

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Debby Higgins
February 2, 2016
2:30 p m. ET

Operator: This is conference # 95159201

Operator: Good afternoon. My name is (Suzanne) and I will be your conference operator today. At this time, I would like to welcome everyone to the National Training Program Monthly Update Webinar Conference Call.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Debby Higgins, you may begin your conference.

Debby Higgins: Thanks, (Suzanne). Hello, everybody and thanks for joining us today. We're going to have three topics today. And I want to apologize because we changed the agenda a little bit. We will not be talking about Form 1095 today. We talk about that next month.

So we will have (Simone Knowles). He's going to talk to us about the Accountable Health Communities. (John Albert) will talk about the Initial Enrollment Questionnaire. And (Melissa Moreno) will provide an update on Medicare Advantage Plan's Voluntary Disenrollment.

Today's call is going to be muted during the presentation. After the presentations you're going to have an opportunity for questions and answers.

And I'll tell you how you can send your questions regarding the accountable health community.

And then (Suzanne's) going to give you instructions on how you can ask your questions. Or if you have questions during the presentations, feel free to use the question via the Q&A chat box located on the left hand side of your screen.

The materials for today's call are available and are listed in the box located on the left side of your screen. And to download the file, just click on the name of the file. Click to save to my computer and then a new window may appear and you can download those.

I'm going to remind you that the call's intended as an informational call for partners. It's not intended for press purposes and it's not on the records. So if you're a member of the press, please email our press office at press@CMS.HHS.gov.

This is CMS National Training Program Webinar provides basic information on the marketplace and Medicare program. You should always consult the relevant statutes, regulations and rulings for the official legal guidance. And with that, I'm going to turn the call over to (Simione). (Simione)?

(Simone Knowles): Thank you, Debby. I want to thank everyone for tuning in to hear about the Accountable Health Communities Model. My name is (Simone Knowles). And I'm in the Preventive and Population Health Care Models Group here at the Innovation Center.

And I'm really excited to talk to you briefly about the Accountable Health Communities Model. This been a model that I've worked on over the past year. And I'm so excited to hear about everyone's interest and excitement about this model.

Next slide please. And – well, excuse the formatting. So, you know, CMS's aim centered around providing better care, smarter spending and encouraging or improving the health of people. So to help your people – help your people aim.

And we believe that the Accountable Health Communities Model accomplishes all three of these aims by connecting beneficiaries to needed services that address their health-related social needs. If you can go to the next slide please.

Next slide. So we're going to start this – we're going to start this with some major milestones and dates for you to keep in the back of your mind. So the funding opportunity announcement for this model was posted on January 5th. Letters of intent are due next week, February 8th. They are highly encouraged, but they are not required in order for you to apply for the model.

Electronic corporate agreement applications are due March 31st. That's 1 PM Eastern Time. And we are anticipating issuing notices of awards in December 2016, December of this year. And the anticipated start date for these cooperative agreement are going to be January of 2017. Next slide please.

So many of – as many of you on the call know, many of the largest drivers of health care costs fall outside the Critical Care environment. And, you know, we've all seen that sort of paradigm about, you know, 20 percent to 30 percent are affected by the clinical environment. Whereas 30 percent to 40 percent may be affected by one social and economic environment.

And so this model really attempts to get at, sort of, the other, sort of, factors that are felt – affect the individual's health or affect the beneficiary's health. And (this) this emerging evidence of addressing what we're calling in this model the health-related social needs will impact health care utilization and costs.

So this model attempts to do that by connecting the beneficiary to needed services at the point of clinical care. So the AC model seeks to address this critical gap between the health care delivery – the health care delivery system and the system that provides community services. Next slide please.

So what does the Accountable Health Communities Model test? The AHC Model, the five-year model the test (what the) systematically identifying and addressing the health-related social needs of community-dwelling Medicare

and Medicaid beneficiaries impacts health care utilization and cost. Next slide please.

There's – there are going to be five core health care need – five core health-related social needs that are going to be addressed. Those are housing instability utility needs, food and security and interpersonal violence and transportation. Recognizing that communities may also have some sort of community-specific need that they deem important in allowing for that flexibility were also allowing communities to address other needs such as families and social support, education, employment and income and health behaviors. Next slide please.

Key innovations in this model includes systematic screening of all Medicare and Medicaid beneficiaries. Those (have been) beneficiaries who are community-dwelling. And the purpose of that screening is to identify whether there're any unmet health-related social needs.

This model will test the effectiveness of providing referrals to those beneficiaries so that they can go out and access those services on their own. It will also test the effectiveness of providing community service navigation services to high-risk beneficiaries. Because recognizing that there are some people who need just a little bit of extra of help in sort of navigating the, you know, all the services that are available to them. And both of those will be evaluated using a mixed methods approach.

