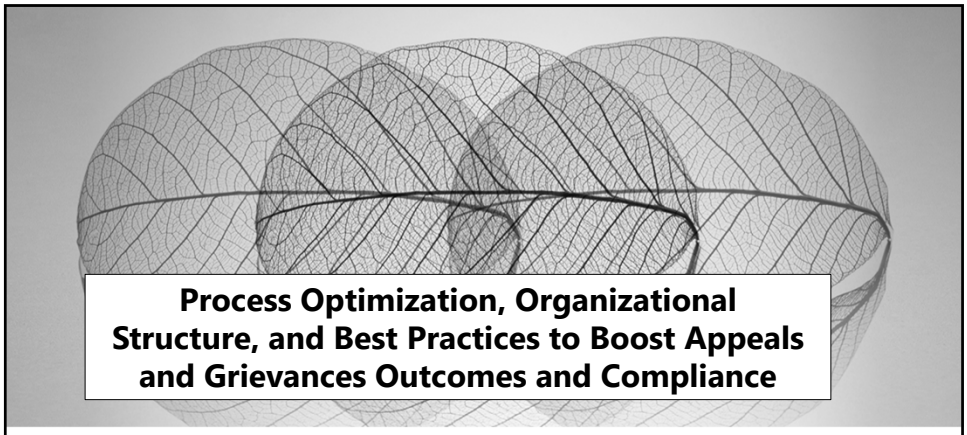

Process Optimization, Organizational Structure, and Best Practices to Boost Appeals and Grievances Outcomes and Compliance

January 28, 2020

ankura
COLLABORATION DRIVES RESULTS

1

Presentation Overview

- Process Evaluation
- Common Audit Findings and Considerations
- Appeal Overturns
- Remediation Best Practices
- Questions

2

PROCESS EVALUATION

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3

Overall Approach

- Most organizations stop at an outcomes-based approach to evaluating Appeals and Grievances performance, similar to how CMS tests compliance during a program audit
- While outcomes testing should certainly be performed, a more detailed, end-to-end evaluation provides more thorough diagnostics and more predictive power for what outcomes can be achieved moving forward
- This entails both quantitative and qualitative assessments of numerous facets of Appeals and Grievances functions beyond transaction reviews

An effective Appeals and Grievances evaluation not only identifies current compliance issues, but also pinpoints gaps and risks that have the likelihood to adversely impact compliance in the future.

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4

PROCESS EVALUATION

What Should You Review and Track?

Documentation

- Policies and procedures
- Job aids and checklists
- Training materials
- Templates

Staffing

- Skillsets and specialization
- Case loads
- Seasonality

Organizational Structure

- Roles and responsibilities
- Cross-department lines of communication
- Physical locations (on-site vs. remote)
- Issue escalation processes

Performance

- Productivity
- Quality audit results
- Inter-rater testing
- Incentive structure
- Communication of feedback

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5

PROCESS EVALUATION

What Should You Review and Track? (Continued)

Process

- Workflows and handoffs
- Adherence to documented procedures

Technology

- Home grown vs. purchased systems
- Accessibility of data
- System speeds and downtimes
- Cross-system data exchange

Controls

- Manager / Supervisor oversight
- Pre-closure quality reviews

Oversight and Monitoring

- Audit processes
- L1-L3 oversight

Data Analytics

- Case volumes
- Timeliness
- Decision trends
- Consistency between related data sources (e.g., universes, Part C Reporting)
- Comparison to peers

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6

PROCESS EVALUATION

Best Practices for an End to End Evaluation

- Engage individuals with an impartial view of the department (e.g., Internal Audit, Compliance)
- Follow CMS timelines to "pressure test" universe creation and case preparation processes
- Perform thorough quality review of data universes, including validation against source systems
  - Include representation from all delegated entities or separate systems which contribute data
- Select targeted samples for case walkthroughs
  - Consider expanding sample sizes to include representation from all delegated entities or business units
  - Align targeting approach with those used by CMS (e.g., denials vs. approvals) and perceived areas of risk
- Ensure follow through on identified findings with root cause investigation and impact analyses

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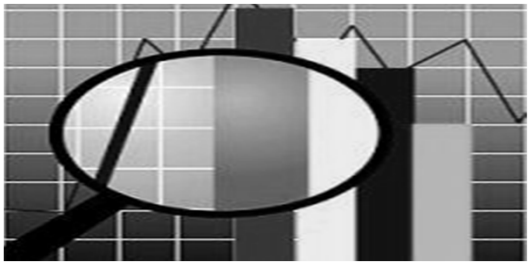
7



