



CMS 2011 MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN  
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## TRANSCRIPT

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Good morning, everybody. It's really great to see so many people here this morning. This is my third time speaking at this conference, and I think each year the conference gets bigger and bigger, which is gratifying to see. I always get a little worried when we're thinking about the next contract year: will folks show up to hear what CMS is thinking about, to kind of give a signal to how the Part C and Part D markets will be for the next year? But I think, given that this room is full and we have, I think, a long list of folks waiting to get in, it really gives me confidence that the Part C and Part D programs are stronger than ever.

I wanted to just kind of open the session. We have a really great series of talks, presentations today and tomorrow really, to talk about the 2012 year. And from our perspective, this work started back last fall. It has now culminated with our final rate notice, call letter, and final Part C and Part D regulation that really set the framework for the 2012 contract year.

This time I thought I would kind of step back a little bit and talk about CMS priorities for the Part C and Part D programs. Over the past year I have heard a little bit of feedback from the client community that CMS hasn't done a sufficient job, that I haven't done a sufficient job in talking about our priorities, what CMS cares about, so folks can just kind of meet our standards, meet our rules, and follow our priorities. So I thought, just real quickly, just kind of outline just a few thoughts. Can we go to slide two?

And really, just to step back a little bit, I want to focus on three priorities. So as I think about the 2012 year, I think about what we at CMS now are focused on are kind of three areas. And so when folks ask me what are CMS's priorities for the 2012 year, this is going to be my answer: the first answer is that we are focused on policy consistency. Over the past couple of years we have done a lot to simplify the program, to simplify choices for beneficiaries. As folks here in the audience know, you know, we have, you know, tried to cut down on the number of overall plans being offered in the market. We have pushed hard to ensure beneficiaries had meaningful distinctions. And so we are very proud of those priorities, but, you know, I think folks hopefully saw through our rate notice and call letter is that we haven't, you know, pushed new initiatives.

We really think 2012 is the year to kind of catch up, to hold steady. We still hold true to the principles to make sure the beneficiaries can navigate the Part C and Part D programs, can make choices, can understand their choices. But really, from an overall contracting perspective, what we are trying to push for this year is to hold steady consistency to, you know, let the system catch up a little bit, to let the client community catch up. We understand that we've pushed hard, we've pushed a lot, but to us, 2012 is really a year of consistency. I don't want to say "stability" necessarily, because we still have new policies. We have a final Part C and Part D regulation. We have the Affordable Care Act provisions to implement. But I think, from a CMS perspective, what we're really trying to articulate is an overall notion of consistency.

The second priority is quality improvements. And we have spoken in the past and we will talk a lot today about the five-star bonus payment system. And obviously the law plus the demonstration that we've – that we announced through the rate notice, hopefully sends the signal that we care about quality improvement. We have plans to focus on how they can elevate up the scale. We have, through demonstration authority, we have changed – we have changed the bonus payment structure to allow and to reward both attainment as high star ratings but also the improvement of star ratings.

But stepping back from the bonus payment system, we continue to believe that the five-star quality system is first and foremost a consumer tool, and second, a payment mechanism. So that means, to us, we want consumers really to focus

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on, to understand, to ask what's the star rating of the plan. It's our hope that plans over time begin to market themselves as four-star/five-star plans. We are going to continue to send – to send market signals to alert beneficiaries to plans that are either very high ratings or very low ratings.

So, a couple of examples, starting in 2012, we are going to allow five star plans to market year-round. And, you know, this is not just a payment incentive, but this is a market signal. Those plans that are the highest performing within the program will have new opportunities to attract and to market beneficiaries. Conversely, for plans that are at two star for a consistent – for a long period of time will face a different prospect with the program, and the program is – we, CMS, are trying to push plans that continue to have low star ratings for continuous periods of time to not offer products to beneficiaries.

So, to us, the five-star quality improvement is both about payment incentive, but more important, about sending signals to beneficiaries to sending – giving consumers tools to how they should think about their choices both in the Part C program and the Part D program. And I think, from our perspective, the strategy is working already.

We have seen overall growth in the MA program for 2011 so far relative to 2010. I think overall we're seeing a 6% increase in Medicare beneficiaries going into Part C plans in 2011 compared to this time last year. But we're seeing even faster growth into plans that are four star and higher. So we think that the conversation, the communication, the focus around the star rating system is working. SHIP counselors, beneficiary advocates are already talking about – talking about choices. What's gratifying to me and the staff is to hear from plans themselves tell us how they are focused on improving their overall star ratings.