There's also going to be a component of this model that focuses on aligning community partners. And that's sort of a community level intervention coupled with an individual level intervention to address the beneficiary's needs. If you go to the next two slides, we're going to go into the model structure.

And so the AHC Model will fund awardees. We're calling them bridge organizations to serve as hubs. And these hubs will be responsible for coordinating the efforts in the community. The bridge organizations will be responsible for identifying and partnering with clinical delivery sites. And

we'll go in a bit – into a bit more about, you know, what constitutes a clinical delivery site.

They're also responsible for conducting systematic health-related social needs screening and making referrals to providers. We call them community service providers that are able to address the needs that are identified. They're also responsible for coordinating and connecting community dwelling beneficiaries who have (help really) the social need with those community service providers. And also align model partners.

And we'll go into more in depth about what constitutes (to) model partner. Help optimize the community's capacity to address health-related social needs. Next slide.

So the Accountable Health Communities Model are organized into three tracks. And each track has a particular – we're testing a particular hypothesis or invention. Track one is the awareness track where we will test increasing the beneficiary awareness of available community services through information dissemination and referral.

Track two is assistance where we're providing community service navigation services to this beneficiaries with accessing services. And track three is the alignment intervention where we're encouraging this partner alignment that we talked about to ensure that community services are available and responsive to the needs of beneficiaries. Next slide please.

Key metrics in the model. And they were – they'll be a number but the sort of the key metrics for this model are going to be – we're going to understand how providing these interventions impacts health care utilization. And that includes a whole host of services. But in particular, emergency department visits, inpatient admissions, re-admission and utilization of outpatient services.

We're also going to be taking a look at total cost of care. Not – and, you know, that will – that will be specifically total cost of health care services. But to the extent that we are able to get information about other services that the beneficiary accesses.

Then we will – we will be able to, you know, develop a clearer picture of the total cost of care for that beneficiary. We're also going to be looking at provider and beneficiary experience. Next two slides please.

So next we were looking at model requirements. So when we talk about model participants, we're talking about first that bridge organization which again is the hub. We're talking about at least one state Medicaid agency. And we'll talk a bit more about why that's – why the state Medicaid agency participation is important.

We're also talking about community service providers (that) have capacity to address those core health-related social needs. And again, supplemental helpfully is social needs as, you know, they're selected by the award recipient. As well as clinical delivery sites.

And here is where it's going to be key. So in order to make sure that we have, you know, (is a) comprehensive access to services, we're requiring in the funding opportunity announcement that when you proposed clinical delivery sites that it – that at least one – that there are at least one type of clinical delivery site represented. That means that there – you know, the entities that you proposed, at least one of them has to meet the definition of a hospital as, you know, defined in the FOA.

Has to be a provider of health – of primary care services. And has to be a provider of behavioral health services. Next slide please.

So bridge organizations are model participant requirements. Bridge organizations have to collaborate with (model) participants to develop the application proposals, to identify existing community resources, to design and implement the intervention in a way that makes them that they – that the believable it would be successful. Provide a streamlined navigation process and develop (gap) analysis and action plans that promote synergy.

As you can see, depending on the track that an award recipient is awarded the fund for, they are sort of different levels of engagement with the community as well as with beneficiaries. The state Medicaid – next slide please.

The state Medicaid agency is required as a consortium member. And they must dedicate staff time to activities related to the model. And the purpose of this consortium – the purpose of this partnership with the state Medicaid (in the seem) the form of a consortium is to support data collection and reporting needs, sustainability planning, an annual intervention review, participation in the advisory board and I'll track three. And a review of the AHC intervention and a letter of support.

In order to screen for health-related social needs, bridge organization will have to use a standardized screening tool across all tracks. They have to determine the appropriate way to administer that tool. And there will be some (TA) provided to them in order to determine – to make that determination.

And they have to systematically submit all information received through that tool. And make – make that tool available to all beneficiaries regardless of language, literacy level or disability status. Next slide.

Bridge organizations will also have to create a community resource inventory. And this inventory lists or contains a list of all committee services and community service providers that are able to address the health-related social needs that they are screening tool will identify. They also require to update this inventory. Next slide please.

I'm going to go a little bit faster because I realize we're behind time.

Debby Higgins: Sure thing. Yes. But you can – you got some time.

(Simone Knowles): OK. Thank you. And so one component of the – of the AHC Model is going to be the learning system. And the learning system will support shared learning and continuous quality improvement between the bridge organizations, between other model participants as well as CMS.

And it will facilitate the movement of timely and accurate information to allow bridge organizations to share promising practices and learn from their peers. And this learning system will be supported by our implementation and monitoring and learning system contractor. Next slide please.

