

Centers for Medicare & Medicaid Services
First Friday Call
Clinician Outreach Meeting
Moderator: Jill Darling
Friday, May 4, 2018
1:30 p.m. ET

Operator: Good afternoon. My name is (Heidi) and I am your operator for today. At this time, I would like to welcome everyone to the First Friday Call Clinician Outreach Meeting.

All lines have been placed on mute to prevent any background noise. After the speakers' 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.

Dr. Gene Freund, you may begin your conference.

Eugene Freund: Hi, all, and welcome to today's meeting. We're a little bit late, so I just want to give the standard reminder that this is an informational only call and not for the press. Press are willing to listen – are welcome to listen in. However, reach out to our press contacts if you're looking for quotes or further information.

And that's all I have. First off on our real agenda is conversation about appeals and grievances and Medicare Advantage. And Catherine Rippey from our Office of Hearings and Inquiries, Commander (Timothy Lape) from our Chicago Regional Office and Ray Swisher also from that office and Marty Abeln from the Center for Medicare will each talk a little bit about different corners of that effort and then we'll open it up for questions after all of them have had the chance to talk.

So, go ahead, Catherine, if you wouldn't mind.

Catherine Rippey: OK. Great. And thanks a lot. Can you hear me?

Eugene Freund: Just fine.

Catherine Rippey: OK. Great. Thanks so much for putting this together, Gene. We really appreciate it. You had reached out to me as the Medicare beneficiary ombudsman to join you for the call today, which I'm happy to be a part of. But really, I'm going to tee it off and introduce our true experts in the areas of Medicare Advantage Plan Appeals and Grievances.

And so, I believe I'm going to kick it off by introducing Marty Abeln with Centers for Medicare and he is going to get us started in this discussion. Thank you.

Marty Abeln: Thank you, Catherine. And my name is Marty Abeln. I work in the Medicare Drug and Health Plan Contract Administration Group. It's kind of a mouthful. We call it MCAG. And specifically, within that group, I work in the division of plan policy as a policy analyst.

And I was asked to talk a little bit about some areas that I know from my experience we get lots of questions on. And these are areas around provider payment.

And what I found I would do at my having done this call before is sort of just give a quick outline of the – from my experience that I do a lot of interactions, which providers, physician groups, and so forth, and specifically in terms of their interactions with MA plans in terms of payment and non-contract payment and other topics too.

And what I thought I would do is just briefly cover some of what I would say are the hot topic areas and I'm going to (structure) a little bit and throw in a few things that maybe a little bit beyond payments but are areas where we got lots of questions on and we're – well, we're working on in some cases.

So, I'll just start off and right – again, I'm going to give a brief outline of the topic areas or overview and then I think we're able to certainly have some

things to add to what I say. Ray, who is working in the regional office, has a lot of direct experience and insight into what's going on with providers too.

And for my part, I hope to stimulate some questions because what we want to do is make sure we're giving you information that's useful that you want (than) I don't know this group real well, which I'm not exactly sure what level of detail or what specific kind of questions are sort of in your – are you most concerned about.

But I'll just do a quick overview on contract payment. And when we talk about MA plans, we may have a contract with the provider, payment – and I think (inaudible) you all know, but I'll just quickly say this and not spend a lot of time on it unless you want to ask questions, but the payment is based on the contract, right?

And we actually have a clause in the regulations, called the non-interference clause, which gives the MAOs the ability to choose the providers they contract with among qualified providers and then they also have the right in CMS, except for very limited circumstances, doesn't interfere with this. They have the non-contract provider and they get to negotiate their contracts.

We do require that the negotiated contracts have a prompt (pay provision) in them. But by and large, their contracts are a matter of negotiation. So, it's not unusual for us to get complaints from a contracted provider that I'm not getting paid or the plan is doing something that I – withholding payment or something in that regard.

By and large, we – it's difficult for us to intervene in that because, for one thing, we're not in a position where we could say we'll send this your contract and we'll have our Office of General Counsel review and interpret it for you.

You can imagine hundreds if not thousands of contracts out there that would be impossible for CMS to do. And it's a legal (document) anyway that if a provider or contracted provider and the MAO have a dispute and they can't resolve, it ultimately would end up in a court.

So, we generally don't get involved in contract disputes with that said. And in some cases, we've had contracted providers say that the plan is putting so many restrictions on and it's hard for them to (furnish) medical necessary tariff.

We think that beneficiary access to service is being jeopardized by some sort of difficulty between the plan and the contracted providers. Maybe the MAO is having financial problems. Maybe their – they have some restricted policies, making it difficult for the provider to furnish medically necessary appropriate services.

