2015 Medicare Advantage and Prescription Drug Plan Spring Conference & Webcast Transcript

2016 Call Letter Updates – Medicare Part C

Welcome back everyone. Thank you for being timely for our first break today. We are going to go ahead and get started with our next speaker for today. Our next presenter is here to provide an overview of key items announced in the CY2016 call letter for the Part C program. Please welcome Heather Kilbourne.

Good morning everybody. I'm here to kick off the talk today on the call letter. I just want to warn you, it's kind of a doozy, so get comfortable. We've got a lot of material to cover. Okay, so I'm representing the Policy Division, and like I said, I'm just going to be doing the Part C sections of the call letter and then after, a few colleagues will come out and cover the Part D areas.

So I'm going to discuss the Part C and the final call letter that was issued on April 6th of 2015, and we're going to be covering the topics of the call letter that received the most public comments, and some items that we'd like to provide some clarifications for. I'll first begin with a brief overview, and then I'm going to provide resources where you can find information about the CY2016 beta review and beta submissions, and then I will cover the following topics:

We'll be doing the value-based contracting to reduce costs in health-care outcomes -- improve health-care outcomes, not reduce them. We'll do contract consolidation, then we've move on to the guidance to verify networks are accurate and provider directories are current. Then we'll do the guidance for all cycle submission of summaries of MOC change, then standardizing the health risk assessment, and finally we'll cover guidance for in-home health assessments. And then I'll provide you with a list of resources, and if we have time, I will answer some questions.

Back to the Top

All right, so the 2016 call letter contains information on the Part C and Part D programs that Medicare Advantage organizations and Part D sponsors need to take into consideration when preparing their 2016 bids. CMS has designed the policies contained in this call letter to improve the overall management of the Medicare Advantage and prescription drug program, with four major outcomes in mind. Those four outcomes are, one, continued program vibrancy and stability; two, value for beneficiaries and taxpayers; three, better quality care for beneficiaries; and, four, improved compliance for plans and sponsors. This year, to achieve these outcomes, CMS's call letter activities followed four major theme; improving bid review, increasing costs, promoting creative benefit design, and improving beneficiary protections.

So let's discuss the benefits in bid review. Each year CMS provides Medicare Advantage organizations with all of the necessary tools and information in advance of the bid submission deadline. And therefore, we expect that all MAOs submit their best accurate and complete bids on or before Monday, June 1st, 2515. That's the statutory deadline I think everyone's probably aware of since it's May. The most up-to-date benefit and bid review information can be found in our April 14th HPMS memo. It's titled "Contract Year 2016 Medicare Advantage Bid Review and Operations Guidance," and then in-depth guidance is also provided throughout the final call letter, and additional Part C benefit information is found in Chapter 4 of our Medicare Managed Care Manual. And for specific questions regarding the bid, like specific bid issues, please e-mail mabenefitsmailbox.lim.org, and there, you'll also find links to other reference materials and be able to ask direct questions, and get very prompt responses, I hear.

So now we'll move ton the value-based contracting to reduce costs and improve health outcomes. CMS consistently aims to issue policy that is designed to drive quality improvement in the care provided to Medicare Advantage enrollees and we recognize that one way to do this is through innovative program design. In January of 2015, the secretary announced the Administration's vision for moving the health-care system toward paying providers based on quality rather than the quantity of care that they provide. Commercial organizations, as well as CMS, have increasingly taken steps to make certain that health-care providers operate most efficiently, reduce costs, and improve health outcomes of patients. Such programs often involve physician incentive programs and frequently include financial incentives paid to providers.

Through the innovation center, CMS is testing a wide variety of new payment models, including different types of accountable care organizations, bundle payments for episodes of care or related health-care services, and primary care medical home. The overall goal of these payment models is to improve quality of care and reduce costs. More specific goals include reducing hospital readmission and improving performance on specific health-care measures. This is all issues I think you'll hear frequently throughout the day. The reducing costs and improve quality of care, that's something that CMS is very focused on right now, as I think most of you plans are focused on.

