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Print and ePresentment: New rules for managed care organizations

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In October 2017, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced an initiative called Patients over Paperwork.[1] The initiative focused on streamlining regulation to reduce unnecessary burdens on health plans and providers, as well as increasing efficiencies and improving the member experience. In April 2018, the CMS Final Rule for Contract Year (CY) 2019[2] incorporated policy changes driven by the Patients over Paperwork initiative that allows Medicare Advantage and Part D plan sponsors to provide specific types of plan information, such as the Evidence of Coverage (EOC) electronically instead of in hard copy.

Under the final rule, the Annual Notice of Change (ANOC) and the EOC documents are now two independent documents with different delivery requirements and flexibilities. This may seem like a simple change, but it requires serious thought and planning by health plans. It is imperative that health plans pay attention to these changes.

Benefits for health plans

Beginning with CY 2019, ANOCs and EOCs no longer need to be combined in the mailing due to members by September 30 each year. Health plans now have until October 15 to provide EOCs electronically. The ANOC must continue to be delivered by September 30 each year, which is 15 days prior to the Annual Election Period (AEP), and must be received by enrollees ahead of the EOC, allowing enrollees to "focus on materials that drive decision-making during AEP" as CMS suggested in the final rule.

CMS estimates this new rule has the potential to save health plans $54.7 million a year from 2019 through 2023.[3] These savings will come from eliminating or significantly reducing expenses related to printing, fulfillment, and mailing costs (e.g., paper, prepress and printing, bindery, lettershop, USPS postage, logistics carriers) for the EOCs.

Beyond the monetary savings, health plans now have more time to produce the EOCs. In addition to having two more weeks until these documents are due to members, health plans that provide EOCs electronically also free up part of the timeline previously dedicated to prepress, printing, and mailing of the EOC books.

Health plans must use the extra time wisely

CMS has explicitly stated that the extra time for EOC creation "will also provide an additional two weeks for MA [Medicare Advantage] organizations and Part D plan sponsors to prepare, review, and ensure the accuracy of the EOC, provider directory, pharmacy directory, and formulary documents."[4] Health plans need to use the time wisely and get these documents right the first time, or be prepared for fines and sanctions from CMS.

Some health plans may quickly realize that the extra time to create these documents is a mixed blessing. They must allow additional time for document review from all participating departments, including Marketing,

Product, and Compliance. Review of required documents must include all stakeholders and departments in an in-depth review of content pertaining to members' plan benefit information, co-pays by drug tier, and phone numbers and TTY, just to name a few.

Health plans need to take an enterprise-wide approach in their review process. Other departments, including, but not limited to, Operations, Pharmacy, Provider Network, Call Center, Health Services, Long-Term Care (LTC), and Claims, must be brought into the review process to ensure 100% accurate documents. This exercise should be like the one that happens annually during a health plan's annual budgeting process.