RADAR on Medicare Advantage

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CMS Opens Additional Doors With 2020 Marketing Updates

In keeping with the administration's theme of lessening the burden for Medicare Advantage and Medicare Part D organizations, CMS's newly updated Medicare Communications and Marketing Guidelines (MCMG) contain multiple flexibilities that were previously unavailable to plan sponsors. These include a loosening of rules around co-branding, educational events and marketing of rewards and incentives programs (RI programs), as well as the ability to operate a call center dedicated to prospective enrollees.

Last year was the first year the agency unveiled the guidance formerly known as the Medicare Marketing Guidelines, made some modifications to the definition of "marketing" and included a new category of "communications" that doesn't require CMS review *(RMA 8/2/18, p. 1)*. And at 81 pages, the 2019 MCMG was markedly shorter than its 124-page predecessor. Although CMS at press time hadn't posted a redlined version of the complete 2020 document, an Aug. 6 memorandum from the CMS Medicare Drug & Health Plan Contract Administration Group highlighted the various updates, including the deletions from 2019, and urged plans to cross-reference the memo with the existing MCMG.

"The deletions are more important than the insertions," says Michael Adelberg, a principal with Faegre Baker Daniels Consulting and a former top CMS MA official. "Probably the most important deletion concerns the prohibition on holding back-to-back educational and marketing events. This seems to open the door to piggybacking marketing sessions on educational events."

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Rewards Vendors Vie for MA Business as CMS Relaxes Rules

Since a 2015 CMS rule gave Medicare Advantage plans more flexibility to offer rewards and incentives programs (RI programs), the agency has continued to loosen up what was historically a limited benefit, allowing completed health risk assessments to qualify as rewardable activities starting in 2019 *(RMA 3/1/18, p. 1)* and now offering some flexibility around plan marketing of specific rewards and incentives (see story, p. 1). This is potentially good news for the many RI program vendors that have sprung up in recent years as health plans become more interested in incentivizing healthy behaviors that can lead to higher star ratings and HEDIS scores. AIS Health spoke with three vendors to learn more about this increasingly competitive space and how they are attempting to differentiate themselves.

With a focus on identifying, engaging and rewarding noncompliant members for completing "high value" activities, Minneapolis-based ***NovuHealth*** has offered RI programs to Medicare and Medicaid insurers for about five years and is seeing increasing interest from plans that view them as a "market differentiator," co-founder and CEO Tom Wicka tells AIS Health. He estimates that roughly three-quarters

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of MA plans have some type of RI program in place, but that fewer than half of those utilize what he refers to as "intelligent engagement."

"Our business model is very much about engaging our health plans in tailored, very specific annual solutions designed for their health plans and their individual quality performance," he says. This means assessing a plan client's prior two years of data to "establish a compliant and a noncompliant population," so that if a patient did something in 2017 that they didn't do in 2018, they would be put into a "targeted population for high-level engagement in 2019," he explains. NovuHealth also looks at the different targets CMS sets for star ratings on specific measures in order to identify the proper target population, the frequency of communication, the RI values and the right content that will have an impact on specific members.

These activities can make all the difference between 3.5 and 4 stars, perhaps by moving certain measures that have been "stuck" for a long time, Wicka contends. He points to a 2017 case study of one large MA plan client with 430,000 diabetic members — of which half were not attending recommended care appointments — that used NovuHealth to engage a target group of 26,000 members and reward them for completing specific activities relating to closing gaps in care. Twenty-six percent of diabetic members were considered "engaged" prior to the start of the program, and after 10 months that rate improved to 72.1%, exceeding the insurer's goal of 50%. That insurer improved its overall star rating from 3 to 4.

Because NovuHealth's contracts are based on performance, if an RI program is falling short of its agreed-upon targets, the company must alter its engagement strategies, increase contact frequency or potentially try new content to land at the agreed-upon performance. "We're looking at the data on a weekly basis and delivering weekly performance [reports] back to the plan," says Wicka. "And generally we met 90% to 100% of performance commitments last year across all of our customer contracts."

