



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Real Time Caption Transcript

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Welcome and Opening Remarks

Jonathan Blum, CMS Deputy Administrator and Director, Center for Medicare

Jonathan Blum

Good morning, everybody. I really want to thank everybody for coming out this morning to Baltimore. Just seeing everybody out here in the audience, and knowing how many are watching by web confirm to me the interest in the MA program. In 2011 the program will be as strong as ever. I want to talk about the policy direction that CMS has followed this year for the 2011 upcoming year, some things that can you look forward as we go into the open season, the open marketing period. But also things to look forward for the 2012 year.

As we enter into the marketing season this fall I think we all have some challenges to think about and to talk about this morning. We are going into the season following historic legislation that was passed this spring. I think it's also fair to say there's lots of confusion regarding the Affordable Care Act, I think the population group with the most confusion is the Medicare population. They have heard from various positions, there are perceptions that are simply untrue. There's perceptions that the MA program is going away. When I talk to seniors they always ask me about this. The challenge for us is to reassure Medicare seniors that the Part C and D program will be as strong as ever. There's tremendous interest, there's tremendous opportunity. CMS remains committed to the MA program and the the Part B program. I think we have a challenge ahead of us to assure seniors and beneficiaries that plan choices are strong. Plan options are strong, and the program will be as strong as ever. I would argue that it will be stronger this year and next due to the work of the plans and CMS.

I wanted to talk about some of the efforts that the CMS staff have made to improve how we communicate to Medicare beneficiaries. One of the observations is that the materials that CMS has produced through its handbook and website can be improved. One of the observations I had had is CMS communications around the programs, Part A, B, C, D. To the beneficiaries the terms don't have much meaning, that's a construct of the statute, not how beneficiaries think about their benefits, experience their benefits. They don't think about hospital insurance, physician insurance, prescription drug insurance -- they want coverage. They think about the plan, they think about who sends the statement, they don't think about CMS, they don't think about Part A or B. They think about their plan, they think about their coverage.

This is an effort that still continues, to think about how we communicate plan options and choices. We want to make sure it's more understandable, more visual, more graphical. You will see changes this year in the handbook and the website. We also have a four-page brochure to illustrate some of the changes. This is just one small step. The goal is to help beneficiaries understand when they think about Medicare coverage the elements. What are the decision points a beneficiary needs to make? We're really trying to make away from the historical statutory terminology that CMS has often used in the past and make it more tangible.

We're taking small steps going forward. We're working with the plan and beneficiary communities to make improvements. This is an area that CMS really wants feedback. Picture a



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world, possibly next year or two, where all of our communications coming from CMS are coming from the plans, have common elements and common icons and common pictures and descriptions to how beneficiaries compare plans for different benefits. Think about how we think about food labels or credit card statements, we can compare and contrast. These consumer decision points are much more difficult for the healthcare contracts, much more difficult for the kinds of elements that beneficiaries have to think about. But I strongly believe that we can simply, we can make more clear, we can make more understandable plan choices, plan decisions, coverage decisions, coverage options. We hope these will be helpful to beneficiaries. We are hopeful these are helpful to plans when they're marketing to beneficiaries. One small step that CMS plans to take to simplify the program, make it less complicated. I hope it will improve and increase overall enrollment. If we make the process as easy as possible all of us will all experience much more confident choices, much more satisfied beneficiaries and I believe that beneficiary growth will continue to grow in Part C and D context.

Please look at the brochure, give us your feedback. And think about the world where these kinds of icons, graphics will not just be what CMS produces, but also what we ask the plan to communicate to beneficiaries through their materials.

The other thing I wanted to talk about is our ongoing efforts this fall up coming to ensure that plan communications to beneficiaries are accurate and are helpful. Over the past several years, as I'm sure you know, we have received concerns regarding beneficiaries that have been delivered messages that have not proven true once they enrolled with a plan. I'm happy to report that last year we saw overall decreases in complaints. We hope that trend continues for 2011. I just wanted to talk about that CMS will continue its marketing surveillance activities, it's secret shopping, we are also monitoring social media, this is a new way for plans to communicate to beneficiaries. We just wanted to let folks know this will also be a part of our marketing surveillance activities to ensure that plan communications and marketing materials are accurate and honest. When beneficiaries have more confidence in their choices, they have more confidence that CMS is overseeing the marketing materials, the program is stronger, and beneficiaries and Congress and various oversight agencies have overall confidence in the program, which helps to serve CMS and also helps to serve the plan community, as well. The CMS staff asked me to talk about the check list, the readiness check list. The staff put tremendous into providing a helpful guide to ensure plans are prepared and ready for the upcoming season. Please look at it, please use it, please put it on your desk top screen saver, what have you. We're trying to make the process as simple and helpful as possible. Please also give us feedback. We want to make sure that plans have the materials they need that will help reduce and help bring down the need for down stream compliance actions in the future.

Hopefully this tool is helpful, hopefully it's a vehicle to help plans prepare. We really encourage plans to use it. Also, please, give us feedback regarding how helpful the tool is, so we can make improvements for the 2012 campaign year.

