

The Role of Oversight and Monitoring and the Use of Analytics to Increase Effectiveness of your Compliance Program

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Agenda



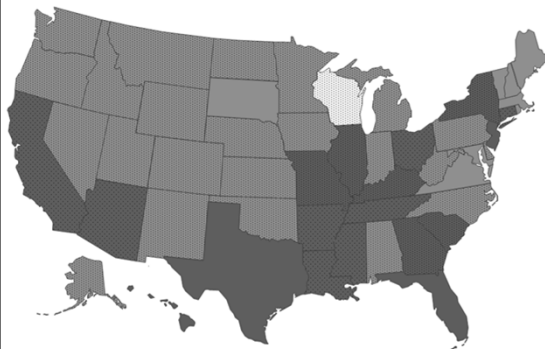
1. Who is WellCare
2. Why use Analytics?
3. CMS Mock Audit Process
4. Individual Compliance-related Projects
5. Continuous Monitoring Process
6. Questions

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WellCare Health Plans, Inc.

WellCare Health Plans, Inc.

Company Snapshot



- Medicaid, Medicare Advantage & Medicare Part D PDP
- Medicare Advantage & Medicare Part D PDP
- Medicare Part D PDP (49 states & D.C.)
Medicare Supplement (39 states)

As of September 30, 2014

Founded in 1985 in Tampa, Fla.:

- Serving approximately 4 million members nationwide.
- 224,000 contracted health care providers.
- 71,000 contracted pharmacies.

Serving 2.3 million Medicaid members, including:

- Aged, Blind and Disabled (ABD).
- Children's Health Insurance Program (CHIP).
- Family Health Plus (FHP).
- Supplemental Security Income (SSI).
- Temporary Assistance for Needy Families (TANF).

Serving 1.8 million Medicare members, including:

- 371,000 Medicare Advantage members.
- 1.4 million Prescription Drug Plan members.
- 45,000 Medicare Supplement policyholders.

Serving the full spectrum of member needs:

- Dual-eligible populations (Medicare and Medicaid).
- Managed Long Term Care (MLTC).

Spearheading efforts to sustain the social safety net:

- The WellCare Community Foundation.
- Advocacy Programs.
- Creation of Public-Private Partnerships.

Significant contributor to the national economy:

- A FORTUNE 500 and Barron's 500 company.
- Approximately 6,500 associates nationwide.
- Offices in all states where the company provides managed care.

Why use Analytics?

Analytics Rationale and Trends

- Industry Trends & Evolution
- Integrated Risk Management
- Regulatory Actions and Activities
- Trusted Advisor

Industry Trends



Health plans across the sector are revamping organizational approaches in partnering and utilizing their Compliance business partners

Organizations are making significant investments to enhance C-suite and Board of Directors reporting, dashboards, operational performance and risk monitoring reporting

C-Suite leadership and the Board of Directors are looking to Compliance to help drive growth and reduce G&A, while managing and mitigating risk

Health plans are moving toward integrated monitoring of operational performance and compliance

Health plans are organizing around their business in order to optimize organizational structure

Source: PwCare **making significant investments to enhance C-suite and Board of Directors reporting, dashboards and operational performance and risk monitoring reporting**

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Industry Trends: Evolution of Analytics



Health plans are evolving their analytics with the most significant focus on several core fundamental areas

Focus Area	Description	Results Achieved
Integration of regulatory / compliance requirements into operational performance reporting	Health plans are re-designing operational reports to ensure that how they manage their business is coupled with how they meet regulatory and compliance requirements	<ul style="list-style-type: none"> Improved operational performance Increased regulatory compliance Reduced level of effort related to organizational compliance
Transformation of management and executive-level dashboards	Health plans are evolving dashboards to implement more "predictive" capabilities to trend compliance and integrate "indicator flags" to detect operational or compliance failures	<ul style="list-style-type: none"> Implemented proactive approach to managing both compliance and operational performance Increased regulatory compliance
Evolving analytics for compliance-related audits and reviews	More progressive payers are using targeted sampling methodology aligned with that of CMS, as opposed to random, statistically valid sampling	<ul style="list-style-type: none"> Reduced effort by business areas to support audits Enhanced value to the business in streamlining remediation and prevention efforts
Profiling of providers to link compliance, care management and quality together	Health plans are comparing quality measures across providers with relevant data sets (HEDIS, claims) to look at the end-to-end care management value chain	<ul style="list-style-type: none"> Enhanced view into the linkage of quality performance to outcomes, down to provider level Remaining on pace with direction regulators are headed