He adds that technology is a central part of a successful RI program, as is offering customers a range of ways to communicate, whether it be via the NovuHealth digital platform that is white-labeled with the plan, a call center or text messaging.

Choice in the way you communicate and what you can offer plan members is absolutely critical to RI program operation, weighs in Bill Warshauer, vice president of sales with Dallas-based ***Hawk Incentives,*** a Blackhawk Network Company. "Overall we should enable and empower that recipient to choose how they want to engage, [and as] we offer up opportunities not just assume that everyone will want a Target gift card; some people might not live within 50 miles of a Target," he says. "You don't ever want to assume anything, so giving reward choice and giving a communication style of choice is all about making the best experience for that particular customer."

As the business-to-business arm of Blackhawk Network, which is responsible for the gift card kiosks prominently displayed in many large retailers and grocers, the "rewards provider" is able to curate unique content on behalf of the plans, like offering a wellness gift card that can be used at five or six different retailers. Or it can customize incentive choices based on member preference; for instance, digital cards can be emailed to members while others may prefer to have a card mailed to them. When asked how a typical partnership with a plan is structured, Warshauer says the plans set their requirements in terms of the different performance expectations and actions they'd like to see play out, while Black-

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hawk delivers on the creative content, communications and rewards.

That also involves a level of personalization, offering specific actions to a set of plan members rather than "blasting a communication out to a user base with potential opportunities," and proving that the member completed their wellness check or other required behavior. "From there, the data insights that we're capturing — the rates at which members are responding, the types of actions individuals are taking and how we see them engage with the individual reward — are all shared back with the plan" to enhance their understanding of participant behavior and track which incentives resonate best and help inform future reward strategy, he explains.

Warshauer adds that Blackhawk launched Hawk Incentives about two years ago, recognizing the "significant amount of value" it could create for plans that are trying to drive healthy behaviors. And while the subsidiary is seeing greater uptake of RI programs each year, "I think we're still at the cusp of really having an impact and [seeing] the true benefits of these programs," he says.

Denver-based ***Welltok*** has offered incentive services since it was founded 10 years ago as a data-driven, Software as a Service company, but its 2013 acquisition of IncentOne enhanced the firm's capabilities to manage rewards as part of its CaféWell health optimization platform. WellTok's Rewards Services division touts a "flexible" technology platform that can personalize various elements of the consumer experience and offer condition-specific rewards in a variety of modalities.

"Advancements in machine learning and analytics have enabled us to better target people who would be most receptive to targeted interventions and the incentives that would be most effective," Katie Kopansky, health optimization economist at Welltok, tells AIS Health. But because CMS requires that RI programs must be designed so that all enrollees are able to earn rewards and must be offered to all enrollees without discrimination, "we keep it at the population level for MA plans to determine incentive strategy and receptivity."

Welltok also uses machine learning in combination with proprietary consumer data to operate its Medicare Retention Solution, which it says has helped lead MA plans to reduce disenrollment rates by up to 30% and improve disenrollment-related star ratings from 2.5 to 4. That analysis identifies key predictors, including copays, health care services utilization, competitive plan options and demographic factors to help determine who would be most receptive to "disenrollment prevention outreach."

One trend the company has observed in recent years in the RI program space is MA plans moving toward offering "health-restricted spend cards and OTC benefits-type cards," says Kopansky. This means members can use the cards at a select number of retailers such as a Walmart or a CVS and for only certain categories of items. "Plans are using this for targeted spend related to the member's health condition...while limiting certain items for purchase, such as glucometers, blood pressure cuffs, etc.," she explains.

RI Space Could Use More Flexibility

While MA plans have significant leeway in designing RI programs that are specific to their members' needs and interests, they are subject to certain requirements. For example, rewards or incentives earned during one contract year may not roll over to the next, they must not exceed the value of the health-related service or activity for which they are being offered, and they must not include certain health-related activities such as completion of a federally mandated survey.