In those kind of scenarios where we (see) beneficiary requirements at risk or a potential, we definitely will talk to the MAO. So, while we don't intervene in every case, we are concerned if something is happening that represents a problem for beneficiaries.

Non-contract providers as a different topic, it's – in a way, it's easier because the regulation side of the MAO (would have paid) a non-contract provider is required to pay that provider the amount they would have received under regional Medicare rules. That's for (422214). And they're also subject to the prompt payment provisions at (10422520).

We have a document on our website that's called the MA payment guide for out of network payments. And that's – we maintain that. It hasn't been updated for a little while, but it's going to be updated shortly.

And it basically describes the payment methodologies for original Medicare users so that – what's supposed to happen is a non-contract providers furnishes a service they send in a claim to the MAO that if it's a clean claim it's supposed to be processed within 30 days. If it's not a clean claim, it's supposed to be processed or denied within 60.

But bottom line is if a non-contract provider sends in a claim to an MAO, if the MAO has to adjudicate it, if you will, within 60 days if the provider doesn't withdraw. That is to say if the MAO doesn't – if the provider doesn't withdraw, the MAO has to either pay it or deny it within 60 days.

Now, the advantage for the denial is – and obviously for non-contract provider gets paid, that's what you want. But if they don't get paid, then they get a denial. And then the non-contract provider has appeal rights.

They can either appeal – excuse me – they can either waive liability and – against the beneficiaries so they would say they're not going to pursue recovery against the beneficiary, but they're going to file an appeal under their own behalf with the MA plan and that appeal goes through the plan and then goes to an independent review entity that basically it follows CMS guidance, works as contracted with the government and these very objectives and determining whether something should have been covered.

So, non-contract providers can get appeal rights if they have a claim denied. And of course, the other option for them is just to build the beneficiary, which they could do. They could say I don't want to bother with your plan. I'm just going go with you. And then, presumably, the beneficiary would file an appeal. So, there are important protections if people follow the rules for non-contract providers.

Now, I'm going on – these are – I mean it's important to talk about it in the realm of contract to non-contract providers. And one related area is recoveries. So, we have gotten questions from providers complaining about it.

So, the MAO paid them at some point for some services out of network if they furnish to a (manual event) that come back six months later, let's say, and they're doing post payment reviews and then doing recovery, you know, saying that some of these claims were mistakenly paid and we want to recoup payments. So, that's an area where we've gotten questions and it's a scenario where we're paying close attention to and working on.

Another area that's been something of a hot topic is MA use of prior authorization rules within their network. And I'm not going to say a lot about this right now because it's not specifically on our agenda. I'll just say that MA plans can use prior authorization. But if they use prior authorization, it has to be disclosed of where evidence of coverage document and prior

authorization from CMS' perspective is considered an organizational determination.

So, if a provider – a contracted provider is required to get a prior authorization before they consent for this knee replacement or some particular service that becomes formally speaking an organizational determination subject to the timelines – timeframes that are in a regulation at 422566.

CMS is going to be issuing guidance and HPMS memo to MAOs sort of clarifying the rules around prior authorization and trying to encourage them to use best practices, reduce unnecessary burden for providers, do what they can to streamline the prior auth process, and to generally make sure that it works well and they adhere to the timelines that are in the regulations for prior authorization request.

So, that's really a quick overview. The other topic that comes up – and again, I – we've got enough to talk about this plan directed care and that is scenarios where all MA plan is obligated to cover a service when it's serviced by a contracted provider or when the contracted provider directs beneficiary to go out of network to a provider. So, contracted provider stands in the shoes of the plan is one way to think about it.

And if you go to a contracted provider, you're an MA enrollee, essentially the MA – that contracted provider represents the plan. And if he or she furthers as a service, the beneficiary is going to be held high risk.

Now, it's possible the MA plan might come back depending on what's in their contract and say, "Contracted provider, you shouldn't have furnished that service because it wasn't – it didn't meet criteria." And that would be a contract dispute, but the beneficiary would be held harmless in those scenarios.

So, I threw out a lot there fast. But I'm hoping it will generate some questions and we can focus in on what most of that concern is. So, that was a really quick overview of the few topics. I'll stop with that and turn it over to Dr. Freund.

Eugene Freund: Actually, let's open it up to see if there are any questions for Ms. Abeln.

Operator: Certainly. As a reminder, if you would like to ask a question, please press star then one on your telephone keypad. And we'll pause briefly to compile the Q&A roster.