So I think, you know, to us, 2012, one of our top priorities is to ensure that we have as a continuous push for plans to increase their star ratings for beneficiaries to gravitate towards plans that have higher star ratings. And the same time that we have this conversation, both in payment terms, but also in marketing terms, that plans that are higher rating should have more attractive benefit packages, should attract beneficiaries. And CMS will continue to find ways through non-payment mechanisms to encourage beneficiaries to sign up with those that have the highest star ratings, but to avoid those plans that have lower ratings.

And then the third priority that I'll talk a little bit more about is the focus on compliance. And so as folks in this audience know, we have heightened our over -- heightened our focus on performance for compliance. I heard a lot of feedback regarding the audit process that CMS implemented last year. We are going to improve that process to address some of the concerns. But the focus on compliance, the focus on performance will continue, and I want to offer some thoughts about that. So can we jump to slide three.

So before I talk about compliance, I also want to just to discuss our efforts to be more transparent than in the past. And we have heard concerns from the client community that some of our rules, some of our processes, some of our negotiating strategies haven't been clear to the plan community. CMS put out the information after the plan bids were submitted. We have taken those concerns to heart. I want to talk a few seconds about some of the changes that we have made, not in terms of policy, but also – but in making our priorities more clear to the plan community.

First is this year we decided to put up front our criteria for the total beneficiary cost assessments that CMS used last year to assess plans that were proposing to offer high cost increases for beneficiaries. This year we've heard loud and clear that plans want to see those criteria up front prior to the bids are submitted. We have done a lot over the past year to explain and to take feedback to our five star quality rating criteria. We're going to hear more this morning about the criteria. But, really, the notion that we have is that we want to go through notice and comment processes to ensure that the plan community has an opportunity to understand where we're pushing the star ratings. Where we're pushing it is to focus more on outcome, to focus more on patient experience. And so CMS's commitment is to ensure that we have full and open processes to want to propose changes to the five-star rating system, but also to take feedback to how those changes should be implemented.

We just, yesterday, I think, put online the OOPC model for plans to assess, to evaluate, to understand so that we can, you know, provide more information for – provide more feedback to how we assess out-of-pocket cost changes. It can also – what I want to talk about next is just some feedback and some of the overall trends, the overall perspectives that I am taking, the staff is taking to our performance audits over the past couple of years. So with that we'll go to the next slide.

But before thinking about going into the areas of focus, I wanted to also just talk about the reason why CMS is being more transparent. So, one, we are responding to the plan community; but the other reason we are trying to be more transparent is that we have a much more condensed calendar for 2012 than we had for 2011. The Affordable Care Act pushes for the day when beneficiaries can select Part C and Part D plans; however, it didn't change the time period for

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our processes, for your processes to submit bids. So from a CMS perspective, from a plan perspective, we have to do a lot more work in a much more condensed time period. So part of the reason we are trying to be more clear, to be more transparent, is that we really want plans to submit their best bids on June 6th.

So in the past there's been this notion that there has been time to go back and forth, you know, for CMS to come back and say, "Well, that bids not right, come back to us." The time period's condensed, and so one of the reasons, the second

reason CMS has put out this information is so that we can get the best plan bid from plans on June 6th so we can avoid some of this back and forth. I think from how the plan community should think about CMS is we're not going to have time, we're going to have the luxury, the flexibility to have several exchanges. So when you submit your bid, can you hear CMS staff come back and say, "Well, this doesn't suffice, this doesn't meet our standards," please assume that's the one call you're going to receive. There's not going to be the time, the luxury for the iteration. So we're putting information out front so everybody has it, but, one, to respond to the plan community; but, two, to respond to our calendars that we all have a much more condensed schedule to work with.

Going back to performance audits, I just wanted to kind of highlight some trends, some findings that CMS is finding when doing performance audits with plans. And I think it gives some indication to what CMS is focused on, to what we care about, to some of the trends that we see. I didn't put on the number of plans that have gone through performance audits that have areas of concern to these four categories, but it is high. And so if you were to see percentages with a number of plans that have gone through performance audits that don't meet CMS standards, there would high percentages by all of these, which is a concern. I think, hopefully, by us articulating what our concerns are, that will help to elevate the entire plan performance throughout the Part C and Part D community.