Although Kopansky says the 2019 addition of health risk assessments as a permitted health-related activity in MA was a "move in the right direction," she says potential "game changers" could include more flexible rewards eligibility requirements and the ability to offer rewards that impact an individual's health status. "This could be in the form of durable goods that can change lifestyles or improve living conditions [e.g., air conditioners for people with asthma] while at the same time driving healthy behavior," she suggests.

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Aetna, Humana Project Major MA Enrollment Gains in 2019

Following a 16% year-to-date increase in Medicare Advantage membership reported by Anthem, Inc. last month *(RMA 8/1/19, p. 1)*, Aetna Inc. and Humana Inc. in recent weeks posted second-quarter 2019 earnings that were aided by substantial growth in their MA segments, while Cigna Corp. expressed confidence in its ability to grow that business in 2020.

CVS Health Corp. on Aug. 7 reported a 55% year-over-year increase in consolidated adjusted operating income to $4 billion, which it mainly attributed to the November 2018

addition of ***Aetna Inc.*** and growth of the pharmacy benefit manager. The Health Care Benefits segment, which includes MA and the SilverScript Part D business, contributed $17.4 billion of revenue, which on a consolidated basis grew 35.2% to $63.4 billion as of June 30, 2019.

Y-o-Y Aetna MA Membership Is Up 30%

Aetna this year embarked on its largest MA service area expansion ever, and enrollment in its MA products increased by roughly 33,000 lives from the first quarter of 2019 to 2.26 million members as of June 30. That's an increase of 30% from 1.73 million MA lives it reported in the year-ago quarter. During an Aug. 7 conference call to discuss recent quarterly earnings, Executive Vice President Karen Lynch said Aetna made substantial membership gains in both group and individual MA, and that the service area expansion contributed to about 25% of growth on the individual side. President and CEO Larry Merlo added that the Prescription Drug Plan business qualified in 31 out of 34 regions to receive auto-assigned low-income subsidy enrollees in 2020 and the company is eyeing "opportunities to accelerate PDP to MA conversions."

CVS reported adjusted earnings per share of $1.89, up from $1.69 EPS a year ago, and raised and narrowed its adjusted EPS guidance for the year to between $6.89 and $7.00, compared with a previous estimate of between $6.75 and $6.90.

Meanwhile, ***Humana Inc.*** on July 31 said enrollment in its individual MA plans grew 15.1% from the year-ago quarter to 3.48 million lives as of June 30, 2019, and projected full-year enrollment growth of 16% for the highest individual MA membership increase in a decade. The company since the fourth quarter of 2018 has enrolled 420,500 additional individual MA members, and raised its projections for full-year individual MA membership growth from a prior range of 415,000 to 440,000 members to between 480,000 and 500,000 new MA lives.

Chief Financial Officer Brian Kane during a July 31 earnings conference call noted that Humana identified these positive trends early enough to be able to invest its outperformance in Medicare bids for 2020 to help offset the impact of the 2020 headwinds caused by the health insurer fee (HIF) return, and at the same time has been "working diligently to identify and invest in initiatives in 2019 to further lessen the impact" of those headwinds. These include accelerated investments into its integrated care delivery model, such as "automation within the clinical and pharmacy spaces to drive better and more efficient outcomes" and "customer support services to simplify and streamline the customer experience." The company also unveiled a $1 billion accelerated share repurchase plan.

Humana Lowers PDP Loss Projections

Humana also updated its projection for an anticipated enrollment decline in its PDP segment, and said it now expects to lose 700,000 members in 2019 compared to a previous estimate of 700,000 to 750,000 enrollees.

The company reported adjusted EPS of $6.05 as of June 30, 2019, and raised its full-year EPS guidance from previous expectations of between $17.25 and $17.50 to approximately $17.60, for growth of about 21% in 2019. Humana also recorded a consolidated medical loss ratio (MLR) of 84.4%, up slightly from 84.1% in the year-ago quarter, which it said was partly driven by the HIF moratorium and offset by the benefit related to its MA clinical programs, member engagement and lower-than-expected medical cost trends.