Eugene Freund: I think we do have – we do have a question from Mr. Bill Finerfrock in the room. So, we can start with that.

Bill Finerfrock: OK. Hi, Marty.

Marty Abeln: Hi, Bill.

Bill Finerfrock: Bill Finerfrock, I haven't talked to you for ages.

Marty Abeln: Yes. I remember your name. I haven't talked to you in a (few months).

Bill Finerfrock: The – in terms of the non-contracted arrangement and you indicated that they could be paid under the rules. They would apply under traditional Medicare. So, in the case of a rural health clinic as an example, they would have to pay them based on their cost base rate?

Marty Abeln: I think that's right Bill. I have to – there's sort of judgment that's made for the – I mean you've looked at the non-contract payment guide, right?

Bill Finerfrock: I looked at it. I actually did find it relatively recently. I've never seen it before. So, I just wanted to – I think they have to provide them with a rate letter so that they know what rate to pay.

And I guess the question – so, the question was should they send them in or how would they indicate – because they're submitting it on a (UB) claim instead of a 1,500 that the plan would recognize that as a rural health clinic. Our concern is that they don't know that it's an RHC claim.

Marty Abeln: I can check on that. It's interesting because the non-contract payment guidance is shared by several components in CMS. I mean I worked on it that (inaudible) is (Shawn O'Grady) in MPPG, the payment group, who has the

lead for non-contract payment issues and so is (Bill Rendon) in the Office of the Actuary.

So, the RHC question does come up. So, what I could do, Bill, is I think I have your e-mail address (we must exchange). I could get you a specific answer on what you're just asking and send it to you.

Bill Finerfrock: And what about the co-insurance and those (except the) others that becomes confusing particularly when it relates to rural health clinic. Medicare says it's based on the allowable rather than on the RHC rate because the RHC rate is often going to be higher than what the allowable would be to how does; that get resolved.

So, again, maybe it's the same people, but how to know what's there to collect from the beneficiary ...

Marty Abeln: Well, they would always collect whatever the plan allows cost sharing, right? So, they (inaudible).

Bill Finerfrock: (Even) as a non-contracted – even as a non-contracted?

Marty Abeln: Yes. It's – if I'm in a PPO and I go out of network to get a particular service, whether it's RHC or anyone else, the non-contract provider is supposed to collect the plan allowed cost sharing, whatever that is.

And then the plan for their part is supposed to pay the difference up to what they would have – they pay them their regional Medicare payment rate. They would have received less the plan allowed cost sharing that they presumably collected from the beneficiary.

Bill Finerfrock: So, a lot of the PPOs, for example, might be a 70/30 split instead of an 80/20 ...

Marty Abeln: Absolutely. It could be ...

Bill Finerfrock: ... they would affect the higher amount and then they would get 70 percent of their RHC rate?

Marty Abeln: Exactly.

Bill Finerfrock: OK. That's what I thought and that's what we interpreted. It still gets confusing. We get people – when we get the plan, we don't seem to know what to do sometimes.

Marty Abeln: All right. I'll check and see and maybe we can beef up our guidance on RHCs and the payment guide too.

Bill Finerfrock: With questions about – on the benefit side, would you be appropriate for that because that's the other – one of the others that come up is that the plan will deny a claim for a service. This isn't necessarily an RHC but even a traditional Medicare. So, the plan will come back and say, "We're not going to pay for that."

And then they show them the documentations and say, "Wait a minute. This is a service that's covered by Medicare." And it was our understanding that the plans were to pay for all services covered by traditional Medicare and they're not honoring that in a number of different instances that have been brought to my attention.

Marty Abeln: Well, I mean, it – like I said earlier, if – assuming that this is a claim that's like – if we clean this example, someone on the PPO goes out of network and gets the service. The MA plan that PPO (really) is not required to get any kind of prior authorization or (work) clearance before getting an out of network service. They might be advised – well advised to do that just to be sure they can have it paid for but basically don't have to.

It's not that they can't – the PPO can't require that. If they go out of network, they get a service. The non-contract providers send the bill in. The PPO has to pay for that and then they collect the non-contract provider (close collects) whatever the out of network cost sharing is from the beneficiary.

And then the PPO has to pay the client as long it's medically necessary in a plan covered service. If it's not medical necessary, if it's not a plan covered service, the MAO could deny the claim within that – and the denial process

has to fit in just as I described within the 30 or 60-day timeframe. And if they deny it, then there is the appeals process that's going to be available to the non-contract provider.