COMMON AUDIT FINDINGS AND CONSIDERATIONS

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8

Appeals – Intake

- Categorization as ODs vs. appeals – ensure appeals are not misclassified as ODs
- Assignment of standard vs. expedited – ensure cases implicating medical exigency are processed as such and that no inappropriate downgrades occur
- Initiation of multiple requests when applicable (e.g., appeal *and* grievance)
  - Despite discontinuing call logs, CMS still evaluates and continues to find errors in proper classification through its review of other transaction types
- Appeals must be filed within 60 days of the date of OD denial notification, unless good cause exists – use the universe definition of denial notice date and be sure to consider good cause
- Requestor must be a valid requestor with the appropriate documentation, when needed
  - Post-service payment appeals can only come from non-contracted (not contracted) providers, and must have a valid Waiver of Liability (WOL)
  - Direct member reimbursement appeals can be submitted by the member or an authorized representative with a valid Appointment of Representative (AOR) form or equivalent notice
  - For pre-service appeals, requestors that are not (a) the member, (b) the member's treating physician, or (c) acting on behalf of the physician must have a valid AOR form or equivalent written notice
  - If not provided at time of appeal submission, must be able to evidence outreach for missing documentation (e.g., AOR, WOL) that would validate requestor

9

Appeals – Processing, Decision Making, and Notification

- Extensions may only be taken on pre-service appeals and only when in the best interest of the member
  - Must provide requisite notice to the member regarding the extension, including his or her right to file an expedited grievance
  - NOTE: Revised CMS guidance does not allow extensions for Part B drugs
- Documented evidence of outreach for additional medical records or information when needed, including timing, method, and outcome of outreach
  - Revised CMS guidance established a minimum of one attempt as sufficient, but encourages plans to adopt best practices for multiple attempts using multiple methods – ensure adherence to internal policy on number and type of outreach
  - For expedited pre-service appeals, if medical information is needed from an NCP, the request must be made within 24 hours of receipt of the request
- Medical necessity cases require review by a Physician not involved in the initial decision
- Approval notices must provide the conditions of the approval (e.g., duration, limitations)
  - For cases received from a member representative, notice must be provided at a minimum to the representative – plans may elect to also notify the member
  - NOTE: Revised CMS guidance no longer requires notification for adverse cases which are forwarded to the IRE

10

Appeals – Timeliness

- Evaluate entire universe for timeliness calculation and percentage for all applicable tests
  - Identify patterns for untimely cases (e.g., specific processors, days of week)
  - Pinpoint process bottlenecks that could impact timeliness
  - Track specific timeframes, not just overall percentages, to ensure that adverse factors (e.g., volume spikes, staff shortages) do not result in a surge in untimely cases
- Typically, any timeliness measure for standard cases that results in less than a 95% timeliness percentage is considered a CAR finding
- For expedited cases, any cases not meeting timeliness may be cited as a condition
  - Untimely expedited pre-service appeals (EREC) are likely to rise to an ICAR finding
- Account for additional time for written notification in alignment with mail policy
- For expedited cases, ensure that you are providing oral notification
- Ensure that all adverse and untimely cases are sent to the IRE
- Timeliness of IRE forward is particularly important for adverse cases
- For dismissals, ensure that the full adjudication timeframe has elapsed prior to dismissal
- NOTE: Revised CMS guidance includes shortened timeframes for Part B drugs

11

Grievances – Intake

- Initiation of multiple requests when applicable (e.g., grievance *and* OD)
- Requestor must be a valid requestor with the appropriate documentation, when needed
  - Requestors that are not the member must have a valid AOR form or equivalent notice
  - If not provided at time of grievance submission, must be able to evidence outreach for missing documentation (e.g., AOR) that would validate requestor
- Ensure expedited grievances are captured and processed as such
  - Disagreement with the decision to take an extension
  - Disagreement with the decision to not expedite a determination
- Grievances implicating Quality of Care issues must be captured as such
  - Related to whether or not the quality of covered services provided by a plan or provider meets professionally recognized standards of health care (e.g., misdiagnosed, inappropriate treatment, care adversely impacted the member's health)
- All distinct issues in a grievance must be identified, categorized, and investigated
  - Complex grievances may contain many different issues

