CMS Plans to Alter OEV Call Rules, Summary Of Benefits Document to Be More Useful

CMS intends to change for 2015 both the content and layout of the Summary of Benefits document that Medicare Advantage plans give to enrollees to make it more understandable and suitable for consumers, an agency official said at CMS’s spring MA and Part D conference May 6. And another official said that CMS is reassessing the value of the outbound enrollment verification (OEV) calls that the agency requires MA plans to place, and expects to make changes to enhance their usefulness.

The coming changes are among several outlined during the Marketing, Surveillance and Compliance Update session of the conference, which this year was conducted for agency outsiders via a webinar only because of budget limitations. During the session, CMS officials also summarized the results of their “Secret Shopper” surveillance of marketing during the 2013 Annual Election Period last fall, which they said generally showed compliance improvements compared with previous AEPs. And they outlined future areas of marketing compliance focus for the agency.

Those potential future focuses, said Christine Reinhard, an attorney who is a health insurance specialist in the Medicare Drug and Health Plan Contract Group in CMS’s Division of Surveillance, Compliance and Marketing, include plan payments to providers excluded from Medicare. Other focuses are administrative requirements and attestations (including ones related to agent/broker compensation), timeliness of services delivered to beneficiaries who win appeals, and ensuring that beneficiaries get promised services in a timely manner.

The upcoming changes to the Summary of Benefits could be among the most significant revisions. Erica Sontag, also a health insurance specialist in the Division of Surveillance, Compliance and Marketing, explained that testing found beneficiaries

continued on p. 7

MA Plans Post Strong First-Quarter Results, But Warn on Impact of Pay Cuts, Sequester

Medicare Advantage plans still generally are reporting strong earnings, aided by continued low medical-services utilization, based on figures and comments on first-quarter results of publicly held firms presented late last month and early this month. But several of the plan sponsors also pointed to storm clouds on the horizon in the form of not only payment-rate reductions but also the industry fee that starts in 2014 and the expected return of higher utilization patterns.

The prime example of all of those trends may be Humana Inc. The MA-focused firm on May 1 posted first-quarter net income of $473 million or $2.95 per diluted share, up strongly from $248 million or $1.49 a share in the year-ago period, albeit aided by some extraordinary items. Revenues climbed to $10.49 billion from $10.22 billion. The insurer also boosted its earnings guidance for the remainder of 2013.

President and CEO Bruce Broussard in the earnings conference call with investors pointed to several reasons for the gains, and most of them also were cited in other MA
sponsors’ quarterly financial reports. One was that “we...experienced favorable medical expense trends in most lines of business,” he said. “This was primarily driven by lower levels of hospital utilization after the flu season rapidly abated in the third week of January.”

Even aside from that, though, according to Broussard, Humana had “strong operating performance” in each of its business units. This included stand-alone Prescription Drug Plans (PDPs), noted Chief Financial Officer (CFO) James Bloem, which benefited from “a favorable drug utilization mix” versus the 2012 period.

But both executives cautioned against expecting the good financial news to last indefinitely. Broussard said that Humana’s calculations of the overall 2014 MA rates, for instance, indicate a decline in the company’s MA payments from the government of “well over” 4%, including the impact of the annual insurer fee that starts in 2014. In light of this, he added, “we remain uncertain if 2014 will be a year of earnings growth.”

Moreover, he asserted, the risk-coding “recalibration formula” changes CMS made in the final 2014 rate notice (MAN 4/11/13, p. 1), combined with the impact of another year of “rebasing” of counties by the agency, means that “certain of our stronger markets will see a rate pressure in the mid-to-upper single digits for 2014.” Chief Operating Officer Jim Murray, in response to a question, indicated those include MA HMO-heavy markets in Florida, Louisiana and Las Vegas.