So, in theory, if people follow the rules, then they – even if the provider doesn't get paid because presumably the only reason the plan will be denies is because it's not medically necessary or not covered, but that's something that could be appealed and would go into an independent review entity for a final determination.

Bill Finerfrock: One of the – an example that I've been given is that as you know very often a particular service will be covered and it will be linked to certain ICD 10 codes, right? And so, Medicare will say, "For these six codes, this is an appropriate – you bill the CPT code as appropriate."

The folks will bill it and then it will get rejected because the plan says, "Well, we don't recognize the same ICD 10 codes as Medicare. And therefore, that's non-appropriate service in the context." And sometimes, it may be a local coverage decision that they will share with them, and say, "Wait a minute. Here is what Medicare says – local contractors says we'll cover this service if this is the diagnosis." And the plan comes back and says, "Well, we don't care. We don't recognize that."

Marty Abeln: Yes. It's never good when people don't play nice in the sandbox together because our rules in theory should address this. There are sort of two issues there. And the first issue is that it's really clear that both the plan and the MAO should know the original Medicare pay for services. They're required to have that kind of knowledge.

So, they should know what the payment rate is. CMS is weary of getting involved in all of these things because we could get inundated trying to – especially if we got some – it could be a (thing if it) would be inundated trying to solve some of – answer some of these questions. But that said, it's – the rules are clear what MA plan is supposed to do and the rights of providers.

And yes, an MA plan is not living up to its end of the bargain to the extent that we can be informed about it and we would talk to the MA plan about it if

we – we want to these be worked out by, frankly, between the provider and the plan. And maybe part of the answer is that maybe we need to make our guidance clearer (about) the team it guides so that there's something to point to.

So, that's something we could look at because administratively if we say that every non-contract provider this has a dispute of some sort it can cause (immensely) – we continue (to inundate) with calls cost and we don't have the resources to answer hundreds of calls that we think might be generated and some of the calls might be less critical than others.

So, we're trying to set this up so it's going to be implemented by the parties with minimal need for CMS to intervene. Maybe the guy that could help is Dr. Freund.

Bill Finerfrock: Yes. That's what we have Gene for. We take this to Gene and then he fixes – he just wave his wand and ...

Eugene Freund: I don't. Of course, just (needling) me about how much power I don't have. But anyway, maybe this was the time to talk a little bit (of those) because I heard the conversation segue a little bit from sort of the payment rates and how providers in MA plans are paid to issues around what's covered.

And I think that some of our speakers were actually going to be talking a little bit more about sort of the appeal process there because I think that's kind of one of the areas that Bill was getting at.

Marty Abeln: Yes. I'm not an expert of the appeals process. So, it would be great if other folks can speak more (fully) for those questions.

Eugene Freund: And also we are – we have those conversations at the start of the Q&A queue. So, there might be people in the queue waiting to be recognized too. So, before we move on, I got to respect the fact that we opened up that door.

Operator: Thank you. We do have a question on the line from (Jen Galley) with (AA&P). Please go ahead.

(Jen Galley): I think my question was answered because I was going to ask is there any set up in the guidance anywhere that we can read this – all this things that you told us. And I think you said there was in your conversation that you just had. And I send this under the title that's on this.

Eugene Freund: Yes. It's actually in my direct e-mail box waiting for you to push them because there might be some other links that come up later in the call. So, thank you, (Jen), but that is a good reminder and I'll follow up on that before I leave the building. Any other questions before we move on to other speakers on this topic?

Operator: There are currently no further questions in the queue.

Eugene Freund: OK. So, Catherine, do you or Commander (Light) or Mr. Swisher want to talk a little bit more about the sort of appeals and how we work our way through those kinds of issues?

I think what I heard from Bill was essentially that sometimes the parameters plans might put around covering the service if the Medicare covered service might be different from what Medicare might cover around them and how does – how does one sort of get to that point where maybe this is the plan acting within their scope using the tools they can use and maybe a plan (drawing) not to cover things that Medicare is supposed to cover and (thus) the plans supposed to cover?

Raymond Swisher: OK. Do you want to turn it over to us then, Gene? This is Ray Swisher. I'm the – I don't think Marty knows this. I'm the newly appointed associate Regional Administrator in Chicago for health plans. I've been an account – I'm sorry – a branch manager for 13 years prior to that in Medicare Advantage.

So, Marty and I work closely together and a lot of provider issues. And with me, I have Commander Tim (Lape) who is a pharmacist by training but also an account manager here in our office. And we come from the provider side of things in the beginning of our careers. So, we definitely have compassion for a lot of the issues that do come our way.