The fact that Humana was able to identify positive 2019 trends early in the year and invest outperformance in its 2020 MA bids is "an important consideration because it appears that [Humana] offered more generous benefits in 2019 relative to some large-scale peers, which explains why HUM is growing twice as fast as the Individual MA market in 2019," wrote Barclays Capital Inc. securities analyst Steve Valiquette in a July 31 research note.

Reporting a 10% increase in adjusted EPS to $4.30, ***Cigna Corp.*** on Aug. 1 raised its full-year EPS guidance by 25 cents to 35 cents to a range of $16.60 to $16.90 per share, representing growth of 17% to 19% over 2018. And although the company reported a slight dip in the Government segment of its medical membership to 1.38 million lives as of June 30, Cigna Corp. President and CEO David Cordani during an Aug. 1 conference call to discuss second-quarter 2019 earnings highlighted the "tremendous growth opportunity" in MA for 2020 and said the company expects to achieve between 10% and 15% average annual growth in its MA membership, "driven by both product and geographic market expansion beginning in 2020."

Cigna also reported a slightly elevated MLR of 81.6%, which it attributed to the addition of Express Scripts Holding Co., the HIF moratorium and a higher MLR in its individual business. The company as of June 30 had more than 3.2 million stand-alone Part D members, up from 771,000 a year ago, largely due to the addition of Express Scripts.

Contact Valiquette at steve.valiquette@barclays.com. ✧

Working Group Recommends New SSBCI Be Clear, Equitable

Beginning in 2020, Medicare Advantage organizations will be able to offer "non-primarily health related" items and services to certain beneficiaries through Special Supplemental Benefits for the Chronically Ill (SSBCI) established in the Bipartisan Budget Act of 2018. CMS has given plan sponsors broad discretion in developing non-medical services that were previously not allowed in MA plan bids and is allowing them to target certain benefits to individuals' conditions and needs, but a working group of diverse stakeholders suggests that a set of "guiding principles" is needed to ensure the successful implementation of new SSBCI.

Benefits Offer 'Unprecedented' Flexibility

While the new benefit category provides MAOs with an "unprecedented degree of flexibility" to address social determinants of health, it "also creates challenges around benefit clarity, equity and manageability," observes the new report, "A Turning Point in Medicare Policy: Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill." The paper reflects the consensus of experts from 30 different organizations focused on senior care and long-term services and supports (LTSS) — all convened by research and advisory services firm Anne Tumlinson Innovations and the Long-Term Quality Alliance (LTQA), with funding from The SCAN Foundation.

"These new benefits, while modest, really represent a major change in the way Medicare operates," remarks Bruce Chernof, M.D., president and CEO of The SCAN Foundation, a Long Beach, Calif.-based independent public charity devoted to transforming care for older adults. And as people are living longer and with multiple chronic illnesses, "what's clear is that a little bit of help is the difference between going to the emergency room or not... and these new benefits really recognize that helping people thrive at home is good for their health, is a good way to keep them out of hospitals if they don't need to be there and it's a better use of resources....So I think it represents an important step forward."

Successful Implementation Is Critical

That said, "it's very important that you implement these successfully and well," Chernof tells AIS Health. And since SSBCI represents new territory for CMS, the plans and the beneficiaries, The SCAN Foundation and its partners sought to "bring together a range of what we thought of as odd bedfellows — individual health plans, trade organizations, home and community-based service providers, advocacy groups — to really talk about, 'What does it mean to get this right?' Because the sooner we can get it right, the sooner there will be many products out there and those products will be successful and we can show that this is going to be [impactful]."

The availability of SSBCI is of particular interest to LTQA because its members are focused on advancing LTSS and integrated care for people with functional limitations, and people often end up spending down their assets in order to access these types of services through Medicaid, explains LTQA Executive Director Mary Kaschak. The working group, which included many of LTQA's members, developed the principles over two in-person meetings in the spring as well as through phone calls with smaller teams, she tells AIS Health.