Asked what the company might do about the coming squeeze, Murray replied that “we’ve got premium [hikes] and benefit cuts that we can evaluate on a market-by-market basis.” In several markets, he continued, Humana has risk-based arrangements with providers who will help the company absorb some of the hits, although the company may not want them to incur too much out of fear of damaging “one of our strongest assets.” CMS’s use of a maximum allowable Total Beneficiary Cost increase for 2014 of $34 per member per month, down from $36 PMPM for 2013, “may have some unintended consequences, because we’re evaluating that in terms of whether we want to exit a market now,” he asserted.

None of this, though, will stop Humana from making major investments in the MA business that it considers desirable, executives emphasized. The company already, Broussard noted, for instance, boosted the number of its care management-related workers to about 7,600 on March 31 from 4,400 one year earlier. He added that Humana has 180,000 seniors in chronic condition care programs now, up from 125,000 a year ago, and expects to have 275,000 in those programs by the end of 2013.

Cigna Says Rates Will Cause ‘Market Disruptions’

Cigna Corp. President and CEO David Cordani also warned that the final MA rates for 2014 will cause “market disruptions.” Speaking in the company’s May 2 earnings call, Cordani said Cigna calculates the net impact as a “mid-single-digits” reduction, excluding the impact of the new “industry tax” and varying, of course, by service area. He added, though, that there also may be benefits for Cigna in this, since the tough climate could present opportunities for acquisitions in the MA arena.

“We’d expect to have less than average disruption” compared with other MA operators because of the “provider-collaboration model” that it increasingly has used since acquiring HealthSpring, Inc. in 2012 (MAN 10/27/11, p. 1), he maintained.

Even Cigna, however, already is experiencing some MA challenges. The company’s MA medical loss ratio (MLR) for the first quarter, noted Cordani, was 84.3%, up 3.2 percentage points from the year-ago period, with about one-third of that increase due to the higher prevalence of the flu.

While part of the flu impact was offset by favorable prior-period reserve development (PPRD) as utilization remained low, indicated CFO Ralph Nicoletti in response to a question, Cigna expects the MA MLR to continue edging up during the rest of the year. That’s not all bad, he noted, since MA plans must meet a minimum 85% MLR beginning next year. Nicoletti said MA now accounts for...
about 15% of Cigna earnings, a figure much higher than before the HealthSpring purchase.

**Aetna Inc.** on April 30 also reported a rising Medicare MLR. Its figure, which includes PDPs and Medicare supplement as well as MA, was 87.8% for the first quarter. This, pointed out securities analyst Carl McDonald of Citigroup Global Markets in an April 30 research note, is more than 3 percentage points above the figure for the year-ago period. But analyst Matthew Borsch of Goldman Sachs said part of that may result from the huge Teacher Retirement System of Texas (TRS) employer group plan it landed for MA last summer (MAN 8/2/12, p. 1).

The company’s overall Medicare MLR, said CFO Shawn Guertin in the earnings call, is expected to be in the “mid-to-high 80s” for all of 2013, up from the mid-80s in 2012 partly because of the effects of the ongoing federal sequestration, but in line with its previous guidance. He noted that Aetna posted a big increase in MA membership, to 941,000 at the end of March from 605,000 one year earlier, with the aid of the TRS contract.

The government-programs plan specialist — **Coventry Health Care, Inc.** — that Aetna just completed acquiring (MAN 4/23/12, p. 1) also reported a substantial membership gain. Coventry said on May 1 that it had 309,000 MA coordinated care plan (CCP) members on March 31, up 24% from the end of 2012. MA revenues were slightly down in the first quarter, to $831.38 million from $834.31 million in the year-ago period, when revenues were aided by a $141.8 million reserve release, the company said.

Coventry posted an MA-CCP MLR of 84.6% for the first quarter, slightly up from the 83.9% in fourth-quarter 2012 and an adjusted 82.9% for last year’s first quarter.