One of the things that we really try to encourage providers to do is to establish a relation with the plan and go to the plan first when they are having a dispute of any kind, whether contracted or non-contracted to always start with the provider representative. I am not naïve and I have to think that every time you go that route that you get 100 satisfaction or attention even to your issue, but I would definitely encourage all of the providers to start there.

And if the provider representative does not respond to you or gives you an unfavorable outcome, you can reach out to the compliance officer at the plan. That is where all of our account managers here at CMS interact with the plan. It's our main portal into the plan. They are responsible for the plan's compliance with Medicare regulations and guidance. So, it's a very important person in your escalation of an issue with the plan.

We get involved if there's just no resolution at that level. And I'll give you an example. When one provider is not being paid for something that is covered by a local coverage determination or that's one provider dispute, but when you start seeing three maybe an age of association gets involved because it's more systemic than it's just an individual dispute, we're very, very interested in that.

And we have different ways of reaching out to the various regional offices. We could share that with Gene. We do have e-mail accounts for all of our 10 regional offices. And it's also on CMS.gov. So, I would encourage all of the providers to avail themselves of that.

What Dr. Freund was getting to was the appeals process though, which was ordinarily something that a beneficiary would have avail themselves, but I'll give an example of a non-contracted provider. If they do have a waiver of liability for the beneficiary, again, holding the beneficiary harmless, you could avail yourself as a provider acting in the place of the beneficiary in the appeals process.

It's a (five-level) process. Hopefully, things are resolved at the lowest possible level. But if necessary, it could go ultimately to judicial for

rendering. So, I'm going to turn it over with Tim and maybe Tim if you want to talk about the five levels of appeal.

(Tim Lape): Oh, sure. Yes. Hello, Ray, and hello, everyone. Thanks. This is (Tim Lape). So, the two levels that are within the MAO, the Medicare Advantage Organization, it would be the first level, which is – there are two processes within the levels within the plan. There is a standard process and an expedited process.

This has more to do with the return of a decision that the plan will make from one day to three days, or in the case of organizational determinations, it will be a 72-hour time limit or a 14-day limit. But the two levels would be called the coverage determination level and then the second one will be a re-determination.

Beyond that, a third level is available if the dispute – if the provider is still disputing the service or is not being provided would be – to the IRE, the Independent Review Entity.

This was mentioned I think earlier on the CMS side that the Independent Review Entity, which is currently (maximus) or would also the QIO would basically just (looks) their independent review body. They will look at the issue and compare it to what the plan has done, what the provider information has submitted to the Independent Review Entity, and run to a decision that way.

Beyond that, there is the Office of Medical Hearings and Appeals. It's an ALJ hearing. And then the fourth level would be the Medicare Appeals Council. And then, of course, as Ray mentioned, depending on the dollar amount, it could go all the way up to the federal district court in terms of the appeals.

Raymond Swisher: So, I think – does that give a broad enough overview for everyone and maybe there are other questions that you'd have for any of us?

Eugene Freund: And the first two – this is Gene Freund. The appeals that go directly to the plan, of course, and then to the independent review, isn't that kind of managed

by the plan when you're making the appeals or am I confusing private insurance and ...

(Tim Lape): (This) is the initial coverage determination, of course, does go into the plan. And then when the plan in the instance of a non-contracted provider, let's say, denies the claim or the service, the MAO will supply appeal rights to the plan. A lot of those appeal rights, the timeframes and also a reasonable description of the denial reason so that the provider will understand specifically what was denied, not just a we're not going to cover it type statement.

Raymond Swisher: The appeals process, I kind of got an implication in your question that it's like a (box of the in-house) kind of thing, but it is monitored very closely and it is (augmented) by CMS on a regular basis and we're constantly monitoring the appeal overturn rate with our plans compared with other plans as well.

So, it's not that provider is just out there subject to the whims of the plan on a given day. It's strongly monitored program.

Bill Finerfrock: Actually I was getting more toward what is the process for a practitioner out there to go through and just wanted to confirm that they basically are working with the plan at the outset and that after the independent review appeal. I think independent review has not been successful. That would be the point which you would escalate it beyond the plan. Am I wrong about that?

Raymond Swisher: You're correct.

Bill Finerfrock: OK. I'm still struggling a little bit with the steps and reconciling what Ray said with what Commander (Light) said or Captain (Light). So Ray your – it kind of like yours was more of an informal review and that Captain (Light) what you're talking about is a formal appeal?