Source: PwC

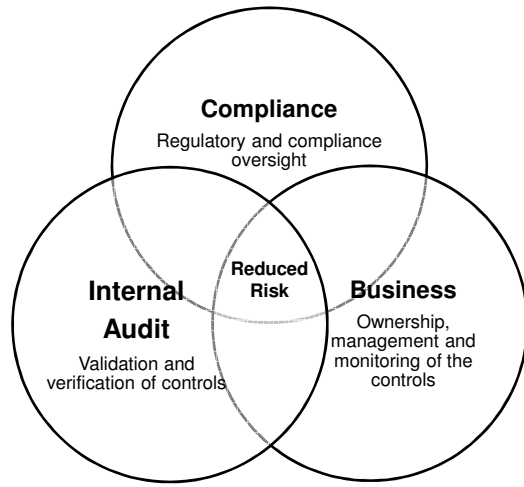
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Managing Enterprise Risk



Data and Analytics Driven



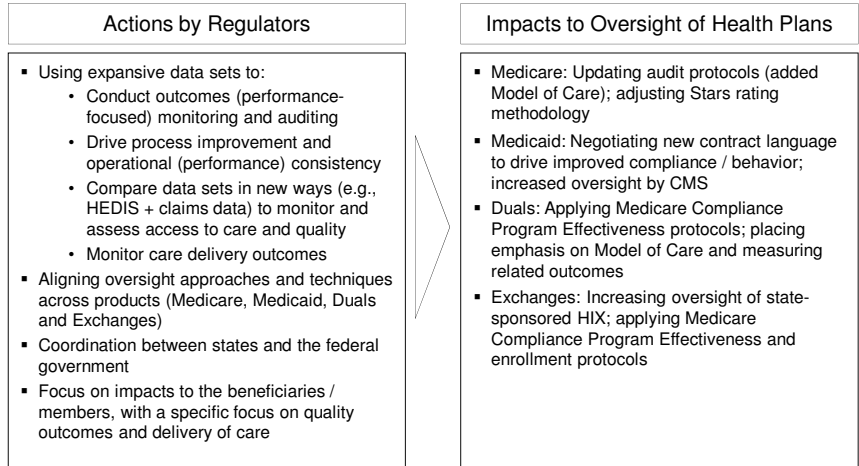
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Regulatory Actions & Sector Impact



Regulators are using inter-agency coordination across federal and state levels to align oversight approaches and techniques, with a distinct focus on assessing delivery of care and quality outcomes



Source: PwC

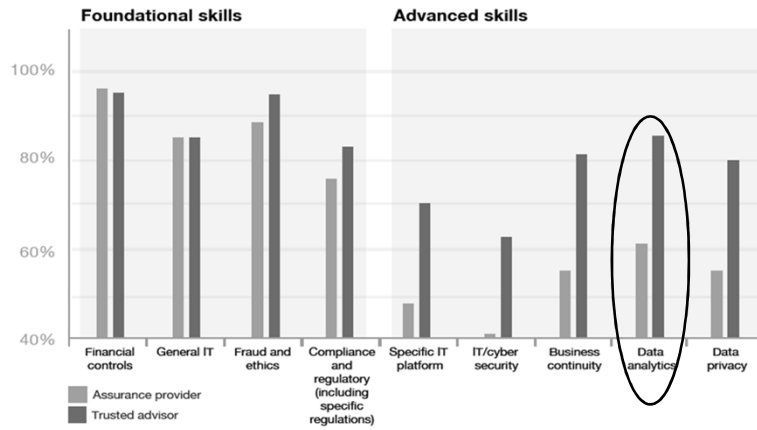
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Profile of Trusted Advisors



Trusted advisors more often possess advanced skills



Percent of respondents indicating internal audit is performing well

Source: PwC 2014 State of Internal Audit Survey

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CMS Mock Audit Process

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CMS Mock Audit Process



1. Formulary Administration & Transition (FA)
2. Coverage Determinations, Appeals, & Grievances (CDAG)
3. Organizational Determinations, Appeals & Grievances (ODAG)
4. Outbound Enrollment Verification (OEV) – Not applicable for 2014 protocol
5. Special Needs Plan - Model of Care (SNP MOC)
6. Compliance Program Effectiveness (CPE)

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CMS Mock Audit Process - FA



The following were the key areas analyzed for Formulary and Transition transactions:

- **Formulary Analysis**
 - Year-over-Year
 - Protected class
- **Rejected Claims Analysis**
 - 70 – Drug not covered
 - 75 – Exceeds plan limitations
 - 76 – PA required
 - 78 – Cost exceeds maximum
 - 7X – Days supply exceed plan limitations
 - 88 – DUR reject error

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CMS Mock Audit Process - CDAG



The following were the key areas analyzed for CDAG transactions:

- Coverage Determinations
 - Timeliness (Process / Notification)
 - Duplicates
 - Tolling
 - Denials
- Appeals
 - Timeliness (Process / Notification)
- Grievances
 - Timeliness (Process / Notification)
 - Access to care

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CMS Mock Audit Process - ODAG



The following were the key areas analyzed for ODAG transactions:

- Organizational Determinations
 - Timeliness (Process / Notification)
 - Duplicates
 - Denials
- Appeals
 - Timeliness (Process / Notification)
- Grievances
 - Timeliness (Process / Notification)
 - Access to care

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CMS Mock Audit Process - OEV



The following were the key areas analyzed for OEV transactions:

- Year-over-Year Membership Analysis
- Communication Analysis
 - Member outreach
 - Member notification

CMS Mock Audit Process – SNP MOC



The following were the key areas analyzed for SNP MOC transactions:

- Membership Eligibility Analysis
- Health Risk Assessment (HRA) Completion
 - Timeliness
 - Completeness
- Individualized Care Plan (ICP) Completion
- Analyze utilization of services

CMS Mock Audit Process – CPE



The following were the key areas analyzed for CPE transactions:

- Associate training - Fraud, Waste, or Abuse (FWA) and Compliance
- Compliance / FWA Incident Analysis
 - Timeliness
 - Resolution
 - Reporting
 - Completeness of information
- Policies & Procedures Analysis
- Exclusion Check Analysis

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CMS Mock Audit Process – Results

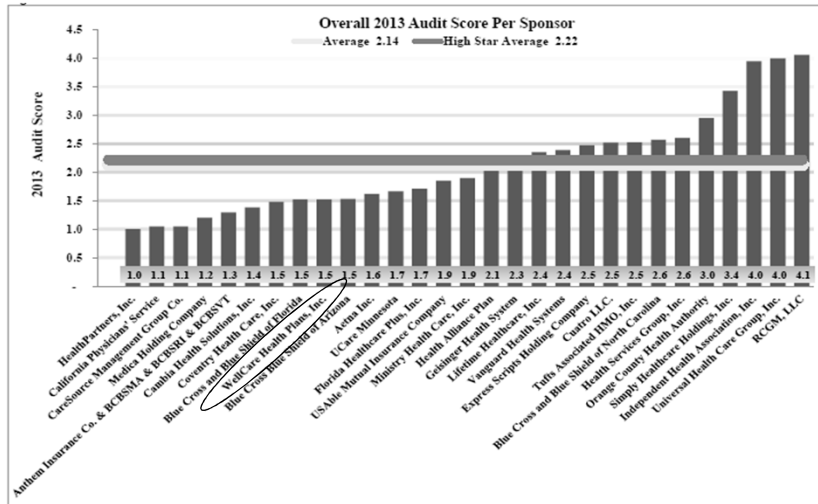


- Identified approximately 80% of issues noted by CMS
- Created comprehensive corrective actions that addressed many issues prior to actual CMS audit
- Reduced the number of Corrective Actions Required (CARs) and overall audit score due to enhanced control environment
- Prepared business units / owners for webinars and audit process

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CMS Mock Audit Process – Results



*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited in 2013. The high star average is an unweighted score across those sponsors with a star rating of 4.5 or greater.

Note: Figure 6 of CMS' "The 2013 Part C and Part D Program Annual Audit and Enforcement Report" issued October 16, 2014

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Individual Data Analytics Projects



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Individual Data Analytics Projects



- Annual Notice of Change (ANOC) / Evidence of Coverage (EOC)
- Claims Interest
- Credentialing
- Vendor Payment Processing
- Drug Utilization Review (DUR) Process
- Provider Directory
- True Out-of-Pocket (TrOoP)

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ANOC / EOC Project



Objective:

To perform reconciliations to ensure all eligible Medicare members received an ANOC/EOC kit

Procedures:

Reconciled membership data from core systems to the vendor print files to ensure completeness in accordance in with CMS guidelines

Outcome:

Business adopted enhanced automated reconciliation process based on data analytic scripting developed

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Claims Interest Project



Objective:

To perform a recalculation of interest payments to late payment claims

Procedures:

Recalculated the interest for all claims for completeness and accuracy in accordance with prompt pay guidelines