Back to the Top

So, in order for these models to succeed in the long term, health-care provider must make operational changes within their organizations, and these changes will only be attractive if a critical mass of payers, including CMS supports these financial models for health-care payments.

However, before making any fundamental changes to the Medicare advantage program, CMS has to first test and evaluate these new models effectively. To begin this process, in CY2016, CMS will reach out and have conversations with MAOs regarding how they are using physician-incentive payments and value-based contracting of provider services to achieve these goals. Based on this input, our hope is to, this year, also ask MAOs to share data with us regarding their adoption of these alternate payment models. We received many comments on this section in the draft call letter supporting CMS's general goals, and we were happy to hear that. And commenters represented a wide variety of people, including physician groups, beneficiary advocates, plans and other stakeholder, and they all supported and expressed interest in CMS's efforts in this area.

We would like to clarify that any information MAOs share with CMS on this subject will be completely voluntary, and we look forward to working with all interested parties to better understand the value-based contracting initiatives that are probably already in place as we work to support and accelerate the implementation of programs to improve efficiency and quality of care in the Medicare Advantage program. CMS will consider all input as we move forward in our efforts to encourage value-based contracting and before we make any updates to the MA program regulation. So that's it for value based. Let's move on to contract consolidation.

In CY2016, and going forward, CMS has encouraged MAOs operating more than one MAPD contract under the same product type and under the same legal entity to consolidate these contracts under a single contract ID. Please note that this is separate from MAOs request to consolidate individual plans or PBPs. This is leaving one plan -- not just about leaving one plan under a single contract ID, it's actually about consolidating two separate contracts.

Here we're discussing con consolidations at the contract level. MAOs are not permitted to consolidate contracts at different product types. For example, an MAO may be prevented to consolidate two PPOs, two HMO, or two private fee-for-service plans, but an HMO and a PPO will not be permitted to consolidate. We get a lot of questions on that. And CMS has already provided specific guidance on the content of consolidation requests be an HBMS memo dated February 6, 2015, and additionally, all contract requests for this year were due on April 15th. However, we want to encourage this type of contract efficiency going forward so we wanted to take this opportunity to remind MAOs about this call letter topic and also to inform you that we'll be adding more information about this subject in our future manual updates.

Back to the Top

So now let's talk about the guidance to verify that networks are adequate and provider directories are current. Under current program roles, Medicare Advantage organizations are required to maintain accurate provider directories for the benefit of enrollees. In the final call letter, CMS reinforced the existing rules regarding the accuracy of these directories to make certain that plans are aware of their responsibility to maintain accurate directories at all times.

CMS also clarified its expectation that plans update directories in real time and have regular ongoing communications with their providers in order to ascertain their availability and specifically whether or not they're accepting new patients. We found this extremely important to all of our beneficiaries. Consistent with the requirement to maintain and monitor an adequate network, MAOs are expected to establish and maintain a proactive structured process that enables them to assess on a timely basis the true availability of contracted provides, which includes, as needed, an analysis to verify that the provider network is sufficient to provide adequate access to covered services for all enrollees.

An effective process would include regular ongoing communications with providers to ascertain their availability, and specifically whether accepting new patients; MAOs are also expected to require contracted providers to inform the plan of any changes to street address, phone number, office hours or any other information that might affect that provider's availability. And finally, they were expected to develop and implement a protocol to effectively address complaints related to enrollees being denied access to any contract provider with follow through to make corrections to that online directory. I told you this one was a long one. Next slide.

We are reinforcing that in order for us to consider that MAO compliant with our regulation, MAOs must include their online provider directories all active contracted providers with specific notations to highlight those providers who are closed or not accepting new patients at the time. We clarified that MAOs are expected to update their online provider directories in real time, which means MAOs are to make updates when they are notified of changes in a provider's status or when the MAO itself makes contracting changes to its network of provides. Additionally, MAOs are expected to communicate with all providers on a monthly basis regarding their network status, including whether or not they're accepting new patients.