Raymond Swisher: That's correct, yes. I was talking about more like establishing a relationship with the plan provider relations branch to see if it could be resolved on a less formal basis.

Bill Finerfrock: OK.

Raymond Swisher: But then the formal is always available to the provider or the benefits (peer).

Bill Finerfrock: Right. And you made reference to the point of contact within the plans would be the compliance officer?

Raymond Swisher: Primarily, its provider relations and those names and numbers are advertised by the plans. We do require that but I was offering if for some reason they were not responding to you in a timely way, you could always reach out to the compliance officer as well.

Bill Finerfrock: OK. Yes and I – and I’m aware of the (leasing) of the (broader) relations, are the compliance officers’ names and contact information available publicly?

(Tim Lape): Yes, they’ll be on their website.

Bill Finerfrock: OK.

(Tim Lape): At a (minimum).

Bill Finerfrock: We’ll probably just (overlooked) them, OK.

Raymond Swisher: Well, hopefully you don’t need it.

Bill Finerfrock: Well yes – yes.

Raymond Swisher: It’s great.

Bill Finerfrock: No, the preference is always to try and resolve it at that kind of informal level but sometimes they do run into situations where, you know, just it’s not working out the way you would hope.

Raymond Swisher: I understand.

Eugene Freund: OK. Any other questions? This has been a really helpful sessions. I want to give our discussants chance to add anything more that they think is important for us to hear and also see if there are other questions on the line.

Operator: We do have a question on the line and for anyone else if you would like to queue up, please press star then one. And your question comes from the line of (Robert Bennett) and I'm sorry we didn't have your company name. Please go ahead, your line is open.

(Robert Bennett): Yes, hi Dr. Freund. Thanks for having this call. As always, long time listener, first-time caller you know.

Male: Yes, right.

(Robert Bennett): Why don't you – and I promise I won't be as hard on folks as Bill Finerfrock has been but I was delighted to hear that an HPMS guidance might be coming out and (MA) plans that talked about best practices for prior authorization. I was wondering, two things, if any sort of timing could be referenced because I usually just have to go to the CMS website and kind of hit refresh to see when those things come out.

And then also, you know, and maybe even more importantly if you could elaborate a little bit further on what best practices is meant, you know, whose standards you might be looking at? That would be great, thank you.

Marty Ablen: This is Marty Ablen. I really can't get into the specifics on what's in the memo yet, it's still in clearance. But it should be out in the next, you know, two to three weeks, something like that, relatively soon.

As I mentioned earlier, the uses of prior authorization has been a – there has been a lot of discussion in the agency about it with respect to – because we received complaints from providers about the, you know, what's considered unnecessary burden in completing prior auth requirements.

So we're, you know, as far as the best practices, we looked around to see what's being done in the industry but I can't say what we've identified. And we're certainly not requiring a particular best practice but we're encouraging MAOs to be as transparent as possible and to reduce unnecessary burden and recommending may adopt some of that standards that are more prominent in the industry but the guidance will have more details on that when it comes out.

(Robert Bennett): I appreciate that, thank you. I look forward to seeing it.

Marty Ablen: Sure.

(Robert Bennett): Thank you.

Operator: And your next question comes from the line of (Allison Mathison) with (ASCERS), please go ahead.

(Allison Mathison): Hi, this is (Allison). I had the exact same questions as the prior caller, so thank you.

Operator: And again if you would like to ask a question, please press star then one on your telephone keypad.

Eugene Freund: OK. Assuming no more questions, I won't – I think it's time to move on. And again, thank you all for this conversation. It was really informative and really helpful and I'm glad we had it and as always I learned a few things and hopefully it helps and we'll – we maybe back with questions again, so thank you.

Lisa Wilson, do you have an update on the exchange?

Lisa Wilson: Hi all, Lisa. It's been a long time since I'd been able to speak with you all because we were busy, (inaudible) (grindstone), running about – I think it was about 13 pieces of guidance in a (reg) for display in early April. So on April 9th – I mean – yes, on April 9th, we published our annual Notice of Benefit and Payment Parameters. And I'm sure that you all had a chance to at least scan portions of it.

So I'm not going to, you know, go too far but I do think it's important for you to understand that in addition to the Notice of Benefit and Payment Parameters, we also issued our Annual Letter to Issuers – Annual Letter to Issuers. That's kind of the sub-regulatory extension if you will of that payment notice and that's where we provided additional guidance to plan this year.

That letter hopefully was a little bit easier for folks to ready because we basically said if we – if we're keeping things the same, we're not going to put in this letter. If we're making changes, we're going to include it. So we try to make it, you know, a little easier for folks to review this year. And we also issued quite a few other pieces of company guidance.