The bridge organizations and their model partners will work with the learning system to create driver diagrams. Which is one other requirements of the implementation plan. Provide data and feedback to CMS at regular intervals. Align data-driven decisions with successful outcomes.

Participant in learning system events. And these maybe in personal or virtual. As well as engage state – and state Medicaid agencies is necessary to achieve model goals. Next two slides we'll go into the eligibility criteria as defined in the FOA.

So we made this pretty broad. Eligible applicants include community-based organizations, individual and group provider practices. The hospital and health systems (is just of) higher education local government entities, tribal organization. And applicants can come from all 50 states, U.S. territories and D.C.

Again, we made it pretty broad because we recognize that it will take a, you know, a confluence of entities working in partnership to address these health related social needs. And that that may not – and the best sort of lead organization isn't necessarily a health care entity. There may be others in the community with the connections to the community and the beneficiaries who might do just as good a job. If not, better.

Also for – if you have any questions about the (corporate of) agreement, we're going to ask that you direct them to our email address. So accountablehealthcommunities@CMS.HSS.gov. (And then) we will be posting FAQs on a weekly basis.

So even if you – so if you ask a question, you will not – you won't receive an individualized answer. But you should check the FAQs every week because they are updated on a weekly basis to see what the response to your question is. Next slide please.

Important updates can be found on our website. And if you go to innovation center's website and look for Accountable Health Committee Model. Or you can click the link as you see it in front of you.

For assistance with your application or issues with grants.gov, you can go to grants.gov directly and contact support@grant.grants.gov or dial the 1800 number. Thank you very much.

Debby Higgins: Thank you so much, (Simone). I appreciated it. As (Simone) mentioned, you can send your questions if you have any to accountablehealthcommunities, one word, @CMS.HHS.gov. He's not going to be able to answer questions today.

Some of you have written that in. So if you can redirect those questions to the email address I just mentioned, accountablehealthcommunities@CMS.HHS.gov, you can hear back from them directly. Thanks so much for your time.

And now we're going to turn it over to (John Albert). He's going to talk to us about initial enrollment questionnaire. Give us a second while we shift and then (back).

(John Albert): Hi there. Good afternoon, everyone. My name is (John Albert). I'm with the division of Medicare Secondary Payer Policy and Operation. And I wanted to – I was invented to talk a little bit about the discontinuation of the initial enrollment questionnaire process which right now goes out through the welcome package that the Medicare beneficiaries receive.

The IEQ is a tool that's been around for a long time that basically allows beneficiaries to provide basic information regarding other coverages that maybe primary to Medicare. Be it group health plan coverages as well as in non-group health plan meeting, workers comp liability or no-fault insurance.

The IEQ is one of the many tools that in the past the Benefits Coordination Recovery Center used to gather other payer data. It used to be known as the Coordination of Benefits Contractor. But again, we have reorganized some of his processes. And again BCRC is the new acronym.

The reason for the discontinuation of the IEQ was because of legislation. And it's in accordance with the Medicare Access and CHIP Reauthorization Act of

2015, otherwise known as MACRA. It repealed this they refer to as duplicative secondary payer provision. It also ends, for those that are familiar with it, the IRS associated CMS data match project which is used to gather (any) similar information directly from employers as a result of data match that we did with SSA and IRS.

As of January 1, 2016, request for completion of the IEQ were no longer included in Medicare's initial enrollment package. The web portal is still available on the MyMedicare.gov site. It's still there to take in data from anyone who received the welcome package prior to January 1, 2016. And as we like to say also that anytime a beneficiary needs to report information to CMS, they can report to the Benefit Coordination Recovery Center that information. So that process hasn't gone away at all.

In terms of like sort of the why, although it's a piece of legislation. CMS has been collecting out for a number years since 2007 insurer data that basically is the same data that a beneficiary and employer (want) to report to us. There are mandatory insurer reporting provisions. In Section 111 of the Medicare Medicaid SCHIP Extension Act, these were implemented almost immediately for group health plan coverage and then gradually over the next couple years for workers comp liability no (thought) reporting.

Historically insurer data has always been the most accurate data that we've received. Also the thing about the Section 111 data is that it's updated and reported regularly. IEQ is a one-time only process that occurs, again, right before the beneficiary enrolls on Medicare when they first enroll in Medicare.

And it's never updated by the time (for shay) whereas the insurers report this data to us on a regular basis. And they also update the information, provide new information, new coverages, et cetera, for any time there is a Medicare secondary payer situation. So basically the insurer process which is current and ongoing made the IEQ and the IRS SSA CMS data match a redundant process. In fact, within our systems, we have hierarchies of data of which the IEQ is at the bottom of the hierarchy.

And also because people know about the Section 111 reporting through insurers, basically asking for this information from employers and beneficiaries and others, they learned about this process that, "Hey, I have already given that information to my insurer." And they've reported it to CMS. So therefore, the participation rate for both the IEQ and the IRS data match questionnaire process that employers received has (filled) quite a bit. So the participation is down to probably about 20 percent.

