Medicare Advantage Compliance Basics

Overview

1. Elements of a Compliance Plan
2. Evaluation of Corporate Compliance Programs
3. DOJ Evaluation Guidance Impact On…
   - Investigations
   - Oversight
   - Discipline
4. Risk Adjustment Data Validation (RADV)
5. Recent Enforcement Activity

Basic Compliance Consideration

7 Elements of a Compliance Plan

1. Written Policies and Procedures
2. Designated Compliance Professionals
3. Effective Communication
4. Preventative Auditing and Monitoring
5. Enforcement of Standards
6. Prompt Response to Potential Compliance Violations
7. Effective Training of Staff

Basic Compliance Considerations (cont)

In February 2017, DOJ issued a memo titled

"Evaluation of Corporate Compliance Programs"
https://www.justice.gov/criminal-fraud/page/file/937501/download

Intended to be flexible, the **Evaluation Guidance** lists **11 topics** and **120 sample questions** DOJ may use when evaluating corporate compliance programs.

Basic Compliance Considerations (cont)

The DOJ perspective is critically important for federal programs

- Can impact criminal/civil resolutions, the size of fines or penalties, monitoring, and the terms and conditions of a Corporate Integrity Agreement
- Focus of DOJ Evaluation Guidance is how compliance controls are actually being used and responded to by senior management and business units
- DOJ will look beyond the elements or formal structures of compliance programs to see how they impact (or do not impact) operations of the organization both in the day-to-day and when red flags appear

DOJ Evaluation of Compliance Programs

- **Topic 1** – Analysis and Remediation of Underlying Misconduct
- **Topic 2** – Senior and Middle Management
- **Topic 3** – Autonomy and Resources
- **Topic 4** - Policies and Procedures
- **Topic 5** - Risk Assessment

DOJ Evaluation of Compliance Programs (cont)

- **Topic 6** – Training and Communications
- **Topic 7** – Confidential Reporting and Investigation
- **Topic 8** – Incentives and Disciplinary Measures
- **Topic 9** – Continuous Improvement
- **Topic 10** – Third Party Management
- **Topic 11** – Mergers and Acquisitions

DOJ Evaluation Guidance Impact on ***Investigations***

• 42 C.F.R. § 422.503(b)(4)(vi)(G) and related guidance requires "a system for promptly responding to compliance issues as they are raised"

DOJ WANTS TO KNOW:

If your investigation and analysis:

- **Identifies the "root cause" of the misconduct**
- **Who made that analysis**
- **What specific remediation is being undertaken to prevent it in the future**

DOJ Evaluation Guidance Impact on ***Oversight***

• 42 C.F.R. § 422.503(b)(4)(vi)(B) requires "the designation of a compliance officer and a compliance committee who report directly and are accountable to the organization's chief executive or other senior management"

DOJ WANTS TO KNOW:

Whether your senior leaders…

- **Have encouraged this type of misconduct through words or actions**
- **Have demonstrated their commitment to compliance and remediation of misconduct**
- **Whether your compliance functions have sufficient sway within the company to effect change**

DOJ Evaluation Guidance Impact on ***Discipline***

• 42 C.F.R. § 422.503(b)(4)(vi)(E) requires "[w]ell-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program"

DOJ WANTS TO KNOW:

- **What disciplinary actions the company has taken in response to misconduct**
- **Whether disciplinary rules were applied consistently**
- **What incentives exist for ethical behavior**

CMS PI Focus to Date in Medicare Advantage

Risk Adjustment Data Validation (RADV)

- Medicare Advantage Organizations submit diagnoses to CMS to support their enrollees risk adjusted payments. RADV validates that diagnoses submitted for payment are supported by medical record documentation.
- RADV recovers improper payments based on diagnoses submitted to CMS that are not supported by medical record documentation.

Miscellaneous Considerations

MCO Fraud and Abuse Efforts

- **Impact to Providers**
  - **Follow CMS compliance rules, especially F&A reporting, training, use of exclusion list, offshore activity**

Recent Enforcement Activity Involving Managed Care/Medicare Advantage

- In 2017, DOJ intervened in the *Swoben* False Claims Act litigation.
- In 2017, EviCore Healthcare (previously CareCore National) paid $54 million to settle allegations that it failed to properly review prior authorizations
- In 2012, the SCAN Health Plan paid nearly $320 million to settle allegations that it received overpayments resulting from actuarial errors that SCAN then concealed SCAN also paid $3.82 million related to allegations that it inflated patients' risk adjustment scores