So, I thought I would spend just a minute talking about sort of the goals with the payment notice here this year, and then a few of the kind of highlighting, if you will, of the policy. So, one of the major portions of the rule was the idea around empowering states, to increase their flexibility and have them be able to improve affordability.

We also looked at areas to strengthen program integrity, empower consumers and of course promote stability. So just you know around those provisions, you know, thinking about sort of increasing flexibility, we made a proposal around the essential health benefits to allow insurers to offer more affordable plan.

We finalized a – the ability for states to have additional flexibility and how they select their EHB or essential health benefits benchmark plan. The final rule provides states with a lot more options than they have had in the past. So instead of being limited to 10 options, they can choose from over 50 EHB benchmark plans used for 2017 or actually go in and select specific EHB category such as drug coverage or hospitalization.

They can also build their own set of benefits. They could potentially become their EHB benchmark plan all within, again, within, you know, the 10 categories and their outline delineated in the statute. We think the new improvements in things like our – or also, you know, kind of switching gears to another proposal that provided more flexibility to states is in their qualified health plan or QHP certification standards.

Again, we're seeking to – I think it's important to think about, you know, sort of – if there's dual regulation where the states and the – and the federal government are both examining an area of certification process. This

administration wanted to return that (inaudible) authority to the states. So, I think the example there is network adequacy.

I know that's one where a lot of you pay close attention and leaving the burden on issuers related to essential community providers. And another area – a couple of other areas, you know, (inaudible) program integrity, we took some important look at our Risk Adjustment Data Validation, also took some important look at APTC program integrity to implement stronger check to verify the applicants actually earned the income that they claimed that they do.

We sort of codified several issues around special enrollment period, aligning the enrollment options for all dependents who are newly enrolled in exchange coverage through a special enrollment period and being added to – added to an applicant with current enrollees regardless of the SCP that they qualified under.

We made several proposals around the medical loss ratio or MLR. Again, those of you who had been kind of following along since the beginning know that there's a lot of action with MLR in the first. And a couple of years of the Affordable Care Act, this final rule amends the MLR requirement to reduce burden by reducing the quality improvement activity reporting burdens on issuers.

So, that allowing them to sort of check the box and say, you know, this is the typical amount that most issuers spend on a quality improvement activities. And yes, we're in that – in that same range, they can afford if they have a higher expenditures though and allow states to request reasonable adjustments to the MLR standard for the individual market if the state shows a lower MLR standard can help stabilize if insurance market.

Just two more if you can hang in with me, for just a minute more, we codified some program changes to the SHOP program. Basically, eliminating the online enrollment process through a federal website and allowing employers to enroll directly with an exchange registered agent broker or issuer – issuer.

Importantly, add to (note), one state has actually already taken up this mantle, New York State is already doing this. And then finally, again, kind of harking back to their first days of the Affordable Care Act, thinking about rate review.

The final rule increases the primary role of state regulators in the rate review process by, you know, first exempting the student health plan – health insurance coverage from the federal rate review and also raising the default threshold for the review of reasonableness from 10 to 15 percent just given the high premium increases that we have seen.

So you know, that's kind of the bulk of those announcements. We also extended what we called the transitional policy and for those of you who remember, you know, they talked about grand mothered and grandfathered plans. And if you like your plan, you can keep it. States have it now for the, you know – for multiple years we have (opined) that we are giving states the authority to be able to decide whether that is – I'm going to (say) want to extend that policy also.

So, a lot of guidance was issued in April. I would note that we had a couple of operational milestone and you know QHP certification process begins in our (list) I think next Wednesday. And so it's an important milestone as we get ready for the next plan year which always feels amazing as we, you know, have just – it feels like we have just finished up a lot of the review of the first opening – our open enrollment period.

So, I'll stop there and see if folks have more specific questions, if – and I'll try to answer.

Operator: And if you would like to ask a question over the phone, please press star then one on your telephone keypad.

And there are currently no questions in the queue.

Lisa Wilson: I just missed – being able to make this announcement on last First Friday or the First Friday in April and I guess, you know, everybody has had time to read and absorb all the information this time there you know. But if you do

have a question, feel free to shoot me a note. My name is Lisa Wilson and I'm easily accessible on e-mail. So, it's lisa.wilson@cms.hhs.gov.

Eugene Freund: So we do have one question.

Bill Finerfrock: Lisa, this is Bill Finerfrock.

