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

Open Q&A Session

All right, so this is our open Q&A session, and how we are going to run this is we are going to go through the agenda, and starting at the very top with the first speaker, which is Lieutenant Manteuffel, and we are going to ask Lieutenant Manteuffel one of the questions that came in from our audience today, and then we have approximately three minutes for each speaker, and then that will be it.

So, Lieutenant Manteuffel, if you could step up to the microphone, and the first question that we received for you today is, please elaborate on the requirements for the MAOs to hire a consultant to complete the CMS program audit remediation process. Will the consultants need to be certified, or on an approved CMS list?

Okay. In response to that question, specifically the last part, we right now do not have a specific list, but additional criteria on this topic will be released on the [MOED] conference next month, so that information is forthcoming.

Okay, the next question that we have, and I have to apologize, the printing is very small, and my eyes are old. According to the final rule, we are revising both 422.503D-2 and 423.504D-2, to insert the word timely at the end of both the introductory paragraphs. However, the change hasn't yet been made. When is this expected?

Okay, I wanted to specifically thank this commenter for pointing that out, and bringing that to our attention. You are absolutely correct; I saw the question come in, and looked at the electronic version of the CFR, and I'm also not seeing it, so that is something that we are going to raise to our contacts internally to investigate why that change did not happen, but again, we really appreciate that being brought to our attention, so thank you.

Back to the Top

All right, and that is it for Lieutenant Manteuffel. So our next speaker that we are going to have questions for is Heather Kilbourne.

Hi, guys. So before I answer any of the SurveyMonkey questions, I feel like I might have caused a little bit of confusion this morning, when I answered a question, based on some of the follow-up questions other presenters got. So I did want to clarify, in my provider directory presentation, I may have caused confusion when I said that you're – if your provider is closed to new patients, it doesn't count towards your network adequacy.

That's not exactly what I meant. For your HSD tables and the network adequacy module, you will still put all of your providers into that. You just need to indicate within there, whether or not your providers that you're listing for your network are accepting new patients or not. What is really important in my section was really the provider directories, and that is where it's really important to make sure you have a very highlighted, easy to see notification for your beneficiaries, whether or not you're accepting new patients, or if it's open to anyone, to any new enrollees.

So I hope that that clears any confusion up for anybody, and of course, if you have any follow-up questions to that, just email me or let me know. Okay, thank you.

All right. The first question we received is as follows: My question is regarding a statement on initial and annual HRA. I thought that it was stated that the addition to the HRA that should be completed within 90 days of enrollment into a SNP plan, that the member should also receive a comprehensive assessment in the same 90-day period. It is my understanding that the HRA must be completed in 90 days or annually. I am confused about required completion of another comprehensive assessment completion on all members in 90 days, in addition to the HRA. Can you please clarify? Thank you.

Yes, that one I can clarify. So the only requirement for SNPs within the 90 days is the HRA. When we say a comprehensive health assessment, we're referring to the HRA. So that's the set requirement. It's not an HRA and a comprehensive assessment. We use those terms interchangeably, because as you can tell from the HRA requirements and then our discussion on the comprehensive CDC model, we're hoping everyone sort of adopts or at follows as a guideline, we want the HRA to be comprehensive. That's all that meant.

Okay. The next question. What is your expectation regarding the need for adaptive equipment, as these are not Medicare-covered benefits?

Back to the Top

Okay, so for adaptive equipment, again, this is for, I think, about the in-home health section of my presentation, and one of the best practices was when you're performing the in-home health assessment, that you engage your beneficiary or let them know about any adaptive equipment they might need. In the Medicare Advantage program, we have plenty of adaptive equipment that is covered through supplement benefits, so even if something is not covered through original Medicare, your plan may still cover it through Medicare Advantage Part C as a supplemental benefit.

A good example of that would be safety equipment, like in a bathroom. So that would be something that, as a result of going into someone's home and seeing that they're prone to falls or might need some safety equipment, then you would follow through with getting that patient set up with that equipment. That would be covered through a supplemental benefit.

Okay, and one last question here. What is the expectation of home assessments for MAO plans, if one is not yet established?

So I think that that is referring to an in-home health assessment from a plan who doesn't already have in-home health assessments in place. We understand that it's not a requirement for plans to conduct in-home health assessments, depending on what plan type you are. If that's the case, we're not saying that you need to have one. What we are saying is if you do decide to participate or take that option to perform in-home health assessments, we need them to be comprehensive.

We hope that when you're doing so, you're following the best practices that we listed in the call letter, and we have an expectation that you will use this in-home health assessment to fully engage care coordination, not just use that for the diagnosis codes. And it follows then, that if you do perform in-home health assessments, CMS plans to track any follow-up appointments that come after you put in a code for an in-home health assessment for that patient. So I hope that clarifies that.