**Universal American MA Plans Had Strong Quarter**

The first-quarter 2013 MA MLR of **Universal American Corp.** was 80.3%, and the restated MA MLR after taking into account typical prior-period adjustments was 83.5%, in line with expectations, said CFO Bob Waeglein in the April 30 earnings call. He said the MA business had a “strong quarter, with pretax profits of $38.6 million,” aided by favorable PPRD. Overall, net income slipped to $14.0 million or 16 cents a share from $19.5 million or 24 cents in the year-ago period, but revenues advanced to $563.3 million from $531.8 million.

In response to a question, Waeglein said sequestration is likely to cost Universal American between $6 million and $7 million this year. And Chairman and CEO Richard Barasch said the changes in MA risk adjustment for 2014 outlined in CMS’s final rate notice could hurt the company’s key Houston MA market “a little worse” than it hurts “less advanced markets.”

The same two negatives for MA — sequestration and risk-adjustment changes — also got singled out in the May 3 earnings call of **WellCare Health Plans, Inc.** CEO Alec Cunningham said the impact of CMS’s new risk-adjustment model for 2014 is “negative” for the company’s service areas, especially those in which it has many beneficiaries with “complex” needs and dual eligibles. CFO Tom Tran added in response to a question that the impact is going to be “more than we had expected” and that WellCare is “reassessing” benefits and other product features as a result.

While the company raised its earnings guidance for full-year 2013, it posted first-quarter net income substantially lower than analysts had projected and below that in the year-ago period. Among the reasons for this, Tran explained, was a higher-than-anticipated impact of the flu season, which did not drop off for WellCare as much in February and March as the company had “hoped.”

**Sequestration Is Seen as Hampering Results**

Another reason for the shortfall, he indicated, was the effects of sequestration, which the company had not figured into its February earnings guidance. Cunningham said WellCare is trying to cut costs to deal with the continuing impact of that.

WellCare reported an MA MLR for the first quarter of 87%, well above the 78.8% in the year-ago period although consistent with expectations, according to Cunningham. Tran explained that the insurer had expected this MLR to rise based on the benefit levels it had included in its 2013 MA bids, along with the acquisition late last year of high-MLR MA plans in California and Arizona (MAN 9/20/12, p. 3). Another factor, the company said, was a lower level of favorable PPRD in the 2013 quarter.

The MA MLR also was a problem for **Health Net, Inc.** The company on April 29 said the segment MLR for the first period was 91.9%, much higher than analysts had expected and than the 87.9% in the year-ago period. Analyst McDonald figures the higher-than-anticipated MLR contributed to a “shortfall in gross profits” relative to his expectations of $24.5 million or 19 cents a share. And Health Net President and CEO Jay Gellert said the company expects its MA payment rates will decline about 3.5% in 2014.

For a change, **Triple-S Management Corp.**, whose MA financial results in many prior quarters had disappointed analysts, posted strong first-period MA gains. The company on May 1 said that its MA MLR for the first quarter was 83.1% (or 85.0% adjusted), well below the 91.0% (88.3% adjusted) in the year-ago period, partly as a result of favorable PPRD.

Another contributor, said President and CEO Ramón Ruiz-Comas in the earnings call, was improvements stemming from a new pharmacy benefit manager (PBM)
contract that took effect Jan. 1 as well as “adjustments” in its pacts with primary care physicians.

McDonald said in a May 2 research note that the new PBM vendor negotiated more favorable pricing terms, especially for Triple-S’s American Health subsidiary. Triple-S also reduced MA benefits, he said, which resulted in declining enrollment but helped the company post pro forma net income of $15.6 million or 55 cents a share, well above the pro forma $6.1 million or 21 cents a share in the year-ago period.

Contact McDonald at carl.mcdonald@citi.com and Borsch at matthew.borsch@gs.com.

Medicaid Plans Post First-Quarter Gains in Some Problem States

The best news for managed Medicaid plans in the first quarter was that some of the previously troublesome states for them apparently became less so. These include California, Ohio, Texas, Wisconsin and even, to a lesser extent, problem-plagued Kentucky. Rate changes and other payment-related relief were major triggers for the improvements in most of those states.