When the group held a final meeting in May and discussed priorities in breakout groups, "not every single group got every single thing that they wanted" but there were many shared learnings and people were generally reaching the same conclusions, recalls Kaschak. "So it was a compromise because they recognized that we're all in this together and are committed to advancing these. And we recognize that these are aspirational...that this is what we want to aspire to and we want to work with other stakeholders to advance this agenda and to inform CMS in the future for how they're thinking not only about SSBCI but also the concept of...non-medical support in Medicare Advantage overall."

In addition to meeting the core principle of reflecting individual needs, the working group recommended that SSBCI follow four "balancing principles." They are:

(1) SSBCI are clear and understandable. For example, key stakeholders such as Medicare beneficiaries and their caregivers should receive information about SSBCI that is "explicit and clear, prevents confusion and avoids unmet expectations" about benefit eligibility and other aspects. This could mean actions taken by CMS to increase education and awareness of SSBCI.

(2) SSBCI are equitable. Plans should determine need using consistent guidelines and MA enrollees should not have difficulty accessing benefits as the result of cultural, language or other barriers.

(3) SSBCI are manageable and sustainable. This includes proper alignment of quality measures, risk adjustment and other aspects of payment to ensure that MA plans can meet enrollees' specific needs.

(4) SSBCI evolve with continuous learning and improvement. Working with MA plans and other stakeholders, CMS should evaluate and measure the extent to which SSBCI are contributing to the needs of chronically ill enrollees and adapt these benefits based on learnings. This should include evaluation of services by socioeconomic status, sharing of best practices among MA plans and between plans and CMS, and testing/piloting opportunities extended by CMS to plans, the group recommended.

While LTQA and the working group are now focused on "getting the word out" about the principles, next steps include working within its "stakeholder brain trust" as SSBCI moves into the execution phase to conduct as much shared learning as possible on "what's working and what isn't so that we can continue to advance in this space, because I think there is concern that so much of the success of SSBCI has to do with how they're targeted" and who will benefit, adds Kaschak.

View the report at https://bit.ly/2YS3JCi. Contact Chernof via Camille Ahearn for The SCAN Foundation at cahearn@messagepartnerspr.com or Kaschak at mkaschak@ltqa.org. ✧

A longer version of this story is available on the Member Content page at www.AISHealth.com.

Average Base Part D Premium Continues Decline as Reinsurance Trend Stabilizes

CMS on July 30 released the Medicare Part D payment benchmarks and other bid-related information for the 2020 plan year, indicating that both the average monthly premium for basic Part D coverage and the base beneficiary premium will drop for the third consecutive year. The lowering of premiums is driven by changes in the reinsurance amount, which funds 80% of all Part D costs for beneficiary expenses above the catastrophic threshold and is seeing more modest growth after years of double-digit percentage increases, observes Shelly Brandel, a principal and consulting actuary in the Milwaukee office of Milliman, Inc. Brandel estimates the figure will be $80.80 for 2020, up slightly from $78.88 in 2019.

This observed flattening of reinsurance amounts is likely due to decreasing utilization of high-cost hepatitis C drugs as well as increases in the amount of rebates and other forms of direct and indirect renumeration (DIR) that Part D sponsors receive from manufacturers, she tells AIS Health.

Contact Brandel at shelly.brandel@milliman.com.

Average Base Part D Premium Will Drop for Third Year in a Row

	2014	2015	2016	2017	2018	2019	2020
National Average Bid	$75.88	$70.18	$64.66	$61.08	$57.93	$51.28	$47.59
% change	-4.7%	-7.5%	-7.9%	-5.5%	-5%	-11.5%	-7.2%
Base Beneficiary Premium	$32.42	$33.13	$34.10	$35.63	$35.02	$33.19	$32.74
% change	4.0%	2.2%	2.9%	4.4%	-1.7%	-5.2%	-1.3%
Average Beneficiary Premium	$31	$32	$32.50	$34	$33.50	$32.50	$30
% change	3.3%	3.2%	1.6%	4.6%	-1.5%	-3%	-7.7%

SOURCE: Compiled by AIS Health. Based on CMS's annual release of the Part D national average bid and base beneficiary premium information.

