



ICE Annual Conference



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Overview

- State of the Medicare Advantage Program
- Quality Improvement Initiatives for 2012 and Beyond
- Surveillance and Compliance Strategy
- The MA Program – On the Horizon




State of the MA Program

- Landscape for 2012
- Bid Process 2011/2012
 - Recap of 2011 Bid Cycle
 - 2012 Preparation



MA Landscape for 2012

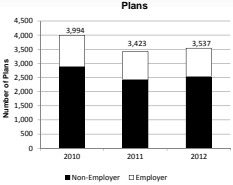
- MA program is on strong footing
- Benefit offerings remain strong and stable
- Impact of non-renewing plans is much smaller than last year
- SNP Models of Care (MOCs) – all approved by the National Committee on Quality Assurance (NCQA)
- Committed to improving and strengthening the program for the future




4

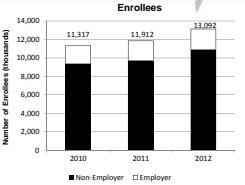
Plan Landscape for 2012 # of Plans/# of Enrollees

Plans





	2010	2011	2012
Non-Employer	2,882	2,427	2,542
Employer	1,112	996	995

Enrollees



	2010	2011	Proj. 2012
Non-Employer	9,347	9,784	10,894
Employer	1,971	2,197	2,198

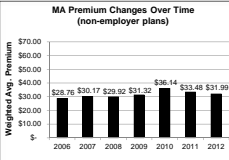
Note: Discrepancies in enrollment totals are due to rounding

5

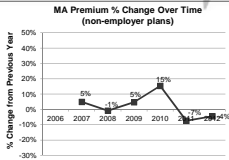
Plan Landscape for 2012 Premiums Remain Stable

MA Premium Changes Over Time (non-employer plans)



Year	Weighted Avg. Premium
2006	\$28.76
2007	\$30.17
2008	\$29.92
2009	\$31.32
2010	\$36.14
2011	\$33.48
2012	\$31.99



MA Premium % Change Over Time (non-employer plans)



Year	% Change from Previous Year
2006	-
2007	5%
2008	-4%
2009	5%
2010	15%
2011	-7%
2012	-4%

Red line is % change from previous year
2006-2011 data is weighted by actual enrollment, 2012 data is weighted by projected enrollment.

- Since 2006 the weighted average premiums for MA plans have increased by \$3.23 (\$28.76 to \$31.99)
- The projected 2012 weighted average premium will decrease \$1.49 or 4% (\$33.48 to \$31.99) from the 2011 value

6

Bid Process 2011/2012

- All plans were required to satisfy CMS requirements for:
 - Cost sharing
 - Meaningful difference between similar plans and low enrollment
 - Changes in cost sharing and/or benefits
- Solicited feedback from the MAO community on bid review requirements and processes
- Considered industry comments in setting thresholds for bid requirements
- Striving for transparency in the bid process, CMS provided MAOs with methodology and tools necessary to ensure all initial bids were accurate and compliant
- CMS is taking a similar approach in preparation for the year ahead

CMS



MA Quality Improvement Strategy

- Overview
- Future Direction

CMS



Foundation of our Quality Strategy

- Subpart D of 42 *Code of Federal Regulations*, Part 422
- 2001 Institute of Medicine report
- Triple AIM
- Health and Human Services (HHS) National Quality Strategy 2011
- HHS National Prevention Strategy 2011

CMS



Components of our Quality Strategy

- ◆ Comprehensive
 - Designed to assess, develop, and implement the best possible standards of care to ensure that health care systems deliver the highest quality of care across all plan types
- ◆ Vision, Mission, and Core Values
- ◆ Goals and Objectives
 - Define specific objectives for our goals
 - Develop metrics to monitor objectives and measure progress
- ◆ Implementation of Action Plan



10

Future Directions for our Quality Strategy

- ◆ Implementation of QI Strategy
- ◆ Implementation of new process for Quality Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) submissions
 - New collections tools and HPMS module
 - “Plan,” “Do,” “Study,” “Act” model
 - Focus on cardiovascular health and hospital readmissions