Also just wanted to note that we have – as part of this process, we've, you know, gone out to all the different sites within CMS. Which was why this probably came up and basically told them to start removing reference to the IEQ through the Medicare.gov. So it will be in our gov pages.

The initial enrollment package also has removed that information (want to hear) Medicare knows about this, et cetera. Again, I guess just to lay the theories or questions that have come up in the past is that the – people are saying, "Well, how do you get this information?" Or, "Why are you no longer doing this?"

Well, again, straightforward, it is a change in the legislation. But also just be aware that we are getting this data through the Section 111 process. And as I mentioned earlier, the historical reliability of the beneficiary data was at the bottom of the barrel so to speak. And that we had a hierarchy design that Section 111 record came in, it would overlay anything a beneficiary and/or an employer had reported in the past.

Another thing to consider also is that the IEQ is purely a voluntary process. There's no requirement to do it. Whereas the Section 111 process is mandatory on insurers. And if they don't report it, they're subject to a possible CMP that's pretty strict. So compliance has been very good and Medicare secondary payer savings has increased quite dramatically since Section 111 went into effect reflecting that we're getting probably three times as much data as we were prior to the passage of the Section 111 legislation.

Other than that, I don't really have much else to offer except that, you know, again, we've, you know, we've removed or will be removing references to the process. Again, beneficiaries are not receiving this as part of the welcome package anymore. But there are still some beneficiaries that may have received a welcome package and can still go in until July 1st of this year and still complete the IEQ. Again, if they have questions as part of that welcome package related to (COB) they can contact the Benefit Coordination Recovery Center for additional information to report additional information.

We would also encourage anyone out there who knows about this process to encourage both beneficiaries and employers to keep their insurance up to date with their current MSP data. Because again the insurer is only as good of the information it receives. So they need to know about an MSP situation and then they can report it to CMS to the Section 111 process.

And I know that insurers have done a lot of work to encourage that reporting of data to them. Because again, they have a legal mandate (count) to report that information in all cases. So that's all I had.

Debby Higgins: (Right). (John), I'm going to open it up for questions. And (Suzanne), if you can open it up for questions. And while we wait, I'll give you a couple that (we) came in on chat.

(John Albert): OK.

Operator: And just a reminder for those on the telephone lines, if you would like to ask the question, simply press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Debby Higgins: The question is, "How do you gather information on any other insurance a Medicare consumer may have if the IEQ is going away?"

(John Albert): Well, again, the – we have lots of processes in place. The primary one again is the mandatory insurer reporting process, otherwise known as Section 111. Which requires all group health plan as well as workers comp no-fault and liability insurers to identify MSP situations to us on a quarterly or more frequent basis. As well as provide updated information as well.

So like for example the IEQ, someone may be working and have group health plan coverage and they would have report that to us. But that's it. Under the Section 111 process, the insurers will report that upon the person becoming a Medicare beneficiary (or) age 65 on most cases.

But they will also update that information when that record needed to be terminated. So not only are we making sure that Medicare doesn't make mistake in primary payments, but also helps private industry from also making their own mistake in primary payments because they get access to Medicare entitlement data as well. So it works to basically ensure that both we and private insurance pay correctly the first time and avoid the more cumbersome recovery process.

Debby Higgins: I have a questions (inaudible)...

(John Albert): Do we have a question in the room?

Female: Yes. So my understanding (inaudible) have to do with Medicare secondary payers. So it's a coordination effort to (this) quality and accuracy and payment. (Right?)

(John Albert): Yes. In pay or order. So identify insurance that would pay primary to Medicare.

Female: OK. So I guess what I'm thinking about is the questionnaire in terms of things that wouldn't be related to Medicare secondary payers such as things that would add (inaudible) identified related to Part D for, you know, people who have creditable coverage maybe during the (VA) or some other form. And that would have been on the questionnaire perhaps, but it doesn't really relate towards ordination of payment such as...

(Crosstalk)

(John Albert): Well, it does. I mean, we do collect MS – Medicare secondary payer data would include prescription drug coverage information as well. And we also collect that through Section 111. The problem with the reporting

requirements is that there are no mandatory requirements related to Part D coordination.

But we've always included that information on any of our questionnaire type of processes that we have and it's included in the Section 111 process. The only incentive that we have really is that in the terms of the insurer's reporting data to us, they're very interested to learn about people who they may not realize have Medicare and they're paying primary for. So to incentivize them, if they agree to report prescription drug coverage information, we'll give them access to Medicare entitlement data on their enrollee.