So first is Part D formularies. We are still seeing issues and still seeing problems with plans implementing the Part D formularies, and I think what our staff has said is that the Part D formularies are different from commercial formularies on purpose. Congress has designed the Part D formularies to be different and probably typically operate with commercial – compared to commercial formularies.

The law requires that plans have meaningful formulary transition processes. CMS has created six protected classes. We find that plans don't always follow the edits that they submit to CMS for approval for prior authorization and for step therapy. So when we look at the plans that go through performance audits, we see very strong deficiencies in how they operate the Part D formularies, and that will continue to be a focus for CMS for 2012.

We also see issues in how CMS – sorry, in how Part C and Part D plans process coverage determinations, how they forge coverage determinations to the independent review entities and the time periods for processing redeterminations. These are areas of concerns that CMS will continue to be focused on. And so I think the way that I think about this is when beneficiaries sign up for a Part C or Part D plan, CMS expects that beneficiaries receive and are entitled to the benefits and the appeals processes that the law provides them.

We see issues with plans following the grievance process procedures. One is, you know, plans properly resolving grievances; and two is properly categorizing grievances as beneficiary complaints; and lastly, we still see issues with how plans enroll and disenroll beneficiaries. So these are not the only issues that CMS cares about, thinks about, but I think that they're the main priorities that we think about, care about, because when you think about all four of these issues, these really go to the benefits and the services that beneficiaries receive.

So as we think about the priorities that we think about what CMS should be most focused on, they're those things that impact, that affect how beneficiaries receive services, whether beneficiaries receive services, and so we still see that a large percent of plans that CMS audits don't hit our expectations.

So over the course of the past year that I've been asked by the plan community several times, so what should plans do differently? What should plan executives think about when kind of interacting with CMS? And given all the strong pushback we heard last year regarding the audit process, I was fortunate to participate in a couple of meetings with 30 or 40 plans or so, and I think the main question came to me of, "Well, what should plans do differently? So what should we think about when we're interacting with CMS?"

And I had a hard time thinking about a title for this slide, didn't want to call it "Helpful hints" because it just seemed too superficial. But I really wanted to offer some perspective, some suggestions to what we think about – I think about when interacting with our staff. And I think the question and, really, the perspective is, you know, how can plans have a stronger relationship with CMS? How can we think about a relationship when we're not, you know, going through audit performance audits, what have you, and to think about a much stronger relationship?

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And I think the first perspective and the first observation I have is that from a plan perspective, what we want to see is that plans know their operations better than CMS, which means, to me, is that when CMS oversees the Part C and Part D plans, when we really think about oversights and compliance monitoring, we look at a whole host of different data. We look at Part D claims data. We look at the appeals data. We have an ability today, much greater than before, to monitor and to assess. And I think what frustrates me and frustrates our staff is when CMS sees trends and sees issues before

the plan does. And so we're going to be very upfront and be very forthright, you know, to let plans know when we see issues or see data trends that are problematic. But I think the first observation that I have is that, you know, from a plan perspective, we expect and we want and we hope that plans have a better understanding of their operations than I do, than our staff does, and I think that's an area that we encourage all plans to focus on.

Second observation is to understand why your beneficiaries are calling. So monitor your call centers. Monitor your call operators. Understand why beneficiaries are calling. What's the nature of the complaint? What's the nature of the issue? That's how CMS, you know, tries to capture early warning. We monitor very carefully our call centers coming in. The same observation we have for the plan community is to really understand, and if you see areas of concern, you see three or four calls coming in with the same issue, that's probably an indication that something is wrong, but it's probably an indication that CMS will pick that up through our data analysis. And going back to the first point, we hope that plans understand their observations better than we do.

Look at Part D claims and why they're rejected, that will give an indication that, going back to the point earlier on the slide, that the Part D formulary is not being run correctly. We have an ability to do very detailed assessments on Part D claims, why they're rejected. We encourage all Part D plans to do the same. You know, take a periodic look once a week, once a day, whatever the right number is – the right time period is, but understand why your Part D claims are being rejected. That's probably an indication that's something going back to formulary compliance is not running well.