11

Plan Ratings Strategy



- ◆ The current Plan Ratings strategy, laid out in the 2012 Call Letter is consistent with the Three Part Aim (better care, healthier people/healthier communities, and affordable care) with measures spanning five broad categories:
 - Outcomes
 - Intermediate outcomes
 - Patient experience
 - Access
 - Process



12

Quality Improvement Strategies



- Plans' quality improvement (QI) strategies should focus on improving overall care that Medicare enrollees are receiving across the full spectrum of services.
- QI strategies should not be limited to only the Plan Ratings measures.
- Retired measures are still displayed publicly on cms.gov and monitored by CMS.
- Poor scores on display measures are subject to compliance actions by CMS.

13

2012 Plan Ratings Weights



- 2012 Plan Ratings will:
 - Weight outcomes and intermediate outcomes 3x as much as process measures.
 - Weight patient experience and access measures 1.5x as much as process measures.

14

Sanctions



- Contracts with serious compliance issues (i.e., CMS has issued enrollment sanctions), will have their 2012 Plan Ratings reduced:
 - Contracts under sanction with 3 or more stars will be automatically assigned 2.5 stars.
 - Contracts under sanction with less than 3 stars will receive a 1-star reduction.

15

Low Performing Contracts



- Since 2011, CMS has marked plans rated less than 3 stars for the past 3 years with a low performing icon.
- An additional cautionary message will appear on the MPF for beneficiaries selecting to enroll in these plans.
- 1-800-Medicare representatives will also reiterate the low performance of these plans to discourage enrollment .

16

Future Directions



- In support of the Three Part Aim, the emphasis on patient experience measures may increase in future years through CMS' weighting methodology
- We are exploring options for rewarding contracts for improvement in future years
 - Demonstration currently rewards MA contracts for improvement
 - Additional rewards for improvement may be delayed until end of demonstration to avoid duplication
- CMS will continue to provide details about these changes in the 2013 and future Call Letters

17

Surveillance and Compliance Activities



- Overview
- Recap of 2011 Activity
- Highlights of Agent/Broker Performance Audits

18

Medicare Marketplace Surveillance



- National program to detect, prevent and respond to marketing violations and misrepresentation in the Medicare Marketplace
- Initially aimed at abuses in Private Fee-for-Service
- CY 2009-Expanded to all Medicare Advantage and Part D Prescription Drug plans
- A broad range of surveillance activities

19

2011 AEP Surveillance Activity



- CMS conducted 1,938 secret shops during the CY2011 AEP
- Results:
 - Less egregious agent actions compared to previous years
 - 126 compliance notices sent to plan sponsors
 - Sentinel effect

20

2012 AEP Surveillance Activity

- Secret Shopping of Public Events
- Unreported Marketing Events
- Surveillance Marketing Allegation Response Team (SMART / formerly Targeted Observation)
 - Year-Round Activity
 - SMART Referral Form
 - Marketing Allegation Sources
 - Method of Investigation
 - Compliance Actions

21

Agent/Broker Performance Audits

- July - October 2011 - part of the broader PCOG performance audits
- Assessing compliance in Agent/Broker compensation and oversight, including
 - Licensure/Appointment
 - Training/Testing
 - Initial/Renewal Payments
 - Recoupment of Payment for Rapid Disenrollment
 - Outbound Education and Verification (OEV) calls
 - Complaints



22

Agent/Broker Performance Audits - Results

- Sponsors generally performed well on licensure and compensation elements
- Concerns included
 - OEV calls not meeting requirements
 - ▶ Conducting focus group testing to improve OEV scripts
 - Complaints not thoroughly investigated nor complete follow up actions taken



23

MA Program-On the Horizon

- CY 2013: All D-SNPs are required to submit State Medicaid Agency Contracts by July 1, 2013
- CMS will release guidance for the CY 2013 MOC approval process this fall
- CMS-4157-P - CY 2013 Parts C and D proposed rule
 - Published on October 11, 2011
 - 60-day comment period closed
 - Implements new statutory requirements; strengthens beneficiary protections; and clarifies program requirements



24