Lisa Wilson: Oh good, hi Bill.

Bill Finerfrock: Hi. We missed having you here in person.

Lisa Wilson: I'm sorry.

Bill Finerfrock: Eugene (doesn't) do a great job but you know. Do you have on your radar screen looking down the road anything in terms of at least information about the various what I would call for lack of a better term faith-based health plans that are – I'm seeing heavily advertised during open enrollment.

And since that individuals can enroll in that if you're in those plans, they meet the ACA insurance requirements come with dramatically lower premiums but different things, just information about those plans and whether or not those plans actually do qualify if a consumer wanted to purchase one of those plans, questions or things to look at or think about with regard to those plans?

Lisa Wilson: Sure, you know, so health care sharing ministry were included in the exemptions that we provide, you know, if you are part of the health care sharing ministry, you know originally we had to run an application process to be able to apply for that exemption.

Now we slowly turned it outward to the IRS and you can sort of check a box and then as part of like normal auditing procedures that you know if you got audited, you would provide that certificate of enrollment. So the IRS is, you know, had taken over the majority of that or all of that work.

And you know, we no longer really interact with the entities anymore, so you know I don't really have much to be able to offer in that arena. I'll try to (say) that it is a valid reason to request an exemption.

Bill Finerfrock: OK, all right, thank you.

Eugene Freund: Thank you Lisa. And Amy Hammonds has been a – is sitting here patiently to talk about the open payments process that's coming upon us.

Amy Hammonds: Thanks Gene. Hi everyone. Just a couple of quick updates on the Open Payment's program, if you've been following along over the past couple of months which is hopefully you have. You know, where we are at in our cycle but right now we have our pre-publication review and dispute period going on.

So, that's when covered recipients can come in and look at the data that has been attributed to them before we make it public. So covered recipients, our physicians and teaching hospitals that reporting entities send payment information into the Open Payment system on.

So, we're actually getting really close to the close of this period, review and dispute will close on May 15th. So, about two weeks out from now and that's for the pre-publication. So if you wanted to look at anything before it's public and if there were any discrepancies or any corrections needed to be made, those have to be submitted in by the 15th.

Just as a reminder, CMS does not mediate the dispute process. Covered recipients should be working directly with the reporting entities to resolve any disputes or updates that are needed. In order to participate in their review and dispute, covered recipients do need to be registered in the Open Payment system.

That's actually a two-step registration process. The first part of that is making sure that you're registered in the Enterprise Identity Management System and then once you're registered in that, you can request access to the open payment system.

If you are already registered but you haven't access your account in 180 or more day, you actually need to reactivate your account. That's a simple process. You just contact their help desk to do that and I'll give you their

phone number. It is 1-855-326-8366 and their hours right now are 8:30 a.m. to 7:30 p.m., that's Eastern Time.

And I really think that's everything that we have for updates. I just wanted to remind everybody that review and dispute period is coming to an end on the 15th of this month.

Eugene Freund: Thank you Amy. Do we have any questions?

Operator: Again as a reminder, if you would like to ask a question, please press star then one on your telephone keypad.

Eugene Freund: OK. The last item on the agenda is I think is going to be a short one, about the new Medicare card update. I always ask if you got issues related to the new Medicare card, that you could bring to us. And today, I'll remind you of two things, one we got a revamped website. So, the website has been reorganized a little bit to, we believe, cover different issues better.

Some of those pages were getting a little bit long as we came up with information needs and added to those pages. So, things had been broken off and hopefully you can navigate around them better now that has been revised and we've done some enhanced outreach mainly to the beneficiary community about that.

Whether there are any issues going on out that you're hearing about with regard to the new cards, there are a few patients coming in with new cards, not tons but mailings are out. So, it will increase over the next month or (two), especially in the area with the first mailing which is basically right around here.

If you go to the medicare.gov new card website, you can see a map of the mailing strategy and actually if you go to the medicare.gov for the beneficiary-related things where you get the information, it's kind of more focus on when is my card getting there as opposed to the cms.gov site which has more focus toward the clinicians and other providers.

So, that's basically all I have as announcements. Any issues or questions that we have on the floor?

And again, (Heidi), we press star one.

Operator: Star then one, yes.

Eugene Freund: To question.

Operator: And there are currently no questions in the queue.

Eugene Freund: OK. Well, thank you all very much for calling in. I'm pleased to have an interesting conversation at the beginning of the call and thanks again all. Our next call will be June 1 and I look forward to talking to you again then. Thanks all.

Operator: This concludes today's conference call. You may now disconnect.

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