I also wanted to talk about the 2010 audit process. I have heard concerns, some complaints from the plan community regarding the change in tone and process for the 2010 audit. They have brought this change to our attention. I want to kind of say there is a change, the change is intentional, the change is one that has been a conscience decision. We are moving towards processes for audits to be risk-based, to identify plans that CMS believes to be risks to the beneficiaries and programs. If a plan is audited I think that's a signal that CMS believes there's a risk to beneficiaries or to the program. That is a change. That is going to be a continued direction for the agency to use our audit resources more targeted to be more towards plans that



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are risk-based. When folks say they're sensing a change, the tone is different, that's true, that's intended. Now if our audit staff are performing their duties in an unprofessional manner, or a manner that is not fair please let us know. But if the notion is that there's a change in tone, change in emphasis, change in focus, that is true, that is intended, that will be the further direction of the agency.

We are also placing much greater emphasis on plan compliance plans. We've heard a lot of criticism, CMS has not placed sufficient emphasis on ensuring plans have strong compliance plans. But as we think about the role that compliance plans has for the programs, the programs that plans put in place, it is vitally important. Compliance doesn't start with CMS oversight, it starts with the plans. CMS will continue to enforce and to ensure that plans have strong compliance programs. This is a direct demand from the OIG, Congress, and other oversight agencies. We find it vitally important. That will be a continued emphasis to ensure that plans have compliance plans in place, to ensure they're meaningful, that they have staff towards these roles and functions. You should expect that going forward, both this year and into the future.

We also have concerns about specific areas that our audit teams have identified. We have concerns about how some plans run the enrollment process, verify enrollment and disenrollment. We expect these processes are realtime and are structured in a way to protect beneficiaries, to inform beneficiaries, to respond to beneficiaries. These will be processes that we will continue to look to ensure they're strong and accurate and plans have invested in the number systems necessary to conduct realtime information. This is an area that we will be watching very, very closely. Going forward we ask the plan opportunity, we will expect the plan community to have the processes in place to ensure that beneficiary decision points and choice points are accurate, are being followed.

Going back to the first theme of making the program less complicated, the system improvements are tied back to the education, marketing activities and the goals that CMS has. We ask the plan community, this will be a particular focus to our audits going forward, these systems and processes are place. We're also finding through our work in the compliance area and also in routine audits that add here's to the Part D rules are not being uniformly followed. We have a lot of concerns about some plans not necessarily following the Part D rules, the Part D construct. The benefit is not necessarily the same as a commercial formulary, there are protections and processes that the program has that is often not found in commercial formularies. This will continue to be a focus and emphasis to our work going forward.

So lastly, just to kind of close up and just to wrap up. I'm sure I've sparked a lot of issues and concerns already. I also want to just ask folks to keep an eye on 2012. While we're here to talk about 2011, the upcoming marketing season. We also need to keep an eye on 2012. More change is coming to the program, as directed by the Affordable Care Act, CMS now is working hard to implement some of the changes coming forward. I want to remind us about some of the changes for 2012. 2012, January 1, sparks the first year when CMS will be paying plans a small portion, but a growing portion, based on their overall quality score. We have a spent a lot of time this past summer to sit down and listen from all different perspectives. We have sat down to listen to beneficiary groups, plan groups, some of the quality experts that think about plans and the fee for service context. We're crafting those rules that you will see later this fall to propose how we plan to convert the current quality star system that we have to a payment bonus. We understand this is a change. We also understand -- we also believe this is an exciting change. For the first time we will reward plans that make investments to hit certain quality outcomes.



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CMS will go through the process this fall. We want to hear concerns, we want to hear ideas, we want to listen to comments for our final rules that will come out next year. Again, we are very dedicated to the process of listening and responding to concerns, responding to ideas. This is a vitally important change to the program, to really change the dynamic from one where plans compete to a program in the future where plans compete on supplemental benefits and overall value and quality that they provide to beneficiaries.

Second, I want to just flag for folks that in 2012 the preceding marketing period is -- will be earlier than it is today. Today it starts in November. The Affordable Care Act has pushed forward the dates, that will put a lot more pressure on us to review bids quicker, to send in information quicker. We are going to be asking plans to do more with less time, we're also going to be in the same position to do more with less time. That's just the world we're this. CMS will do our best to make the processes more seamless, to make it easier, to make it a more simple process. We want the process as simple as possible. Really give us feedback. Help us understand what things could be improved to help the bid process, the information process. We can't compromise on our beneficiary protections, but we can look for ways to increase efficiency, to increase performance, those are issues that CMS really wants to hear from the plan community. Because we're all going to be asked to do more with less time starting next year. CMS has a responsibility to make it as simple as possible, we also ask that in turn that you give us feedback and that you give us ideas, suggestions, I promise we will take them all very, very seriously.

With that, I want to thank everything. It's very reassuring to see so many here in person and there are so many on the web. That reaffirms my belief that in 2011 the MA program, and Part D program will be as strong as ever, I would argue it will be stronger than it is today.

With that, I have time for questions. I'm happy to stick around and take a couple of questions. If not, I won't force anybody. All right. Thank you everybody. Please stop the CMS staff that you see, ask questions. I hope this event is helpful. We look forward to your questions and your participation. Thanks, everybody, for taking the time. [Applause]