Okay. Well, thank you, Heather. We are out of time for your questions. Next, we have Lucia Patrone and Andrea Bendewald, and the third presenter, Elizabeth Flow-Delwiche is unable to be with us for this session, and we noticed that there was quite a bit of interest on star ratings, and we do have answers to some of the questions that were posed to her, that we will try to address during this time. If you do have additional questions, or if you ask questions that we have not answered, we will then post those on the CTEO website.

So the first question that we received, concern for contracts that have not received star ratings. Is this configured as a combined rate Part C and D, or separately?

Back to the Top

Hi, all. So the LPI is not actually based on the overall rating, but rather, it's based on the Part C and/or the Part D summary rating. So they're for the individuals with – that would go back with the summary ratings. It's not the overall Part C and D rating.

Okay, the next question that was received. It is understood that 2016 formulary submissions will not include the naming of non-preferred generics. It is also understood that drug type label number 3, non-preferred generics, may be utilized in the submission. If the plan sponsor decides to exclude drug type label number 3 from the submission, would this be an issue?

Thank you for your clarifying question. As discussed during the presentation, no changes will be made to the current validations that exist in HPMS and the PDP. With respect to the formulary submissions, we do not anticipate any validation concerns. If a sponsor were to choose to exclude the use of drug type label number 3 from their submissions, so that answers that question. However, take it a little further, there is a validation in place, however, for the PDP, which will cause exit validation errors if a non-preferred generic tier is selected within a tier model, and a non-preferred generic is not included, and the tier includes fields for that tier label. Thank you.

All right, Another question received. When does CMS anticipate publishing updating stars specifications for 2016?

So I'd like to preface this answer with, in the beginning of the call letter, I want to say it's in the first ten pages of it, there's the annual calendar. That has all of the dates for when the star rating specifications will be released, as well as the star rating thresholds. So I'll combine two of these questions, actually, Stacey, if that's all right, that the updated stars specifications for 2016 are going to be in the Medicare Plan Finder preview, the first preview, which is generally at the end of August, and then the star rating threshold for new measures, as always, will be held during the second plan preview for Medicare Plan Finder. But please refer to the annual calendar. I know that it's a quite lengthy calendar; however, there's a lot of good information in there.

Okay, thank you. And we are out of time for Lucia and Andrea, but thank you so much, and any additional questions, again, we will post on the CTEO website. Next up we have Donna Williamson, and Donna, we received for you, and that question is, are CCIPs and other QIPs required for PDPs?

The answer to that question is no. Standalone PDPs do not require QIPs or CCIPs; however, MA plans, SNP plans, and MAPDs do require the implementation of QIPs and CCIPs.

All right. The next question that we have received is as follows: QIPs and CCIPs for dual-demo projects. Will CMS want annual and quarterly updates?

Back to the Top

Okay. The answer to that question is that MMPs must follow the same requirements as MA and SNP plans for their QIPs and CCIPs, and that is that they are required to submit a plan section, as well as an annual update; however, my understanding is that the states also want updates, and I believe those are quarterly updates, and those will be submitted outside of HPMS. So again, the duals office, they are really overseeing those MMPs and the required projects, so they can better answer some more specifics surrounding those types of questions.

Okay, and one last question here. What is the likely timetable for use of QIP and CCIP results in the development of new star rating measures, or for replacing the methodology used for existing star measures?

At the time, we have not made any determination around that, and as I mentioned during the presentation, that there's so much variation in the approaches that plans are taking, also target goals, interventions in population, and those things have changed and evolved over these projects, which we expect that to have happened, so it's a really difficult thing for us to say now that, okay, that we're going to be incorporating the results into the star ratings methodology; however we still want you to focus on quality improvement and achieving your goals and improving health outcomes for enrollees.

Okay, and that's all that we have for Donna.

Great, thanks.

Okay, our next group up is Greg Buglio, Kady Flannery, and Nisha Sherry. Okay, the first question received, when will CMS begin requiring HSD submissions, and what will happen if an organization fails the automated criteria check evaluation?

So CMS already requires HSD submissions with the online applications. In terms of referencing the network management module, per the presentation, we're still developing those guidelines, and you can forward those questions directly to, unfortunately, Nisha, to your mailbox. So to Nisha.

All right, our next question is, for the organization initialed HSD submission, will CMS use that information?

Can you repeat that again?

Mm-hmm. For the organization initialed – initiated, sorry, it's my fault.

No, per the presentation, if you initiate your own submission, please refer to the slide, it's even underlined. We will not be looking at that.

Back to the Top

All right. Another question that was received. In an organization, if an organization has questions about how to prepare the HSD tables, what resources are available for assistance?

So there are guidelines throughout the module. There's a document called the HSD instructions, or in this case, the NMN instructions. Those instructions include an explanation of what each field means on the tables, and how to complete that. If you have technical questions, you can certainly contact either the HPMS help desk or myself. So my email is out there, as well. For policy-related questions, again, I would refer you to Nisha.

All right. We have another question for you, Greg. Will an organization be able to request exceptions with these submissions, in a similar fashion to the application process?