One of the major beneficiaries of the changes was Molina Healthcare, Inc., which on April 25 posted big gains in earnings per share and revenues. In the most recent period, the Medicaid plan sponsor said, net income soared to $29.9 million or 64 cents per diluted share from $18.1 million or 39 cents per diluted share in the first quarter of 2012. Revenues rose to $1.59 billion from $1.37 billion.

Chief Financial Officer John Molina said in the earnings conference call with investors that the company’s medical loss ratio (MLR) dropped to 86.1% in the first quarter from 88.1% in 2012’s first period. He attributed the improvement to factors that included a retroactive rate increase in California, better performance in Texas and “flat inpatient utilization.”

The company noted that California had restored Medicaid managed care payment rates to levels prevailing before cuts that took effect July 1, 2011, and had instituted a “modest” boost in rates for the aged, blind and disabled (ABD) population retroactive to this date. The new rates are expected to boost premium revenue at Molina’s California plan by about $400,000 per month, according to the company.

Similarly, said CEO J. Mario Molina, M.D., the firm’s loss-ridden Texas Medicaid program has seen “stabilization” that allows higher payments for some providers beginning this July 1. The first-quarter results in the Lone Star state, the company said, show “considerable improvement” versus first-quarter 2012, aided by a 4% rate hike effective Sept. 1, 2012.

Mario Molina added that he is “cautiously optimistic” that the firm’s Medicaid plan in Wisconsin, another problem state, is “turning around.”

Centene Corp., which on April 23 reported slightly lower earnings for the first quarter (MAN 4/25/13, p. 8), also cited improvements in states where it has experienced difficulties. Premium and service revenues soared 53% from the level in the first quarter of 2012, aided by an expansion and pharmacy carve-in in Texas. And while the consolidated MLR in the first quarter was 90.4%, up from 88.2% in the same period of 2012, it was down from 91.3% in last year’s fourth quarter, Centene added.

The company still has one big trouble spot, Kentucky, where it has announced plans to exit July 5, but the state has contested its right to do so (MAN 11/12, p. 4). “We still have fears that Centene’s planned July 5 exit from the state will not go as smoothly as the company hopes,” wrote securities analyst Carl McDonald of Citigroup Global Markets in an April 23 research note.

Centene did not get the state’s 7% rate increase, which is going to two companies that have not said they’ll leave Kentucky’s program. Both Coventry Health Care, Inc. and WellCare Health Plans, Inc. received those hikes effective Jan. 1 and will get their Oct. 1, 2013, rate boost three months early. This should mean that “both plans should be profitable in Kentucky this year,” McDonald asserted.

WellCare Cites Improvements in Ky. Results

WellCare CEO Alec Cunningham said in the company’s May 3 earnings call that, aside from Louisville-area membership being lower than anticipated, other aspects of its Kentucky Medicaid program have “improved significantly” compared with 2012 results.

The big Medicaid improvements for Health Net, Inc. were in its home and largest state, California. Adjustments that the Golden State made for the company’s Medicaid payments in prior years were worth about $30 million in revenues, said President and CEO Jay Gellert in the April 29 earnings call.

More specifically, said McDonald in an April 29 research note, the pioneer risk-sharing arrangement Health Net has with California on Medicaid “resulted in $20 million in additional profitability” in the first quarter.

Gellert himself said that “we did see SPD [i.e., the costly Seniors and Persons with Disabilities population that Health Net serves in California] trends moderate some in the first quarter, but we still have other issues to resolve.” The company is “encouraged,” he said, by its discussions with the state about those issues, which he did not specify.

Contact McDonald at (617) 247-6312.
SNP Eligibility Verification, MA Transition Rx Fills Are Seen as Problems

Medicare Advantage and Part D plans generally are doing fairly well in areas scrutinized by CMS’s Division of Benefit Purchasing and Monitoring in the Medicare Drug Benefit and C&D Data Group, an official of that group said at a CMS conference May 6. But there is “lots of room for improvement” in some areas, such as eligibility verification by MA Special Needs Plans (SNPs) and access to transition supplies of formulary pharmaceuticals, said Greg Bottiani, an attorney who is a health insurance specialist in that division.