Because in many cases, one mentioned before, about paying right the – you know, the first time, especially for beneficiaries who are under 65, their insurance is (out so) they were paying primary and the person is also getting a primary payment for Medicare as well. They have no idea about that. So we give them access to Medicare entitlement data so they know also on their end that they shouldn't be paying primary where in fact the beneficiaries – Medicare coverage is primary.

So that's kind of a way to incentivize, getting the insurers (know the) people that we do various date – we have like a voluntary data share agreement process with large employers as well. It's a way to incentivize them to give us that prescription drug coverage. Because if they don't give us the drug coverage, we will not share any party enrollment data with them.

Female: That's the incentive, I was just wondering (inaudible) as far as it relates to Part D. Thank you.

(John Albert): Yes.

Operator: We do have one audio question.

Debby Higgins: OK. One more question and we'll go to (you two van). What happens...

(Crosstalk)

Debby Higgins: What happens when an insurer sends incorrect information?

(John Albert): Well, if they send incorrect information, I mean, we won't know that it's incorrect until they tell us that's incorrect. Basically what usually happens is if someone sends MSP data to us and we (build) a record of other coverage on our system, and that person goes to procure (our) services, Medicare will not accept primary payment responsibility. Which then usually triggers a telephone call to the Benefit Coordination and Recovery Center.

You know, that's going to happen all the time. Whether or not it was Section 111 or not. I mean, we get incorrect data all the time. The main thing is just trying to correct as quickly as possible.

And one of the reasons we prefer the Section 111 process as well as I've mentioned some voluntary data share process that allows people to update information electronically on a regular basis. There are some basic portal processes that allow real-time updates on a one – case-by-case basis as well as quarterly or monthly file exchanges.

But basically, if someone submits a record of incorrect coverage or again with the most common thing is, is somebody has coverage and it terminates but we don't know about it yet, we deny a claim. They tell us, "Hey, I retired yesterday and my group health plan is now secondary to Medicare." That's how we – that's where most of the, you know – most of the situations where a record becomes incorrect is because we didn't get a timely update.

But again, that process is updated. Providers are asked to re-submit the claims. Then we pay primary, you know, based on that updated information. And we're done. And it's pretty routine, because again there's always going to be some sort of a lag time between when we get the record and someone being a doctor's office or whatever, a provider following a claim.

Debby Higgins: Hey, (Suzanne), we can take a question.

Operator: Great. Your question comes from the line of Michael Klug of the SMP Resource Center. Your line is open.

Michael Klug: Thank you. (John), I'm wondering if your planning at all to revisit the requirement that provides ask about primary insurance is part of this effort to,

you know, move more to Section 111 reporting and reliance on that kind of information. Or are you looking at that at all?

(Crosstalk)

(John Albert): Well, providers are required – they are required to ask upon admission about other coverages.

Michael Klug: OK.

(Crosstalk)

Michael Klug:...physician offices and things like that. Yes, they are required. And I was just wondering if you're revisiting that or looking at it in the light of the effectiveness you described with the Section 111 reporting. Any possible changes that they are looking at provider requirements?

(John Albert): We haven't looked at them because, again, provider is right (appoint) of service so that's often times how we will learn about another coverage. Again, if, you know, some of the processes – I mean, we don't want to put all our eggs in one basket necessarily. But again, it's a good way to learn about the need to change our record now versus later.

Again, it's a lot easier and less expensive for (all involved) to pay it correctly the first time than have to go back and, you know, either do provider adjustments. Or in the case of Medicare, secondary payer, you know, doing recovery actions. Things like that. So, yes, that – I – you know, I don't see any – like, it does not going to change as far as I know. So...

Michael Klug: OK. Good. Thank you.

Debby Higgins: I mean, I don't – I don't control that process, but, yes. I mean, the provider process has always been kind of ingrained and, you know, that – you're suppose – I mean, providers are obligated under MSP statute to bill correctly. And part of that is asking what coverage do you have. So that's covered on the statute.

Debby Higgins: Did that answer your question, Mike?

Michael Klug: Yes. Thank you.

(John Albert): Yes.

Debby Higgins: Welcome. Next question.

Operator: There are no questions queued at this time. But again, it is star then the number one on your telephone keypad if you would like to ask a question. Your next question comes from the line of (Sheryl Knaff) of – go ahead, your line is open.

Go ahead, (Sheryl), your line is open. You may be on mute.

(Sheryl Knaff): Oh, yes. Sorry about that. My question is related to Chapter 14 which currently does reference the other coverage question that's on the application. That if a member does indicate that we need to reach out to them if we haven't received the (COBC) file from MS. So just curious, is that guidance going to be updated to remove that?

(John Albert): The CO – I'm sorry, I'm not familiar with what that. Is that...

Debby Higgins: Chapter 14.

(Sheryl Knaff): Chapter 14 is about the other pharmacies COB data received from CMS in the daily COB marks file.