CMS Offers Marketing Flexibilities

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Last year's MCMG expanded what can happen at educational events by allowing plan representatives to set up future marketing appointments and hand out business cards and contact information for beneficiaries to initiate communications. But by deleting the word "future" and the stipulation that representatives "may not conduct a marketing/sales event immediately following an educational event in the same general location (e.g., same hotel)," it appears that CMS may allow plans to set up marketing appointments immediately after an educational event, says Kelli Back, a health care attorney in Washington, D.C.

"My read on that is it really is a personal appointment" as opposed to a whole marketing event, Back tells AIS Health. "I suppose you could potentially have several people who would set up their marketing appointment and you could talk to them at the same time, but I don't think it's, 'Hey, we're doing a marketing event after this!' I think it's a little more controlled than that."

MA Plans Can Highlight Rewards

Another example of important "deletions" is around RI programs, for which marketing no longer has to be done "in conjunction with information about plan benefits," nor does it have to include information about all RI programs offered by the MA plan. In other words, a plan could market a specific reward or incentive rather than the whole package, which may be a recognition that plans are offering more diverse RI programs or simply reflects "the overall trend toward giving plans broader discretion with regard to marketing," says Back.

Back points out that CMS also made some significant changes around the inclusion of required disclaimers on all marketing materials. For example, CMS said sponsors may place the federal contracting disclaimer on only one web page and no longer have to include their federal contracting statement on all communications materials.

CMS also removed the benefits disclaimer, non-English translations disclaimer and plan online enrollment disclaimer from the list of disclaimers required to appear on all materials.

Meanwhile, CMS in the section on customer service call center requirements clarified that MA plans and Part D sponsors must operate a toll-free customer service call center for both "current and prospective enrollees" and added a new subsection allowing for phone lines dedicated to marketing activities such as sales and enrollment to operate "during business hours that are different from those defined" for the general customer service call center.

Other key changes include:

✦ ***Five-star plans may create their own gold star icon (or "any other icon of distinction")*** — so long as it does not confuse or mislead beneficiaries, CMS clarified — in their marketing materials rather than use the CMS gold star icon.

✦ ***The deletion of "studies or statistical data" from requirements around plan comparisons*** suggests that CMS may allow for qualitative comparisons. "I'm not sure how I see that playing out," says Back. "I don't see a ton of plan comparisons per se but maybe that will loosen it up." For example, a plan could theoretically look at available benefit information and declare that they have the richest benefits in a certain county, so long as they back that up with some qualitative information, she explains.

✦ ***Plans may include general information on their website about enrollment periods, including the Open Enrollment Period.***

✦ ***By removing Institutional Special Needs Plans (I-SNPs) from special guidance for serving long-term care facility residents,*** CMS broadened the types of plan marketing and communication materials that may be reviewed in the facility. CMS in the 2019 MCMG clarified that I-SNPs may use staff operating in a social worker capacity to provide information, including marketing materials, to residents, and now states that "Plans/Part D sponsors" may use staff members to provide such information.

✦ ***Plans are no longer required to let CMS know about co-branding arrangements prior to marketing them.*** Although CMS did not review or approve such relationships, it previously sought information about them "to review associated marketing materials" and asked that sponsors enter that through the Health Plan Management System. "It wasn't a big hurdle, and CMS wasn't necessarily saying no to or regulating those relationships other than the guidance set forth in the marketing guidelines, but I thought it was interesting that you don't have to enter those or tell CMS about them in advance," remarks Back.

Although there is no formal comment period, CMS in the Aug. 6 notice encouraged stakeholders to review the MCMG updates and submit any questions to marketing@cms.hhs.gov.