Outcome:

Business adopted claims interest exception and outlier process based on data analytic scripting developed

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Credentialing Project



Objective:

To verify accuracy, completeness, and timeliness of the re-credentialing process

Procedures:

Perform data analysis to identify untimely recredentialing, expired licenses, and data integrity issues of key fields in credentialing & core systems

Outcome:

Business adopted reconciliation and aging reports based on data analytic scripting developed

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Vendor Payment Project



Objective:

To verify the accuracy of the vendor payment process and to identify potential fraudulent activities

Procedures:

Data analysis to identify ghost vendors, duplicate payments, accuracy of payments, and related / common ownership in finance and procurement systems

Outcome:

Business adopted exception reporting based on data analytic scripting developed

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DUR Process Project



Objective:

To verify the completeness of the Drug Evaluation Review (DER) identification process

Procedures:

Perform a reconciliation of grievance data to the DER database for completeness in accordance with CMS guidelines

Outcome:

Business adopted real-time reconciliation reporting based on data analytic scripting developed

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Provider Directory Project



Objective:

To verify the accuracy and completeness of the Provider Directory

Procedures:

Perform a reconciliation of the provider directory comparing core system data to the online directory files

Outcome:

Business adopted exception reporting based on data analytic scripting developed

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TrOoP Project



Objective:

Assess the classification, calculation, application, and tracking of TrOoP costs

Procedures:

Review of source data utilized in the calculation of the TrOoP balances. The review could include, but not limited to, the following scenarios:

- Duplicate Claims
- Missing Fields
- Calculation Errors
- Negative Items
- Adjustments/Reversals
- Completeness of Reported Items

Outcome:

Business requested enhanced reporting from PBM based on data analytic scripting developed

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Continuous Monitoring

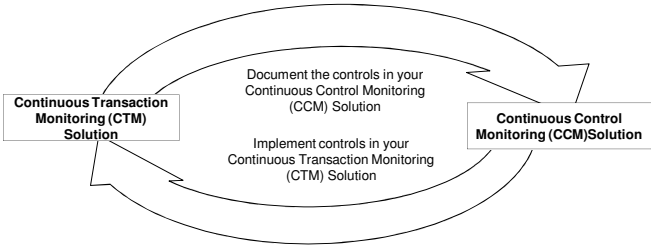
Continuous Monitoring Considerations

Driver: Lower cost to *operate* controls

- Reduce business efforts to operate controls (useful for clients with many manual controls)
- Identify business exceptions and control breakdowns sooner
- Increase business flexibility through moving toward real-time detective controls
- Achieve more coverage of risk
- Remove obvious pain points
- Stop known problematic transactions

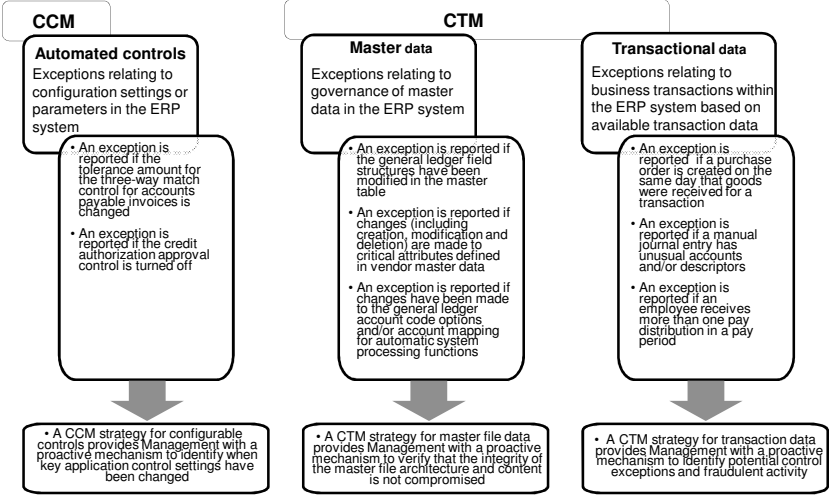
Driver: Lower cost to *evaluate* controls

- Lower the cost of compliance efforts
- Identify control breakdowns sooner
- Lower the cost of business self-assessment of controls
- Achieve better visibility of the compliance framework and the overall state of risk
- Organize risks and controls in a more meaningful fashion
- Policy management to support controls



Source: PwC

Examples of Continuous Monitoring: Focusing on Continuous Transaction Monitoring (CTM) and Continuous Controls Monitoring (CCM)



Source: PwC

Questions?