(John Albert): OK. I mean, you still receive that information.

(Sheryl Knaff): Right. So we're required to verify that, at least annually. But then CMS added another requirement after that. Where if the member indicated on their Medicare application in that one section that they do have other coverage and if we don't receive the COB data from CMS with the other coverage information, then we need to reach out the member to see if they do have creditable coverage or if they were just confused. So I was just curious...

(Crosstalk)

(John Albert): So their – so their instructions that say that you – so you receive like a preliminary file when somebody enrolls in Medicare and if – I mean, the data that – I mean, often – I mean, the data – the COB files are basically daily files that go out to the plans via marks. Then as soon as...

(Sheryl Knaff): Correct.

(John Albert): And as soon any information comes in that, we receive whether it was – you know, again, IEQ or – I mean, IEQ wasn't necessary the first data we received because again a lot of beneficiaries don't even fill it out. We get it from the insurer through the Section 111. So you would receive it as soon as we have it.

I can't speak to Part D requirements. I assume you're talking about the requirement that, you know, you know or about other coverages or, you know, visit the process that the Part D plans can submit called (aces) which is the electronic query process – or not a query process but a – kind of an electronic process to send correspondence to the Benefit Coordination Recovery Center to investigate possible other coverage information. I'm just not familiar...

(Crosstalk)

(Sheryl Knaff): Right. And may...

(John Albert):...(talking) about.

(Sheryl Knaff): Yes, maybe I'm confused. Is the IEQ questionnaire, is that different from the Medicare application?

(John Albert): Yes. That is. Yes.

(Sheryl Knaff): OK. Then I take back my question so never mind. Thank you.

(John Albert): OK. All right. OK. Yes, it's a totally – it's – the IEQ again was – it's a secure portal site that people are told access through MyMedicare.gov to complete basic other coverage information. But that's not the same as the application process (now). The application for Medicare.

(Sheryl Knaff): Thank you.

Operator: And there are no further audio questions.

Debby Higgins: OK.

(John Albert): Isn't...

Debby Higgins: We have a quite – we have a chat question.

(John Albert): What is Internal Revenue Service doing to calculate Medicare and Medicaid overpayments (steps)?

Debby Higgins: I'm sorry.

(John Albert): Oops. That...

(Crosstalk)

(John Albert): I'm not sure what that – it's not – it's not going to do it but the IRS do (matches). I think they're talking about the hub.

Debby Higgins: Yes, I don't know. If you know what is – if you have additional questions that we haven't answered, please send them to training@CMS.HHS.gov and we will work with (John) to get them answered for you. Again...

(Crosstalk)

(John Albert): Yes. The stuff about the – you know, the IRS SSA data match has nothing to do with (ACA) or any of those processes. That's in a – that was in existence back in 1990. It's only for developing, for group health plan coverage. I imagine that people are discussing issues surrounding the hub and the data that it receives from IRS. That's a (sio) issue.

Debby Higgins: OK. Well. thank you for your time. And if anybody have any questions, again, send them to our training mailbox and we will forward them to you and we will get them (respond). Thank you so much.

And we're going to get (Melissa) situated for her presentation on the Medicare Advantage Plans Voluntary y Disenrollment. Give me a second. Hey, (Melissa), are you ready?

(Melissa Moreno):I'm ready.

Debby Higgins: Thank you.

(Melissa Moreno):Hey, everyone. This is (Melissa Moreno) with the division of training. So what we're just going to quickly go over now is more or less probably a reminder for most of you just to be aware of. At this point of the year, now that we passed the Medicare open enrollment period and people have begun, most of them, their coverage, there is another time that we are in right now. But we are quickly approaching the end of it which is allowance for folks who are in Medicare Advantage Plans to change their mind essentially and have what's called the voluntary disenrollment.

So January 1st through February 14th, this is the particular time where if someone is enrolled in a Medicare Advantage Plan and let's say they've decided that this was a mistake or whatever the reason may be, they decide that this is not going to be the coverage that they would like for the remainder of the year. They are allowed to switch essentially back to coverage through original Medicare which is our fee-for-service.

And it's just more narrow. We don't particularly call this any – by any name. We're just aware that it does occur. It is very specific and focused on folks with Medicare Advantage.

So they are only allowed to make certain actions. They cannot switch for example from one Medicare Advantage Plan to another Medicare Advantage Plan. This is really for those folks who just don't want this type of coverage, it's not going to work right for them.

And simultaneously, when they are choosing to go back to coverage through original Medicare, they also have the opportunity at that same time to go ahead and see what Part D plans are available. So that they can get coverage

for their Medicare prescription drugs and go ahead and select a plan and enroll in a plan. In that way, they have total coverage.