Visit the CMS Medicare marketing page at https://go.cms.gov/2c94HlK. Contact Adelberg at michael.adelberg@faegrebd.com or Back at kellidback@gmail.com. ✧

News Briefs

✦ ***After some delay, the Louisiana Dept. of Health (LDH) on Aug. 5 said it intends to contract with four Medicaid managed care organizations, down from five MCOs that currently serve the state's 1.7 million Healthy Louisiana enrollees.*** LDH selected AmeriHealth Caritas Louisiana, Community Care Health Plan of Louisiana (Healthy Blue — an Anthem, Inc./Amerigroup partnership with Blue Cross and Blue Shield of Louisiana), Humana Health Benefit Plan of Louisiana and UnitedHealthcare Community Plan. The awards are not final and are subject to negotiation and a protest period, which has the potential to delay the planned start date of Jan. 1, 2020. Contracts are to be executed on or about Aug. 23. CVS Health Corp.'s Aetna Better Health and Centene Corp.'s Louisiana Healthcare Connections were two incumbents not selected to renew. Centene currently has a 31% market share of the program and had the lowest technical score of all six bidders, which Jefferies analysts found to be "less than encouraging" ahead of new contract awards in Texas that are expected to be unveiled this month, according to an Aug. 8 research note from the firm. Visit http://ldh.la.gov/index.cfm/newsroom/detail/5233 or contact Jefferies securities analyst David Windley at dwindley@jefferies.com.

✦ ***On top of losing a managed Medicaid bid in Louisiana (see brief, above), Aetna Better Health's contract with Kansas Medicaid appears to be on shaky ground.*** Kansas Medicaid officials last month warned the insurer that it had 10 days to remedy issues that included delays in provider credentialing and payments to hospitals. Aetna's contract began on Jan. 1, 2019. Aetna responded with an initial corrective action plan (CAP), but a Kansas Dept. of Health and Environment spokesperson says KDHE "does not feel the plan submitted by Aetna accurately addresses the State's concerns, nor does it present a clear path to compliance." The state has requested a new CAP and plans to meet with Aetna leadership. Meanwhile, an Aetna spokesperson tells AIS Health, "We are cooperatively working with providers and other stakeholders and taking accountability to continually improve our operations and resolve areas of concern. Aetna Better Health of Kansas facilitates our members' care and health improvement on a daily basis." Contact KDHE spokesperson Kristi Pankratz at kristi.pankratz@ks.gov.

✦ ***As CMS finalizes its planned overhaul of the Medicare Plan Finder (MPF) in time for the Annual Election Period that begins on Oct. 15, a new report from the Government Accountability Office (GAO) confirmed the myriad usability issues that senior advocacy groups have been raising for years.*** In response to a request from the House Ways and Means Committee, GAO from February 2018 to July 2019 conducted a performance audit of the MPF by reviewing existing research and CMS documentation on the tool, interviewing CMS officials and stakeholder groups, and surveying State Health Insurance Assistance Program directors. While the tool is intended to be the primary resource for beneficiaries to compare Medicare coverage options, it is generally difficult to navigate, requires clicking through multiple pages to find and compare options, lacks the ability to easily filter and sort plan information, and contains hard-to-understand health terminology, observed GAO. The report acknowledged the planned MPF revamp, and CMS told GAO it will know more about how well the redesigned MPF addresses user needs after it is used by beneficiaries. Download the report, GAO-19-627, from www.gao.gov.

✦ ***CMS in future rulemaking plans to require Medicare Advantage and Prescription Drug Plan sponsors to report data on potential fraud and abuse and corrective actions taken, according to a new report from the HHS Office of Inspector General (OIG).*** In its annual report identifying ways to further reduce fraud, waste and abuse in HHS programs, OIG last month pointed out that it has published six reports related to MA and Part D investigating and reporting of potential fraud to CMS but that plan reporting of potential fraud and abuse by pharmacies and providers is still voluntary and only 60% of MA and PDP sponsors in 2017 requested access to CMS's PLATO system for reporting such fraud. OIG also for the second time recommended that CMS require MA plans to include ordering and referring provider identifiers in their encounter data, which is not currently required but could assist in data integrity processes. CMS has not reported any progress in that area, said OIG. View the OIG report at https://bit.ly/2StDBfm.