you would have a 5-star rating for the year.

Now vice versa, if you're not a 5-star Plan currently and are getting five stars in 2013, the first day you'll be allowed to market under this opportunity and accept enrollments is December 8th, the day after the end of the AEP. And that's because those enrollments have an effective date of January 1st, and that's the first month you have the 5-star rating for the year.

The last item I did want to just touch on is we did put out a draft Guidance for Cost Plans, and we want to thank everyone for their comments. The comments did close last Friday, and we are reviewing them and doing everything we can to get those updated as quickly as possible. A couple quick notes, we have updated our website again. We updated things yesterday. But we understand that this is very late and that a lot of Plans – Cost Plans specifically – like to coordinate and do their enrollment activities at the same time during the AEP because that's when everyone else is having enrollments. So we do realize the potential that this has for their marketing materials, the enrollment forms, and things of that nature.

So we've left the draft Cost Plan Guidance up on the web. And the Cost Plans that have already started developing their materials, they can continue to use the 2012 enrollment materials – meaning the Enrollment Form, the Confirmation Notice, those items – not disenrollments and things that aren't going to happen until 2013 anyway – just the initial enrollment materials. Or if they have submitted their enrollment materials to their Regional Office for marketing review, those can go ahead and go through the process. We're not going to tell Cost Plans to stop printing, trash everything you've done, wait and do it again in like a month.

What we do ask is that you just double check – take a look at what we have on the draft guide and double check and make sure that you indicate that you have to have Part B in order to be enrolled

in a Cost Plan and that it doesn't have Medicare Advantage Rules – meaning you have to have both A and B. So we just want to make sure that the information on there is accurate. So hopefully that will help provide some additional flexibilities in this transition. But again, we are working on reviewing the comments and finalizing the Guidance to get that out as quickly as possible.