So let's move on now to the guidance for off-cycle submissions of summaries of MOC changes. CMS continues to emphasize the importance of the SNP model of care, or MOC, as the fundamental component of the SNP quality improvement framework. We recognize that in order to more effectively address the specific needs of its enrollees, a SNP may need to modify its processes and strategies, providing care during the course of its MOC approval timeframe. So this means if your MOC is approved for three years, and you find out a year-and-a-half in that you need to make fundamental changes that will improve your quality of care, we don't want to stifle you from doing that.

Back to the Top

So, we indicated in last year's call letter that we would establish a mechanism by which SNPs could notify CMS that they're making those revisions to the already approved MOCs. And this year we followed through on that promise in the call letter. Only certain MOC changes require CMS notification, and those changes include more substantive modifications, particularly those that include fundamental organizational changes or changes that are specific and fundamental to the MOC processes and functions. Some examples of MOC changes that do not need to be submitted include updates and demographic data about the target population, regular additions or deletions of specific name providers, because we'll have that this your network, as we just talked about, and grammatical and/or non-substantive language changes.

Okay, SNPs will submit these changes through a new HPMS module specific to MOC. The HPMS module for submitting MOC changes will be available later this year, and additional details and guidance regarding the new module will be provided pretty soon via an HPMS memo. But until that module is live in HPMS, SNPs should continue to document any changes they're making to their MOCs and notify CMS of those revisions, as they do now.

NCQA will then review the summary of changes submitted in HPMS to verify that the revisions are consistent and acceptable high-quality standards, as included in the original approved MOC. However, the revised MOC will not be rescored and the MOC's original approval period will not change as a result of NCQA's review of these changes; therefore, changes made to the MOC cannot be used to improve a low score. So you change your MOC and it's even better two years into it, we're really happy about that, but you still have to do another MOC when your original three-year timeframe ends. And hopefully it will be just as good, if not better.

Now let's talk about standardizing the health risk assessment. All MAOs are to make a best effort to conduct an initial assessment of each enrollee's health-care needs within 90 days of their effective date of their enrollment. Even more, SNPs are required to perform a comprehensive initial HRA that includes assessment of each enrollee's physical, psychosocial, and functional needs within the first 90 days of enrollment and then conduct reassessments each year thereafter. To date, CMS has not required MAUs to use a standardized set of basic components for those assessments. However, in 2012, we did a review of the landscape of HRAs used by SNPs, and we found that over 300 different versions were being used at that time.

After doing some research, we believe that the CDC model HRA, and other components of the annual wellness visit are sufficiently comprehensive to identify the medical, functional, cognitive, psychosocial, and mental health-care needs of enrollees, including those beneficiaries in SNPs. CMS believes that adoption of a standardized framework would provide consistency and CMSs and MAOs data collection processes across all plans, and provide a uniform and comprehensive information to support care planning, health promotion, and promote a proactive approach for initiating preventative and other appropriate care. So that being said, CMS is strongly encouraging MAOs to adopt the components in the CDC model HRA beginning in CY2016.

Back to the Top

In addition to those components, MAO plans are free to include other components or elements that may appropriately assess the needs of enrollees and their specific population, including components and elements designed to meet the care coordination and long-term goals of states that contract with these SNPs to deliver integrated benefits to Medicare/Medicaid enrollees. We do want to clarify, though, at this time that we're only suggesting MAOs use the model. However, we will probably be considering in the future developing and requiring a standardized HRA for use by all SNPs, but this will be done through a notice and comment rule-making process.

Use of the standardized HRA format would assure HRAs are comprehensive and appropriately assess each enrollees physical, emotional, psychosocial, and functional needs, provide uniform and comprehensive information to support care planning, and provide consistency in CMS's and MAOs data collection processes, making data assessment and quantify indication for everyone a lot easier.

