Preparing Your Organization for a Medicare Advantage / Part D Compliance Audit

February 14, 2012

Today’s Discussion Topics

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Introductions

Who is here today?

Question

How many of you have gone through a CMS Audit in the Past 18 months?
CMS Audit Approach – The Basics

CMS has changed its approach for identifying MA-PD and Part D Plan sponsors for audit

- 1/3 rule is out the door
- Utilizing a risk based approach
- Data driven strategy based upon reports received by and other information available to CMS to identify outliers and poor performers
- More and more CMS reporting and data requirements
  - Complaints / CTMs
  - Data Validation Measures
  - RAPS and PDE Data (error rates and timing)
  - Etc.
- Poor operational performance may indicate the plans compliance program is functioning to CMS requirements
CMS Audit Approach – The Basics

Through its risk analysis process, CMS has identified and focused on key areas for MA and PDP audits for 2011:

- Sales Agent Broker Oversight
- Compliance Program Effectiveness
- Prescription Drug Formulary Administration
- Part D CDAs and Grievances

CMS Audit Approach – The Basics

CMS has also changed its approach to conducting performance and compliance audits:

- Gone are the days of an audit guide “open book test”
- Although important, much less focus (and time spent) on policies and procedures
- Outcomes based approach via samples and probe studies
- Real time, on site review of case file and evidence documentation (this vs. request for hard copy documentation of samples)
- Plans are required to provide universes in advance, but are given no advance notice of samples that will be selected and reviewed
- CMS “attachments” provided to plan sponsors in advance describe process, data request and failure thresholds
- Very short notice and response time
- Process can be stressful and time consuming although CMS has promised a revised approach for 2012
Sales agent/broker oversight – Purpose

| CMS continues to view broker/ agent oversight as an area of risk for Medicare beneficiaries |

- To determine if the MA or PDP plan is performing proper oversight of its brokers and external sales agents

- Broker/ agent oversight audit areas include:
  - Compensation, Testing, and Training
    - Compensation paid per the broker agreement/ fee schedule
    - Recoupment of payment for rapid disenrollment
    - Training and test dates
    - *Outbound Enrollment Verification (OEV) calls*
    - *Beneficiary complaints*
  - Licensing
Sales agent/broker oversight – Audit Sample

Samples are selected based on enrollments for the audit period, which are tied back to the agent who enrolled the member

- Sample selection:
  - CMS typically selects one sample for both the licensing and training audit areas
  - Enrollments during the audit period – typically 30 samples
    - Target sample
  - Cancellations of enrollments due to (OEV) calls
  - A listing of all agents/brokers selling for the audit period

- Pass/Fail determination:
  - CMS has said they will allow 20% of the files to fail on the entire sample for this audit.

Sales agent/broker oversight – The Audit

CMS reviews for testing, training, and compensation but also for beneficiary complaints about the agent/broker

- Compensation and Recoupment
  - Commission payment vs. the broker/agent fee schedule
  - Recoupment of payment for rapid disenrollment
- Testing and Training
  - Agent testing and training within the past year based on the enrollment signature date
- Beneficiary Complaints
  - OEV call – CMS approved scripting and proper information
  - OEV call – agent complaints

- All five of the review elements must pass, for the file to pass
Sales agent/broker oversight – The Audit

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<th>Agents must be properly licensed in the state in which they are selling</th>
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- Licensing Review Items:
  - Is the agent properly licensed on the date the enrollment application is signed by the agent?
    - Compare broker/agent license to the signature date of the enrollment form
  - The file either passes or fails based on the licensing of the agent.