Now, this is going to be a process where once they make their decision during this timeframe, their coverage would begin the first day of the month after they've submitted their application. And we like to remind you that it's important for those who are transitioning back to original Medicare that they think about their total coverage options which may also include coverage through a Medicare Supplement Insurance Policy or a Medigap Policy.

And during this particular time, they're going to have in some cases access to a particular trial (rate) which means that they could have a guaranteed issue (right) for a Medigap Policy. So if we have a group of folks who, let's say, they join the Medicare Advantage Plan for the very first time or when they were first eligible at age 65 and they left or left original Medicare and they dropped a Medigap Plan so that they can enroll in a Medicare Advantage Plan. And they've tried it and it's been less than 12 months that they've been enrolled in that Advantage Plan, then they can go ahead and switch back to original Medicare and have a guaranteed issue (right) to Medigap.

Now, why is that important? Because if they don't have a guaranteed issue (right), then they may be subject to some underwriting as far as the plan that they're looking at may be able to ask them about their prior or current health conditions. And as a result of those questions, they could carve out coverage for certain conditions that they have for a period of time. They could raise their rates potentially. So, you know, we want to make sure that they're aware of these special Medigap (right) if they are thinking about switching back to original Medicare.

In addition I thought I just kind of remind you that there's always that gray situations. It's not always black and white. So course, you know, we always like to remember that the exception would also be for those who – if they pass the February 14th timeframe to leave a Medicare Advantage Plan, they could possibly go ahead and make a change and switch to a different Medicare Advantage Plan by using a five star special enrollment period.

So if they go beyond the date and they are thinking that they might need to change, they can take a look at the five-star quality rated plans. And they can check on the Medicare Plan Finder. See what is available in their area. And they can go ahead and submit their application to make that change one time until (the fall). And of course that would also have their coverage beginning the first day of the month after they're enrolled.

We've included just some resources here for you to go ahead and take a look at. The enrollment periods that would pertain to, you know, of course the enrollment period and time periods that people can switch to five star special enrollment periods. You know, any type of special enrollment period in addition to this time that they have to disenroll voluntarily from Medicare Advantage Plan.

The Medicare & You Handbook, a guide for Medicare Supplement Insurance, these are different publications. Of course we also put up the phone number for the access and contact information for the State Health Insurance Assistance Programs or (CHIP) counselors. And the Managed Care Manual which that link takes you directly to the regulation and guidance as far as how these types of changes work and what the criteria are. And it gives you all the particulars and breakdowns according to CMS rules. And you have contact information of course for CMS Social Security and the Railroad Retirement Board.

And I know we've mentioned, of course, if you have questions about some of these presentations, that you can send us questions. And I think we had some links for – some mailboxes for some people.

(Crosstalk)

(Melissa Moreno): And then, are we going to have them all sent to our training mailbox?

Debby Higgins: No, we could ask if you have questions regarding the Accountable Health Communities to send them directly to their mailbox.

(Melissa Moreno): OK.

Debby Higgins: At accountablehealthcommunities@CMS.HHS.gov. But if you have questions for (John) regarding Initial Enrollment Questionnaire or anything else, you can send them to our training mailbox.

(Melissa Moreno):OK.

Debby Higgins: And so here's the link for that training@CMS.HHS.gov. And link to our LISTSERV for our future training. And (Suzanne), yes, any questions for (Melissa)?

Operator: Yes, we have (Sheryl Bapell) of the (WellCare) Health Plan. Your line is open.

(Melissa Moreno):Hello.

(Sheryl Bapell): Hi. Yes, I just wanted to verify is someone wants to take advantage of the (sub store election), do we have to go to 1800 Medicare? Or can plans use an (STP) to put someone in their plan with that?

(Melissa Moreno):A plan that has a five star quality rating can take those enrollments directly and submit that (STP) designation when they submit their enrollment requests to CMS.

(Sheryl Bapell): OK. Thank you. We get a lot of questions about that from the field. And just wanted to make sure we were answering those correctly. Thank you.

(Melissa Moreno):You're welcome.

Operator: And your next question comes from the line of (Christina Adams) Florida Department of Health. Your line is...

(Christina Adams): Yes. Good afternoon. I just wanted to clarify something because I heard you a little while ago stating something about if the client doesn't (stayed) or changing in between the Medigap. Their prices can be (right) because of pre-existing conditions. Isn't that Affordable Care Act supposedly to prevent that and nobody can get (the nine) coverage or get higher coverage prices because of the pre-existing conditions?

(Melissa Moreno): That's a very very good question. And a lot of people have confusion about that. But actually changes that occurred as a result of the Affordable Care Act do not affect Medicare Supplement Insurance or Medigap Policies. So they still have their own rules.