However, again, we want to clarify that we're not mandating this, but we do encourage the MAOs validate that their current HRAs are comprehensive and appropriately assess each enrollees physical, psychosocial, and functional needs. We believe that the elements contained in the CDC model serve as an adequate guide for these assessments, so we are encouraging, if your plan is going to undertake those type of assessments that you look at the CDC model for guidance. And we, again, want to let you know that you are very welcome to include other elements that address the needs of your enrollees, because nobody knows your population better than you.

We'd also like to clarify that we're not suggesting that MAOs modify their current IT applications in order to accommodate the CDC model HRA. We believe that many MAOs already have comprehensive HRAs, and especially already have system and processes in place to effectively assess these enrollee's needs, and we don't believe that our recommendations are meant to be unduly burden some or require MAOs to make wholesale changes to their current practices. We're just making suggestions.

Okay. In this section of the draft call letter we, again, encourage plans to adopt, as a best practice, a core set components for their in-home assessments that they perform and to rate subsequent provided care. We believe that in-home assessments can have significant value as care planning coordination tools. In the home setting of all places, the provider has access to more information than is available in a clinical setting, and we expect plans to take advantage of the opportunities afforded by performance of in-home assessments to obtain and use that full spectrum of information to revise, develop, or implement comprehensive care plans for the effective enrollees.

Back to the Top

We will also, in CY2015, track and analyze care provision following in-home visits. We believe this two-pronged approach, providing guidance on best practices and tracking subsequently provided care, will provide CMS with some evidence that in-home assessments are a means to provide enrollees with all appropriate care and not solely for purpose of collecting diagnoses without providing follow-up care. We also think this approach will provide plans and incentive to adopt comprehensive in-home assessments consistent with the components we identified as best practices.

So now I'm going to go through the list of best practices that we identified. You can also find them in the call letter. All components of the annual wellness visit, including a health risk assessment such as the model CDC HRA; medication review and reconciliation; scheduling appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources; conducting an environmental scan of the enrollee's home for safety risk and any needs for adaptive equipment; a process to verify that needed follow-up care is provided; a process to verify that information obtained during that assessment is properly provided to the appropriate plan providers and that's big with care coordination; provision to the enrollee of a summary of the information, including their diagnoses, medications, and scheduled follow-up appointments planned for care coordination, and contact information for appropriate community resources; and finally, enrollment of assessed enrollees into the plan's disease management case management programs as appropriate.

Plans adoption of such comprehensive in-home assessment should provide additional information to support care planning and care coordination, and we hope could lead to improved health enrollee health outcomes. We also want to note that only diagnoses from risk adjust accessible physician' specialty types may be submitted for payment purpose.

Okay, so I think I'm finished. I want to give you guys some resources. You can find the CY2016 call letter posted on our website, along with the rate announcement. I think it's star something 64. It's attachment six. And this is the link for everyone at home, and hopefully you guys have it pronounced of everything.

For general questions about the regulation you can contact myself, Heather.kilbourne@cms.hhs.gov. For general Part C questions, please contact Nishamarie Sherry, nishamarie.sherry@cms.hhs.gov. So that concludes my presentation on the CY2016 call letter, just the Part C part. You still got a whole other section coming up after me. And I want to thank you guys for your time and attention today. And I'd be happy to take some questions. Anybody?

Hi, Heather. I'm Karen Berry from Aetna, and I just wanted to know, for the online directories update in real time --

Back to the Top

Yes.

-- will that be further defined in the Chapter 3 Medicare Marketing Guidelines?

When we do make updates, I think we do plan to sort of focus a little more on that, but right now with real time we're saying as you find out is when you need to update.

Okay.

Thanks.

Sure.

Hi, Shawn Bishop with SD Health Policy.

Hi.

Hi. I have a question about the components of the in-home enrollee risk assessment.

Sure.