CMS Audit Approach – A Deeper Dive

Compliance Program Effectiveness
Compliance Program Effectiveness – Purpose

CMS wants to know how **effective** your compliance program is

- CMS
  - Plans must not only be able to demonstrate they have the documentation to support the compliance program but also that the compliance program is active and effectively functioning in the organization
  - Determine if the plan meets the seven elements of a compliance program
  - Determine if senior management is engaged in the compliance program
  - Determine if the compliance program is effective in detecting Fraud, Waste, and Abuse (FWA)

Compliance Program Effectiveness – Sample

**Extensive** data / document request to meet CMS compliance audit

- Program Documents submitted by plan
  - Standard documents that meet requirements of 7 elements – Compliance program, policies and procedures, etc.
  - Other supporting documents – Reported issues of non-compliance, auditing results, downstream audit results, list of investigations completed, list of investigations reported to CMS, employee listing by tenure, etc.
- Compliance program effectiveness self-assessment questionnaire
  - 32 pages, 167 questions assessment of compliance program (primarily yes/no, some free text responses)
- Power point template outlining the organizations background and governance structure
  - Reporting of corporate structure, corporate governance, FDR oversight, Medicare operational areas, FWA oversight, performance monitoring
Compliance Program Effectiveness – The Audit

Compliance program effectiveness depends on how well the program identifies FWA and engages the organization in correcting issues.

- While CMS does not establish a failure rate for the performance of a compliance program, it has identified several areas in which plans have not performed to expectations. These include:
  - Lack of engagement by senior management in the Medicare compliance program
  - Poor oversight of FDRs
  - Lack of an FWA program
  - Failure to take action on issues identified as FWA
  - Failure to report identified issues to the MEDIC or other appropriate entities

- How does the organization document and report the elements of its compliance program so that the key personnel are aware of compliance activities/issues?

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Deloitte

CMS Audit Approach – A Deeper Dive

Prescription Drugs and Benefit Administration
Prescription Drug Formulary and Benefit Administration

Formulary and benefit audits are used to determine if you are protecting the rights of your Medicare beneficiaries in delivering drugs.

- To determine whether the MAPD or PDP plan is accurately adjudicating claims based on the approved formulary
  - Tiering
  - Covered versus Non-covered drugs
  - Prior Authorizations, Step Edits, Quantity Limits.....
  - Correct Point of Sale Messaging
- To determine if the plan is delivering the Part D benefits to the beneficiaries in accordance with the CMS requirements
  - Appropriate rejections
  - Accurate transitions of coverage including documentation and communications
  - Consistency in messaging across A&G, CD’s, POS, Member and Physician messaging that is reconciled with the approved formulary
- P&T Committee Recommendations are documented and followed

Prescription Drug Formulary and Benefit Administration

Formulary Administration including protected class—rejected claims must be appropriately rejected and include clear and accurate messaging at the point of sale.

- A Rejected claims samples for protected and non-protected classes are selected
  - CMS reviews the sample for proper rejection based on transition requirements, prior authorization requirements, step therapy, nonformulary drugs, quantity level limits, and other formulary edits
  - CMS has reviewed the entire members rejected and paid claims history even though the claims reviewed are not the claims sampled for review
Prescription Drug Formulary and Benefit Administration

Transition of coverage including protected class—rejected claims must be **appropriately rejected** and include clear and accurate messaging at the point of sale

- CMS requests a universe of rejected claims from January and February of the current year and PDEs for the end of the prior year
- CMS reviews the rejected claims against the end of year PDE data and CMS-approved formulary to identify beneficiaries and drug combinations where a drug had a negative formulary change
- CMS selects a targeted sample of rejected claims for continuing enrollees, which includes both protected and nonprotected class drugs
- CMS also selects a sample of rejected claims from the data for new enrollees that include both classes of drugs

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Prescription Drug Formulary and Benefit Administration

- CMS reviews the samples for instances where:
  - the rejected claim for the beneficiary was properly rejected
  - there is evidence of a historic transition claim
  - the transition claims, were the communications timely and accurate
  - If applicable, CMS reviews that the CDAs, and grievances messaging synchs up with the Part D formulary rejections
  - In some reviews, CMS has gone back as far as two years on a claim-by-claim basis per member reconciling the rejected claims messaging, formulary filings
- In both formulary administration and transition sections, CMS has set the failure rate for protected class drugs at 10% and for non-protected class drugs at 20% of the sample.
### Prescription Drug Formulary and Benefit Administration

Failing the Formulary Administration or Transition testing will result in a P&T audit

- CMS selects a sample of protected class drugs and drugs with utilization management requirements from formulary changes found in the audit time period
- CMS reviews the P&T committee meeting minutes for instances where new drugs are not added to the formulary timely, utilization management is not implemented consistent with industry standards, or internal control failures are identified,
- CMS applies a 20% failure rate to the audit.