Fourth, really encourage plans to oversee their PBMs. Going, again, back to the first point of issues with a Part D formulary management, one observation that we're seeing is that plans aren't overseeing their PBMs very well. The perspective that we have is that plans contract that function out to their PBMs to let the PBMs run it. We really expect and we really hope that plans are overseeing that process day-to-day, because we're seeing a lot of the breakdown happen when plans contract out these functions to PBMs which don't always go smoothly.

One observation is that when we see an issue and we see a problem, that one difference is that when the CEO of a plan is well-informed, when they're focused on an issue, when the board of directors is focused on an issue, we see a much better, much more productive interaction with CMS. And it's those times when the board's not informed, the CEO is not informed, and they're surprised by information, when we have a little bit more conflict than CMS would hope.

So in all of this, one piece of advice, one piece of observation is to keep your CEOs informed, to keep the board of directors informed, to ensure they understand the operations, to ensure they understand what some of the issues are. We see a much more productive relationship with CMS when the CEO and the board of directors is involved, is thinking about issues, is thinking about problems, they have a much faster turnaround with any issue CMS has.

Next two observations, compliance plans matter. Those plans that invest and build well-structured compliance plans seem to have a more successful relationship with CMS. Organizational structures matter. Those plans that focus on organization, that focus on having independent compliance officers, but also think about compliance, not just within a subset of the staff but throughout the organization seem to have a much stronger relationship with CMS.

And lastly is that we encourage plans, similar to what CMS does, is to invest in internal controls, workflow processes, these things, you know, that keep coming up, those plans that have strong investments, that have strong focuses on how the work is actually conducted seem to have a much stronger relationship with CMS.

So one of our goals for 2012 is to be more forthright, to focus, you know, to communicate what we're focused on through the overall compliance strategy, but also to offer observations. And these may seem contrite and these may seem obvious, but really, from our perspective, they matter. And if I could just ask, you know, one thing to this audience is really this first point: we expect, we want, we hope that plans understand their operations, their data, what's going on much better than CMS does. Because while we have an incredible and much stronger ability now to watch claims, to review claims, to watch call center monitoring, by the time it gets to CMS, sometimes it's too late for us to address. So we really want to push on this point: know your operations better than CMS does.

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And lastly, just to conclude, so why does compliance matter? So why the focus on compliance? And I think it goes back to earlier points that we have said, is that this program will grow, this program will increase, it has increased, if beneficiaries and the overall policy community continue to have more trust in the program. And so I firmly believe that one of the reasons this program is growing, the Part C and the Part D context, is because beneficiaries believe the program is stronger, believe the program is being managed better, we're not seeing the same kinds of stories in the papers about beneficiaries having difficulty navigating the program. And so that is why CMS is focused on compliance, not to give the plan community a hard time, but because we want the program to have value, we want the program to grow, we want beneficiaries to think that this program is – both programs, Part C and Part D, provide value to them.

And going back to the plan perspective, if I'm thinking from the plan community, why compliance matters is now it's much more tied to reimbursement. So going back to the notion of five star, five star now is a reimbursement mechanism. Those plans that perform better, that have better compliance, that have better overall quality will have a much stronger economic prospect within the Medicare program.

Those plans that focus on compliance that have a overall very positive relationship with CMS, will be allowed to grow, will be allowed to expand. So it's not just the beneficiaries, though that is the first and foremost priority for CMS, but also from an economic perspective. From a business perspective, a strong compliance strategy will enable plans to grow, to expand, and to ultimately add more members.

So, again, CMS will continue our best to be more transparent to our priorities, to let you know what we're seeing, you know, kind of observations at large, but also some observations about how we think plans should respond. So hopefully as you're hearing some of the presentations this morning regarding the various policy documents that CMS released, the overall framework to how CMS is thinking about the programs to how we're overseeing the programs, we hope that you keep that also foremost.

We have a very strong priority to grow the programs, and our strategies to grow the programs go back to the first three priorities. First, is a kind of a steady state, our consistency in policy; second is the focus on quality improvement; and then third, obviously, our focus on compliance.

So, again, I want to thank everybody for travelling. I want to apologize for some of the indecision of whether this conference would happen. The government is open and so we are here. But I wanted to also thank you for your patience as you were finalizing travel plans over the weekend.

We have time for a couple questions. I know it's first thing in the morning, but if there's any burning questions, I'd be happy to stick around, and if not, I'd be happy also to turn it over to our first panel. I won't make anybody ask questions first thing in the morning. So thank you again everybody. Really great to see everybody here, and thank you for coming.