So for the CMS initiated requests for HSD tables, depending on the type of request, and depending on the purpose we would not make exceptions available, since we're not looking at that data. We wouldn't be looking at an exception either. So depending on the purpose, and I should point out that CMS is also still in the process of developing procedures around exceptions, and the submission of exceptions for the various types of HSD submissions. So hold on, and we'll be releasing that, it's sometime in the near future.

And one last question. When an organization requests an HSD submission, how long will the results remain available?

So for the organization initiated submissions, HPMS will store the latest two submissions or results. So if you come in and request, or submit HSD tables, and you get a set of results, you come in a week later, you get a set of results, you come in another week and get another set of results, we'll maintain the latest two at all times.

Okay, thank you, and that's all that we have for you. Oh, I'm sorry, I lied. I have another question for you. Another few.
Okay.

Is the NMM available to new applicants as well as it is released in July, once they have HPMS access?

So the goal is to have a one-stop shop for network submission. So the long-term goal is that the network management module would be available to both initial applicants, which would mean that we wouldn't have to run a pre-check. You would be able to just come into the network management module when you needed to for that, and do the pre-checks for the application. But we're still in the middle of developing the module, and developing the guidance around that. So the long-term answer is yes, but I don't know it specifically, when that becomes effective.

Back to the Top

You mentioned you can fix the tables and try again. Will the system require you to upload all information again, or just the information identified as problematic?

Okay, that's a good question. So when the tables are going through the edit process, if there are errors, we can't write any of the data to the database; therefore, you would fix the table and re-upload the entire table.

And one last one, I promise this time.

Okay.

Our plan is in rural Minnesota counties. Some counties have very few providers in the bordering counties. If we are able to include only those listed in the servicing counties, we are limiting our true network for access. Do we or can we include the bordering counties?

So the HSD process doesn't ask you to limit the providers to the county that you're applying for. Never has, and still doesn't. So when you're filling out the tables, you'll see a row, you'll see a bunch of columns, and one of the columns is county. You don't list the county in which the provider is located, you list the county in which the beneficiary is located who would receive services from that provider. So there is no restriction of saying you can't list providers that are not in the county, you absolutely can. When you're driving to the doctor, if you live in Baltimore County, and your doctor is in Howard County, you don't hit the county line and go, oh my gosh, I can't go over. We have the same view with the HSD tables. So we're looking at time and distance, not the county. So when you're filling out the form, the county is where are the beneficiaries located, not what county is the office located in?

Okay.

Good question.

Thank you, and we have up next, Jim Canavan, Cindy Falconi, and Patty Helphenstine. All right. This question has to do with incarceration. Please confirm the effective date when plans will see these new transactions and notification requirements.

So we're hoping that this will be, we expect it to be late 2015, early 2016. We're working to implement the structural framework for these system changes in August, like we mentioned. As soon as CMS starts receiving the data, we're going to move quickly to alert plans and start effectuating the new transactions. So we don't have an exact date yet. So late 2015, early 2016.

Back to the Top

And just to add to that, in the August release software memo that we put out in April, we indicated that while we're putting out the software changes to create the structural framework, we're also encouraging plans to do the same, so that they're ready to receive the data once we start, once it's available, and once we're able to send it out.

Okay. The next question has to do with lawful presence. When will CMS start implementing this? Please confirm the effective date when plans will see these new transactions and requirements for notification.

This is really the same type of situation as our incarceration. We are in the process of making significant systems changes, in order to obtain, maintain the data, and be able to share it and apply it to our downstream programs, which in essence is MARx and the beneficiary eligibility query. So at this time, it is delayed. We do not have an exact date, but what we will do, as part of our software release memorandums, we'll be providing advance notice through our normal processing, which is usually three to four months out for advance notice, and a couple of months out for detailed notice, so that plans have time to make the changes that they need. And of course, we'll be putting out guidance in advance as well. The bottom line is, you'll have time to implement it, it won't come immediately without advance notification.

Okay, the next question has to do with good cause. When will CMS provide the criteria and requirements for this timeline?

So we are working on the guidance updates, and trying to get out that information. We know plans are very concerned, and want to make sure that they understand what exactly falls into the favorable or unfavorable categories. And what I would say right now is, generally, what we have in guidance for the criteria, we don't expect it to dramatically change. So, you know, familiarize yourself with that, but we will be putting out more detailed guidance. We're expecting that to be in July, and hopefully able to provide more definitive information on perhaps scenarios or things of that nature, to help you understand, or be able to make those types of determinations.

Okay, and one last question, also on good cause. Plans would like to confirm if the CTM SOPs will be updated to support this process?

Yes, they absolutely will.

Okay.

Thank you.

And that is all the time we have for questions for you, so thank you very much, Jim, Cindy, and Patty. And I don't have any additional questions for Rosalind or Beth. Is there anyone in the audience who has a question for them? Rosalind, do you have any more questions for yourself?

Back to the Top

No. Okay.

All right, then that is it for our Q&A session. I'd like to thank all of our speakers for coming back and joining us.

Back to the Top