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### CMS Audit Approach – A Deeper Dive

Coverage Determinations, Appeal (CDA), and Grievances
Part D CDA and Grievances

CDA and Grievances continues to be a focus area for CMS audits

- Two components of CMS audit requests for CDA and Grievances:
  - Elements that will be reviewed on site
    - Effectuation Timeliness - CDA
    - Appropriateness of Clinical Decision-Making & Compliance with CDA Processing Requirements
    - Independent Review Entity (IRE) Reversals
    - Grievances
  - Elements that will be reviewed remotely
    - Universe submissions in the CMS specified formatting
- Universe sample size specifications depends on the plans number of enrollees
  - Plans that had <50,000 enrollees preceding the date of the engagement letter need to provide three months data, those with >50,000 but <250,000 enrollees needed to provide two months data, and those with >250,000 needed to provide one month data (the months requested is specified by CMS)
  - It is important to have your data analytic and CDA and Grievance departments ready and available to be able to pull all the required data within CMS’ timeframe as well as supporting documentation when CMS is onsite

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Part D CDA and Grievances

CMS selects 30 cases for CDA effectuation timelines

- Of the 30: 10 coverage determination cases; 10 redetermination cases; and 10 cases decided above the sponsor level (IRE, ALJ and MAC)
- For each of the selections CMS expects that following evidence for their review:
  - All letters, emails and documents for the case including:
    - Confirmation of the sponsor’s receipt of the request
    - Requests for additional information (if applicable)
    - Supplemental information submitted by prescriber including receipt date
    - Notices/letters to beneficiaries including logs that show when beneficiary was notified
    - For approved exception requests, CMS will look for evidence within the sponsor’s system that the approval is effective for the remainder of the plan year
- Testing compliance of sample sections by CMS for pass/fail
  - CMS is testing the following: Was timely notification provided to the enrollee (or representative) and the prescriber; and was the decision effectuated in the sponsor’s system within the applicable effectuation timeframe?
  - For non-protected drug class the failure is more than 20% error and for protected drug class the failure is more than 10% error
Part D CDA and Grievances

CMS selects 30 cases for CDA appropriateness of clinical decision making and compliance with CDA processing

- Of the 30: 5 expedited cases; 5 redetermination denials; 10 IRE reversals, and 10 coverage determination denials. (CMS will ensure that 20 cases are protected class drug denials and 10 cases are non-protected class drug denials)
- For each of the selections CMS expects that following evidence for their review:
  - Copy of the initial request made
  - All notices, or letters, showing the sponsor requested additional information from the prescriber, including date/time of the communication
  - All supplemental information submitted by the prescriber including documentation showing when information was received by sponsor
  - Documentation showing the sponsor’s rationale for the decision All notices, letters, and communications to the enrollee (and prescriber, if applicable) demonstrating when notification was made.
  - If auto-forwarded to the IRE, the case file should include documentation showing when the case was forwarded and when the enrollee was notified that the case was sent to the IRE
- CMS is testing the following:
  - Was timely notification provided to the enrollee (or representative) and prescriber, if applicable;
  - Did the sponsor appropriately consider clinical information and comply with CMS coverage requirements (e.g., followed all required compendia);
  - For the cases where the decision making timeframe was not met, did the sponsor auto-forward to the IRE properly and within the required timeframe?
- For non-protected drug class the failure is more than 20% error and for protected drug class the failure is more than 10% error