Speaking at a session of the CMS spring MA and Part D conference, viewed by more than 2,300 registrants via webinar only this year, Bottiani outlined many results of the agency’s data-driven monitoring, which unlike its surveillance activities (see story, p. 1) is conducted across all MA and Part D contracts.

Monitoring of data self-reported by SNPs, he said, found that the specialized plans comply only 32% of the time on initial-eligibility verifications of enrollees and just 49% of the time on continued-eligibility verifications, he said. Moreover, according to Bottiani, the average SNP sent just 12% of disenrollment letters properly. Overall, he added, institutional SNPs performed better in the whole area of enrollment/disenrollment verification than did either chronic care SNPs or SNPs for Medicare-Medicaid dual eligibles.

He noted that CMS in 2012 added SNP enrollments and disenrollments to its formal audit protocols, with a focus on eligibility and meeting required time frames for actions. Also last year, Bottiani added, the agency modified guidance to state that eligibility verification is required and that plans have 21 days to furnish certain information. In final 2014 guidance, CMS may clarify areas of remaining confusion regarding these requirements, he said.

By contrast, he continued, plans are doing “pretty well” on eligibility verifications for Special Election Periods (SEPs). CMS monitoring found 97% compliance on SEP eligibility verifications, 78% on compliance regarding date of eligibility verification and 85% on effective date of enrollment. However, eligibility-date compliance is much lower (68%) for institutionalized MA beneficiaries, added Bottiani.

While overall eligibility compliance is “high,” he said, CMS for 2014 will consider trying to answer lingering questions surrounding SEP eligibility and the proper ways to submit eligibility determinations via CMS systems.

Another area of monitoring focus is formularies, via CMS’s Transition Monitoring Program Analysis (TMPA). In December 2012, Bottiani recalled, CMS said it would analyze, with the help of contractors, access to transition supplies of pharmaceuticals among MA plans’ beneficiaries. A specific focus was on rejected claims involving drugs qualifying for such transition fills.

Bottiani said the agency has found plan sponsors often processed transition fills for only some of the drugs subject to a “cross-contract year formulary change transition fill.” Sometimes, he explained, this resulted from the sponsor not furnishing a complete list of drugs to its claims processor for transition fills, or from coding errors by the processor or sponsor in implementing the new formulary. CMS, he pointed out, has sent warning letters and, in some cases, included with such letters a request for a business plan to correct the problem. Just last month, he said, CMS identified a sample set of potentially inappropriate rejected claims for transition fills and sent the details to plan sponsors for review and response.

Plans Do Well on Call-Center Compliance

In other monitoring areas, though, MA plans seem to be passing with flying colors and improving significantly. This was the case, according to Bottiani, on percentage compliance — now close to 100% — with call-center hold time and disconnect rates, and on access to TTY and interpreter services. However, he also noted that there was a decline from 90% in 2011 to 85% in 2012 in accuracy of TTY and interpreter services. The number of instances of non-compliance in this area rose to 255 in 2012 from 214 in 2011, although it was down from 264 in 2010 and 450 in 2009, he added.

Premium billing accuracy is another strong area. Bottiani said MA and Part D sponsors are charging the right amount of money 90.6% of the time based on an analysis of 10,000 beneficiary records, while 9.4% had a “mismatch” before a retroactive adjustment. CMS is developing monitoring and compliance measures for plan sponsors to reduce the mismatch rate. The study showed deficiencies are more likely in low-income subsidy and other subsidized beneficiaries, he said.