I thought it's a very interesting lesson, I think very comprehensive. One of the elements in it I wanted to know if you could provide some more, I guess, insight into your thinking on what you might be expecting in terms of actual practice.

Okay. I will be happy to.

And that is, one, it has scheduling of appointments.

Oh, to schedule follow-up appointments?

So I just want to know if you can kind of provide any insight on your thinking on what the practice might be for that and how that would --

Well, I think one of the pre best practices is to make sure that whomever is going out is specifically qualified to do those assessments, and are associated well enough with the plan, as well as providers to kind of do, like, a whole care coordination thing and get follow-up appointments scheduled that way. So this doesn't necessarily mean I will sit down with you and call your doctor, and we'll make an appointment.

And that could happen.

Back to the Top

That could totally happen; right? So that would be fine, but I don't think that's necessarily our expectation. I think it would be more from anything from here's a list of providers that, going back to the directory thing, we know are open and accepting new patients, and after this evaluation it seems like you might want to see X specialist, so here is a list of them. Or you need help making your appointments, here is a follow-up number you can call, and we will be happy to help you make those appointments, things like that. I think we're more just wanting everyone to -- we're really focused, I think, as an agency on a whole, and same with plans, with beneficiary engagement, and I think that we really want plans to take advantage of while they have that beneficiary in their home in a comfortable setting, after having all that information, to take advantage of that time to really get them engaged in the process, help, you know, preventative care and giving them a lot of resources, and just a better overall understanding of where they're at on their health status and where they can move forward with that.

Thank you very much.

Sure.

Thank you. Scott Levine, Affinity Health Plan.

Hi, Scott. Hi. Our plan, and I understand many other plans, automatically update our online provider directories the next day after making a change, finding out change to all providers. Does that satisfy the CMS requirement for real-time updating?

Well, okay, so I'm not a compliance officer, and I don't have any authority at this point; right, to enforce anything. So I don't want to overstep the line, but I feel like you should do your best and if you find out about something the night before and the next morning it pops up there, we'll probably be okay with it. But don't hold me to anything.

I'm not going to hold you to it.

Okay, good.

Thank you.

Sure. Any other questions? I'm not sure how we're doing on time.

We're good on time.

Back to the Top

Okay.

So we have some questions from our virtual audience for Heather, and I'll go ahead and start with the first one, which is "Is my understanding correct, we can't submit CY2015 marketing materials past June 30th? But for CY2016, the standard timeline of 45 days before use still applies."

Okay, so that is a marketing question, not something that we really covered in the call letter. But I do have a resource. If, if any marketing questions or marketing material-related questions, we have a special mailbox. It's just marketing@cms.hhs.gov, so feel free. I know as everyone is prepping to get their marketing materials out and ready to go this summer, take advantage of that mailbox. We will be here to help you.

All right, we have another question, and that is, "Now that CMS is incorporating the EDS data into the risk score calculations, do they have an eventual plan to move EDS-only risk scores, removing the need for wrapped submission altogether, and if so, is there an expected timeline for this transition?"

So this happens all the time. That's actually a rate announcement question, which the call letter is contained in, so that makes sense that you would think that I'm the right person to go to, but I don't know anything about risk adjustment. But I do have an e-mail for you. It's the riskadjustment@cms.hhs.gov. So any money or number questions go to them, not to me. And, Christine, do you have a question? Did I say something wrong about marketing?

No. I was going to be able to clarify the marketing.

Oh, yes.

Since we do have someone here. E

Awesome.

Thanks, Heather.

Yeah.

Back to the Top

Marketing: For CY2015 marketing, you can still market through the vast majority of CY2013. October 1st you need to stop marketing the current CY2015 if you begin marketing CY2016. So October 1 is a hard deadline date. If you have documents that you want to use for CY2015, you can absolutely still submit them into HPMS, as long as you need to. So hopefully that clarifies. Go ahead and submit stuff into HPMS. Stop marketing 2015 products on October 1st of 2015, if you plan on marketing 2016. There are some exceptions for age and marketing for people aging in during 2015. If you have further questions, just go ahead and e-mail the marketing mailbox and we'll get clarification for you.