12

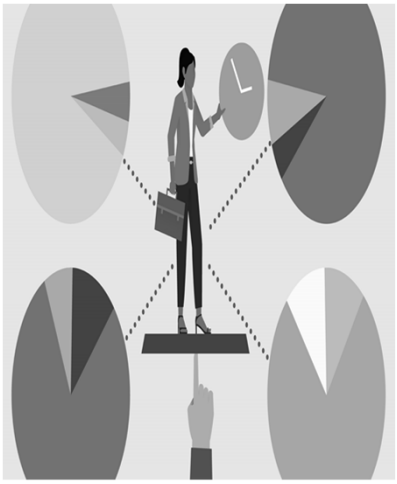
Grievances – Investigation and Notification

- Failure to adequately investigate all aspects of a grievance can stem from not identifying all distinct issues upon intake, or a lack of or delay in outreach / investigation until late in the timeframe
- Extensions may only be taken on when in the best interest of the member
  - Must provide requisite notice to the member regarding the extension, including his or her right to file an expedited grievance
- Ensure you are providing the required type of notification of resolution
  - Grievances received in writing, Quality of Care grievances, and grievances where the member requests a written response must have written notification of resolution
- Quality of Care resolution letters must contain the member's rights to file a grievance with the BFCC-QIO
- Resolution notification, whether provided orally or in writing, must address all aspects of the original grievance
  - Ensure that call documentation for grievances resolved orally provide sufficient detail to evidence thorough resolution of all issues raised in the grievance
- Written notifications must be written in a manner that is understandable to the member

13

Grievances – Timeliness

- Perform similar analytics as for appeals
  - Account for the required type of notification for resolution when calculating timeliness
- Grievance untimeliness typically results in a CAR as there are fewer access to care implications compared to appeals
- Account for additional time for written notification in alignment with mail policy
- For dismissals, ensure that the full adjudication timeframe has elapsed prior to dismissal



14

APPEAL OVERTURNS

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15

APPEAL OVERTURNS

2018 OIG Report on Medicare Advantage Appeal Outcomes

Objectives

- To determine the extent of appeals and overturns of Medicare Advantage service and payment denials at each level of the appeals process during 2014 – 2016
- To assess CMS's 2015 audit findings and enforcement actions related to denials and appeals

Data Sources

- Annual performance data submitted to CMS
- Data from CMS contractors (e.g., IRE)
- CMS audit reports, Civil Monetary Penalties, and Sanction information
- STAR ratings data

Findings

- Although beneficiaries utilized the appeal process infrequently (1%), when they did, MAOs overturned 75% of those cases, with higher-level external entities overturning between 10% and 27%, depending on the external entity
- During 2015, CMS cited 56% of audited contracts for inappropriate denials and 45% of audited contracts for sending incomplete or confusing denial letters to beneficiaries

FOOD for THOUGHT

OIG's findings raised concerns as to whether MAOs are denying services or payment for services that they should not be and, as a result, introducing delays / barriers to care for members, especially those who do not appeal.

Source: September 2018 OIG Report, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials"

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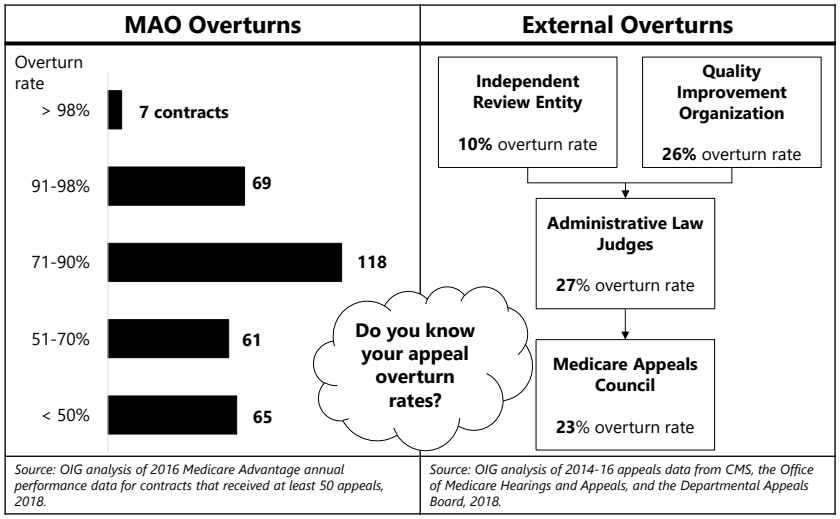
16

APPEAL OVERTURNS

Overturn Rates



Source: OIG analysis of 2016 Medicare Advantage annual performance data for contracts that received at least 50 appeals, 2018.