Contact Bottiani at gregory.bottiani@cms.hhs.gov.
Study Shows MA Members Getting HRAs Have Lower Medical Costs

Medicare Advantage plans and their health risk assessment (HRA) vendors are beginning to defend their use of the diagnostic tool in the face of CMS’s expressed intent to place limits on its use for risk-adjusted payment purposes (MAN 4/11/13, p. 1). The latest example of that defense is a new study jointly released by MA sponsor MVP Health Care and its HRA vendor, Matrix Medical Network.

The study, according to the two firms, showed that MA members who received “kitchen table”-type HRAs in their homes conducted by nurse practitioners (NPs) had better outcomes, including fewer hospital admissions and lower cost of claims, than did a matched control group of members who did not get HRAs over a one-year period (calendar year 2010).

The OptumInsight unit of UnitedHealth Group conducted the retrospective analysis last year using de-identified data covering the experiences of more than 10,000 MVP MA members. MVP has MA plans in New York and Vermont.

Asked by MAN whether the results could be skewed by some sort of selection bias since those members agreeing to HRAs might be considered more motivated to improve their care than are those refusing HRAs, both Matrix and MVP said no. In fact, says Matrix spokesperson Michael John, the members most likely to reject an HRA are ones who believe they are healthy and don’t need the assessment. John tells MAN that 30% to 40% of the plan members it approaches about having HRAs say yes, and that in 15% of the actual assessments, the NP finds a condition that needs immediate treatment.

The study excluded very low- and high-cost members and matched participants to nonparticipants based on their setting of care — either home or a skilled nursing facility (SNF), as well as Hierarchical Condition Category (HCC) risk score, HMO versus PPO membership, and both hospital admissions and emergency room visits during the baseline period.

The findings, as reported by the companies, showed clear-cut trends among the 3,447 HRA participants matched with nonparticipants. Medical expenses during the intervention period for the HRA participants (see table, below) were $1,140 per member per month for home-based participants versus $1,182 PMPM for control-group members and versus about $1,080 PMPM for both during the baseline period. For the SNF participants, medical costs in the intervention period were $1,902 PMPM, versus $2,004 PMPM for control-group members and versus about $2,880 for both in the baseline period, Matrix and MVP reported, with the decline in both categories likely reflecting “regression to the mean.”

On an annualized basis, the companies say, the estimated claims cost savings are $41.46 PMPM for home-based HRA participants and $95.61 for SNF-based participants. They reported that hospital admissions were 5.4% lower for home-based participants and 2.2% lower for those members in SNFs. ER utilization, however, was 5.6% higher for home-based and 10.9% higher for SNF-based participants than for the control group, which the companies say probably resulted from the HRA participants better “understanding the importance of acting quickly” to avoid hospitalizations.

Margaret Martin, director, Medicare operations for MVP, attributes the lower medical costs with HRAs to members getting at least a half hour of assessment by an NP in a “non-threatening environment.” Since patients are at home for the HRAs used in its MA plan, it is easier to get an accurate list of the medications they are taking and care-affecting problems such as lack of heat or food that can result in referrals for subsidized social services, she says. About 5% of its HRAs, according to Martin, directly result in some kind of referral, including to disease management programs.

“CMS feels the HRAs are just for revenue purposes, but they aren’t,” Martin tells MAN. MVP’s HRAs, she adds, include details and instructions regarding its 24-hour nurse phone line, especially since much of its member population is afraid of bothering physicians about medical matters they regard as minor.

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*Compared with matched control group that did not get health risk assessments (HRAs) during calendar-year 2010 study period

SOURCE: Study conducted by OptumInsight for MVP Health Care and Matrix Medical Network and released by the clients April 24, 2013.
John says that Scottsdale, Ariz.-based Matrix agrees with CMS that HRAs need to be done properly, but adds that 96% of Matrix’s diagnosis codes obtained during HRAs are substantiated, well above the industry average. CMS might wind up requiring a follow-up visit with a physician or NP within a “reasonable period of time,” he speculates, indicating that this would not be a problem from his company’s standpoint.

Contact John at mjohn@matrixhealth.com and Martin via spokesperson Robin Wood at rwood@mvphealthcare.com.