Great. Thank you Christina. It's very helpful. It's always nice to have backup. Anybody else in the audience? No?

Okay, our next question from a viewer is, "Can you discuss the Part D appeals expended data collections. Is it possible to have more data as direct uploads rather than data entry?"

I actually have an answer for this one. So as we stated in the final call letter, we plan, this year, to continue discussions of potential data collection system and the system requirements, and we don't expect implementation until 2018 at the earliest. We want to reiterate that we are definitely mindful of the administrative burden on sponsors for any potential future data collection systems and processes, and one of our goals in revising the current process is to include more direct data uploads versus just tedious data entry. And as we develop potential changes, we want to ensure that we have an adequate time to share more details with Part D sponsors for additional input and feedback and allow implementation. So I think a summary of that answer would be more information is coming and we have until 2018, so don't fret.

Okay, we have lots of questions from our viewing audience so we'll move on the next one, and the next question is, "With the format changes made last year to the summary of benefits, do you anticipate using planned feedback on its implementation to address issues and further improve it for 2016?"

That's another marketing question. I'm not sure if Christine wants to help answer that. But can you?

Yeah, she's coming.

Thanks. I'm very happy you decided to attend my presentation, Christine.

2016 -- okay, we're talking 2016 SB; is that question?

Yes. Let me -- was it 2016 on the question?

Back to the Top

Yes, it was 2016.

Yeah, 2016 SB.

All right, we did make significant changes to summary of benefits for 2015. Just to tell you where we are, tell you a little bit, but not being provide you everything that you want to know. We are working on developing a revised summary of benefits. We have discussed with industry representatives about revised summary of benefits. I do not believe that is going to be out for 2016. The 2016 probably, I believe, is going to be similar to what is currently out. But we are constantly reviewing our marketing materials and are making appropriate changes in the medium to long-term to better meet beneficiary's needs and to better address how organizations actually use summaries of benefits, plan highlight booklets to really meet the requirements that we have, along with the best in practices and industry. And so I've told you a little bit, but probably not quite the answer you want.

Much better than I could do. Thank you.

And any other marketing questions?

Yeah, while she's up here? No. Okay, we're good.

Our last question that I have here is, "On Page 138 of the 2016 call letter under guidance to verify that networks are adequate and provider directories are current, is it the expectation that only providers who are accepting new patients should be included in the network adequacy data?"

Yes, that is correct. So for network adequacy, we consider it to contribute to being -- your network being adequate if that provider is available to enrollees. If they're closed, then it doesn't count at this point.

I do have a question.

Sure.

It's really more about Part D, and I was going to wait until after the Part D presentation, but it also involves marketing, so while we have a resource, I'm going to ask it now.

Great idea.

Back to the Top

My name is Lynn Wardinger, and I'm with Geisinger Health Plan, and wondering if there are any plans to revise the EOB? Our members detest the EOB that has become mandatory. It's so much different than what they were used to. We sent out our regular EOB that we also send out to our commercial people. They were used to that. We just have continual complaints and our members are really unhappy with it. So hoping that they would be some revisions to make it more member friendly.

So I will defer to Christine on EOB -- future EOB updates, but I will say that I think it would be very beneficial if we got specific feedback, maybe offline, on particularly what sections the members are finding confusing. I think that would really help us in our development.

And the EOB is not my area.

Oh, there.

So I agree that we certainly need to get feedback. The Part D person might be able to provide you the correct e-mail address, at least to get it into CMS.

Yeah.

But, sorry, can't help.

Yeah, sorry, but thank you so much for your question. And that's good to know. Any feedback is good feedback.

Okay. We are out of time for questions today, so I would like to thank you all for your questions that you posed to Heather, and also would like to thank Heather for presenting today.

Bye.

Back to the Top