You can't buy a Medigap Policy through the marketplace and so forth. And so this is separate from that. We don't want to kind of marry or mix the two. But yes, if they are thinking about leaving a Medicare Advantage Plan and they're in the right timeframe which is now to do it, they should think about strongly looking at the Medigap Policies that are available in their area. Make some comparisons about the time of coverage and what type of Medigap Plan that they're interested in.

And then if they meet the criteria as far as a trial (rate), meaning that they've had that Medicare Advantage Plan. They're trying one for the first time and they've had it for less than 12 months. Or they left original Medicare and dropped the Medigap Plan to try an Advantage Plan for the first time.

And now they're going back, they can get the special trial (rate) which means they're not going to be subjected to any of those pre-existing condition carve outs. They can't raise the rate, deny them coverage. They can't refuse to sell them a plan. But they just need to make sure that they are taking advantage of it.

(Melissa Moreno): OK. Thank you very much.

(Melissa Moreno): You're welcome.

Operator: And your next question comes from the line of (Jessica Hill). Your line is open. Go ahead Ms.(Hill). Your line maybe on mute.

(Jessica Hill): Hi. Sorry. The trial (rate) for Medigap, is it the first time at age 65 or the first time trying Medicare Advantage?

(Melissa Moreno): It can be both. If you are trying a Medicare Advantage Plan for the first time when you turn 65, so you went straight into an Advantage Plan and you never had original Medicare, coverage through original Medicare. But you have

that Medicare Advantage Plan coverage for less than 12 months, you get the trial (rate) because you were trying it. It was the trial period. That's a good way to remember it.

Or let's say you had coverage through original Medicare and at some point you left original Medicare and you had a Medigap Policy and you dropped it so that you could go try out an Advantage Plan for the first time. And again, you keep it for, that coverage, for less than 12 months and you decide it's not for you. You want to go back to original Medicare, that also would give you a guaranteed (issue right).

(Jessica Hill): OK. So if I'm a Medicare beneficiary due to being disabled for 24 consecutive months and I'm age 62 and trying Medicare Advantage Plan and don't like it, I would still have that option as a trial (rate).

(Melissa Moreno): Well, like I said, there's nothing ever black and white. So folks that have Medicare benefits through disability, unfortunately they have a lot more restrictions than it – again, it is unfortunate because, you know, if a Medicare Advantage Plan is going to agree to sell them a plan and they're under 65, that's great. But a lot of times they won't. Or they may have to pay more.

Or let's say they're in a particular state and some states have more rights, expanded rights, in a particular area than other state. So it's important that if someone with a disability is interested in a supplemental policy that they reach out to their State Department of Insurance and see what additional protections that they have for disabled folks who have Medicare – but let's say you do pick up a supplement plan before you're 65 which is unusual, but it can happen. Once you reach 65, then you would have the right to have your premiums at the 65 rate. If that's how your plan is (rated).

(Jessica Hill): Right. I guess I was asking if I'm 62 on Medicare and I choose the Medicare Advantage Plan. Do I still have that trial (rate) or do I have to be age 65 to have that trial (rate)?

(Melissa Moreno): It's really particularly to people who are age 65 but not always. It's just a gray area. You need to see what is available in your state. It can vary from state to

state. But generally overarching, it's going to be limited for folks with disability.

Operator: (OK.) Your next question comes from the line of (Mondeo Clark) from the (House of Representative) of the Virgin Islands. Go ahead, your line is open.

Male: OK. I'm actually (am see this) (Mondeo's) co-worker. I'm (glam with her). But my questions was I have a constituent that has a disability. They're (on) disability (put it that way) and being in the Virgin Islands we're not part of the Affordable Health Care Act.

And she said she's right now in Medicare waiting list which could be another like eight to nine months she said. What options do we have in the territories from somebody that doesn't, you know – I guess she did try to get a medical assistance card but when our Social Security (clicked in) kicked her off, she went over the threshold. So now she's not covered by any insurance until I guess Medicare kicks in. So I was wondering what – are there any options out there for somebody in that situation that you know of?

(Melissa Moreno): You know, I can't really speak to the Virgin Islands specifically. But I can guess, so to speak, the if they are in a lower income range of resource range, they might be able to get some assistance in whatever medical assistance programs you have that are there to catch people in those particular situations before they're ready for Medicare and can't have other insurance. But again, Virgin Islands is really niched out beyond my levels of expertise.

So again, I would contact the State Department of Insurance or whomever entity would regulate that sort of thing to see what protections are there. And also reach out to the (managing) office.

(Crosstalk)

Male: OK. Thank you.

(Melissa Moreno): You're welcome.

Operator: There are no audio questions at this time.

Debby Higgins: Well, thank you everybody. And I want to thank all our presenters today. Our next call is scheduled for March 1st. Thank you again for joining us.

Operator: And this thus concludes today's conference call, you may now disconnect.

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