Source: OIG analysis of 2014-16 appeals data from CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board, 2018.

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17

APPEAL OVERTURNS

How Should We Evaluate Our Appeal Overturns?

- Leverage longitudinal system data to perform ongoing analysis of appeal overturn rates and potential patterns by:
  - Type of service/item
  - Original decision maker (e.g., by delegate, by individual reviewer)
  - Reason for original denial
  - Appeal decision maker
- Review overturned transactions to pinpoint what information, if any, changed between levels of review
  - Pay particular attention to differences in application of criteria between delegate and internal reviewers
  - Determine if the overturn is a result of new information or a different interpretation of existing information, particularly for overturns by an external review entity
- Even if original decision was appropriate, rendering an overturn decision based on the same information that was available for the initial organization determination is problematic as it introduces a barrier to care for members who do not appeal
- Use information on overturns to inform medical policy decisions, upstream training, communication to delegates, and enhanced monitoring

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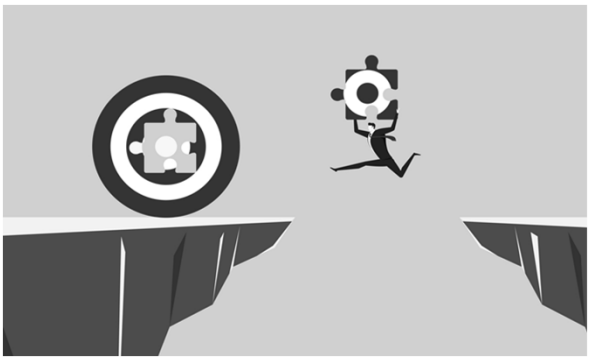
18



REMEDIATION BEST PRACTICES

19

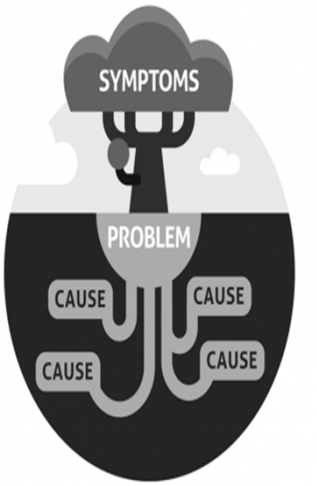
Now We Know The Issues… How Do We Fix Them?

- Aggregate and synthesize information from your process evaluation and "expanded" mock audit to:
  - Risk rank delegates and operational areas
  - Identify gaps in processes
  - Identify need for creation of new materials or updates to existing materials
  - Revisit staffing
  - Identify specific areas
- Create work plan to manage to timeframes

20

Root Cause Analysis

- Effective remediation cannot occur without an accurate determination of root cause
- Once root cause is established, identification of the source of the error (systems, people, process) is essential
- Think twice before attributing issues to individual processor error, as this may often indicate more systemic issues including:
  - Lack of effective training
  - Insufficient policies, procedures, and/or job aids
  - Inadequate controls and oversight mechanisms



21

Corrective Action Planning

- ✓ Utilize established CAP procedures to develop the plan for remediation
- ✓ Make sure to include specific tasks that must be done to correct the issue, reasonable timeframes for completion and validation steps
- ✓ Use existing rules and requirements to make a determination of CAP closure and issue remediation
- ✓ Should the CAP be assigned to an FDR,, include any FDR oversight committees or departments in the development and monitoring of the CAP.
- ✓ Consider the issues leading to the CAP against prevailing contractual SLAs or performance guarantees

22

REMEDIATION BEST PRACTICES

Implementation and Monitoring

- Test effectiveness of remediation activities shortly after implementation to identify and correct anything early on
- Leverage data analytics to perform ongoing monitoring and pinpoint transactions warranting further review based on known areas of risk
- Re-perform testing where needed to identify recurrent issues
- Follow work plan and CAP remediation tasks to make sure that all actions are monitored
- Develop and deliver reporting on the issues to departments such as Compliance, Internal Audit and FDR Oversight to assist in their risk assessment planning

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23

Questions

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24

Your Presenters

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