Part D CDA and Grievances

IRE reversals has been a challenge for most plans

- CMS will do the following with IREs:
  - Determine rate of reversal
  - Select data from the Part D redeterminations
  - Perform a Reversal Rate Calculation
  - Apply a standard
    - If the reversal rate calculated in this step is less than \((1 - \text{the upheld rate})\) under the current plan ratings posted on Medicare.gov at which 3 stars were awarded for this measure, then an overall score of “pass” has occurred
  - IRE Auto-Forwards
    - The number of auto-forward cases are divided by the plan’s average enrollment \((x 10,000)\).
    - If this rate is greater than the rate at which 3 stars were awarded under the current star ratings posted on Medicare.gov for this measure, then an overall failure has occurred for this performance area. Currently the rate for 3 stars and above for Part D plans must be less than 2.1.
Part D CDA and Grievances

This is where you can succeed, especially if you have been in Medicare Plans for more than a few years!

- Of the 15: CMS will focus on grievances related to drug access or pricing issues
- For each of the selections CMS expects that following evidence for their review:
  - Documentation showing when grievance was received
  - Documentation explaining the issue
  - Documentation showing the steps the Sponsor took to resolve the issue, including description of the final resolution
  - All notices, letters, and beneficiary communications demonstrating when resolution notification was made.
- Testing compliance of sample sections by CMS for pass/fail
  - CMS is testing the following: Was the request properly identified as a grievance; and was the enrollee notified of the disposition timely; and did the grievance resolution appropriately address the nature of the complaint?
  - A pass fail rate is assigned to each case based on CMS’ testing and if four or more (20%) fail that is the failure threshold

What to do when CMS calls?

Tom Delegram/ Tom Longar
It is not a Happy Valentines day when…

- Your executive team has been informed by CMS that an audit of their Medicare Advantage, Medicare Advantage Prescription Drug, and Stand Alone Prescription Drug Plans will be conducted in two weeks.
- Internally, you have conducted various internal audit and compliance activities to facilitate compliance with the CMS requirements, but you have not incorporated the CMS “audit attachments into your program.
  - For each of the audit areas Formulary and Benefit Administration, Agent/Broker Oversight, and Part D Coverage Determinations CMS has provided 3 attachments:
    - Audit process and Universe Request
    - Universe Templates
    - Sample Case Documentation Requirements
  - Compliance has 5 attachments which include:
    - Document Request
    - Minimum Document Description
    - Organization Structure and Governance Power Point
    - Compliance Program Effectiveness Self Assessment Questionnaire
    - Organization Background and Structure Questionnaire

Now what? – Get Organized!

- Identify a point person within the organization that is responsible for the compilation and QA of documents and universes in support of the CMS attachments
  - Historically, 5 business days of prep time
  - Oversight typically is the responsibility of the Medicare Advantage/Part D Compliance Officer
  - Will need to mobilize “functional liaisons” from each major business unit that has Medicare Responsibility
- Senior Management participation is critical to ensure that tasks are executed timely and to hold members accountable — senior management also gains an understanding of CMS risks to plan!
- Identify appropriate resources and SMEs within the organization that can effectively facilitate real time reviews with CMS auditors
  - Walk through screen shots, explain the meaning of data elements within multi systems such as claims systems, member services, CDA, etc.
  - Identify a separate individual that will navigate between the systems and tools, so that primary SME can focus on task at hand
- Conduct a dry run of system to make sure the technology is working as intended
Get Busy!

- Immediate next step should be the development of the CMS audit preparedness work plan and the formulation of the PMO team participants
  - Identify participants and set expectations
  - Enterprise wide communication and support from Senior leadership
  - Formulate logistics and planning
  - Focus on compilation and quality of evidence documentation
- Additional activities should include:
  - Staff coaching to prepare for CMS process walk throughs and interviews
  - Development of CMS on-site agenda and scheduled activities
  - Corrective action plan development/documentation

Questions?

Jack Scott
Deloitte & Touche LLP
jascott@deloitte.com
412.338.7555

Tom Delegram
Deloitte & Touche LLP
tdelegram@deloitte.com
412.338.7560

Tom Longar
Deloitte & Touche LLP
tlongar@deloitte.com
612.397.4127