**CMS Will Alter Summary of Benefits**

CMS Will Alter Summary of Benefits continued from p. 1

didn’t understand such terms in the document as “coinsurance” and “original Medicare” and that plans disseminate it only because it is required.

Sontag contended that the document needs to focus on explaining plan benefits. With this in mind, she said, CMS will remove comparisons to “original Medicare,” simplify language and reorganize the document based on the benefits offered, rather than emphasizing more complex features such as the differences in treatment of in- and out-of-network services.

For the covered services themselves, she continued, CMS plans to alphabetize the service categories in the document for easier reference. And after receiving more than 500 comments about possible changes in the Summary of Benefits, CMS plans to revise all four templates in the document, she added. However, MA plans still will be able to use premium tables and a “multi-plan display,” as several plans had asked in their comments, according to Sontag.

The agency has decided, she noted, not to include certain information in the Summary of Benefits that is available elsewhere. She said this includes star-rating information and details about “extra help” in coping with prescription drug costs.

The ongoing review of OEV requirements, said Reinhard, is exploring the appropriateness of such provisions as mandating three OEV calls, with a letter having to be sent out after the second call that fails to reach the beneficiary. CMS representatives and their contractor have been listening to the “quality” of the calls, she explained, attempting to determine what beneficiaries understand and want.

She predicted that this review, which now is just “wrapping up its pilot phase,” will be followed by changes in the requirements. OEV rules have posed compliance problems for MA plans and drew attention in the recent draft 2014 MA and Part D marketing guidelines (MAN 4/11/13, p. 4). The coming changes, Reinhard suggested, could include adjustments to the “model script” and OEV letters as well as to the number of calls.

Reinhard also summarized the results of CMS’s 2013 AEP “Secret Shopper” efforts, which involved surveillance of a total of 1,918 “formal events” in almost all the states and covered 114 parent organizations. Overall, she said, the number of notices of noncompliance and warning letters is declining, meaning that sales agents are performing better in these formal settings.

The “shopping” by CMS did result in 183 “technical assistance letters” (which are not formal compliance notices), Reinhard pointed out. It also resulted in four formal notices of noncompliance and two warning letters.

The top deficiencies found, according to Reinhard, include ones related to marketing of CMS star quality ratings. For example, some MA plans plugged subsets of their overall star ratings but did not furnish their overall rating as required, and some plans touted their star ratings without explaining what the ratings attempt to measure, she said.

continued
One continuing problem in formal events relates to the optional nature of entries on sign-in sheets. While most MA sponsors’ agents holding such events did make clear that attendees don’t have to provide contact information, Reinhard noted, some said that their bosses required them to get this information “to know who’s here.” She said this is against CMS’s rules, as is another recurring problem, failing to notify the agency via the Health Plan Management System (HPMS) in advance that a scheduled marketing event is being canceled.

In another problem area, while the number of “egregious statements” in marketing is declining, MA organizations still need to do a better job of training agents against the use of “absolute statements” in regard to MA plans, she noted, CMS issued four notices of noncompliance and 18 technical assistance letters.

Marketing events not reported to CMS, and ads for such events not sent to CMS for review, also are continuing problems, Reinhard indicated. She said the agency during the 2013 AEP reviewed 4,846 ads covering 8,699 marketing events and 36 parent companies. As a result of those reviews, she noted, CMS issued four notices of noncompliance and 18 technical assistance letters.

And Reinhard said that the agency had issued five notices of noncompliance and recommended three civil monetary penalties based on violations of the timelines for delivery of the Annual Notice of Change/Evidence of Coverage documents to plan beneficiaries.

Other time-related concerns, she said, include that agent/broker compensation data must be submitted via HPMS in late July and that plans need to do a better job of avoiding corrections to their product bids for the following year after the early June bid-submission deadline. On the positive side, there has been “significant improvement” in the timeliness and appropriateness of “uploads” via HPMS concerning upcoming marketing events, added Reinhard.

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