Recent Enforcement Activity Involving Managed Care

In 2017:

- DOJ opened 967 new criminal health care fraud investigations
- Federal prosecutors filed criminal charges in 439 cases involving 720 defendants
- A total of 639 defendants were convicted of health care fraud-related crimes
- DOJ opened 949 new civil health care fraud investigations and had 1,056 civil health care fraud matters pending at the end of the fiscal year
- DOJ received $2.6 billion in health care fraud judgments and settlements
- Over $4 returned for every $1 spent on enforcement, making it a fiscal profit center

What is your **Pain?**

1. FDR attestation is inconsistent
2. FDR requirements for each Sponsor's CMS audit
3. Audits (oversight) inconsistent; not measuring the same requirements/ elements/same methodology
4. Training – limited resources to train, and limited systems, inconsistent requirements
5. Contract (Provider) requirements inconsistent
6. Required monthly reports inconsistent
7. Required universes inconsistent format and creation/providing to Sponsors
8. Code of Conduct – different for each entity
9. Other….

CMS 7 Elements – Clarification

- Element I: Written Policies, Procedures and Standards of Conduct
- Element II: Compliance Officer, Compliance Committee and High Level Oversight
- Element III: 7Effective Training and Education
- Element IV: Effective Lines of Communication
- Element V: Well-Publicized Disciplinary Standards
- Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
- Element VII: Procedures and System for Prompt Response to Compliance Issues

CMS Health Plan Compliance 3 Elements

- Prevention Controls and Activities
- Detection Controls and Activities
- Correction Controls and Activities

FDR Compliance Program

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- **Compliance with regulator expectations:** CMS, holds Sponsors accountable for the compliance of its FDRs with Medicare regulations and requirements.
- **Access to quality of care**: Increased coordination between Sponsor and FDR may enable improved access to care and better member retention.
- **5 star rating:** Cooperation between the Sponsor and FDR may result in improvements to care delivery and data collection.

Lowering the Boom

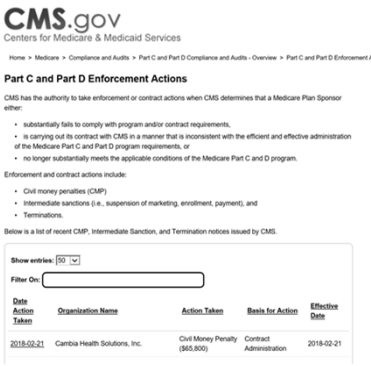
- In the last 5 years, CMS has taken unprecedented enforcement action on plans that perform poorly on program audits
- Enforcement action can include:
  - Civil monetary penalties (CMPs)
  - Intermediate sanctions (suspending enrollment, marketing, and/or payment)
  - For-cause contract terminations

CMS ENFORCEMENT ACTIONS 2013-2017

ACTION	2013	2014	2015	2016	2017
ENFORCEMENTS	23	19	25	22	35
CMPS #	21	16	20	18	32
CMPS $$$	$3.88 million	$3.75 million	$10.3 million	$5.1 million	$7.2 million
INTERMEDIATE SANCTIONS	2	3	4	2	3

Source: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html
As of 2/21/18

CMS ENFORCEMENT ACTION – CONSEQUENCES



CMS.gov
Centers for Medicare & Medicaid Services

Home > Medicare > Compliance and Audits > Part C and Part D Compliance and Audits - Overview > Part C and Part D Enforcement Actions

Part C and Part D Enforcement Actions

CMS has the authority to take enforcement or contract actions when CMS determines that a Medicare Plan Sponsor either:

- substantially fails to comply with program and/or contract requirements,
- is carrying out its contract with CMS in a manner that is inconsistent with the efficient and effective administration of the Medicare Part C and Part D program requirements, or
- no longer substantially meets the applicable conditions of the Medicare Part C and D program.

Enforcement and contract actions include:

- Civil money penalties (CMP),
- Intermediate sanctions (i.e., suspension of marketing, enrollment, payment), and
- Terminations.

Below is a list of recent CMP, Intermediate Sanction, and Termination notices issued by CMS.

Show entries: 50
Filter On:

Date Action Taken	Organization Name	Action Taken	Basis for Action	Effective Date
2018-02-21	Cambia Health Solutions, Inc.	Civil Money Penalty ($65,800)	Contract Administration	2018-02-21

- Reputation
  - Negative news
  - Impact on enrollment
- Direct Costs
  - Enrollments
  - Tools
  - Consultants/Vendors
- Indirect Costs
  - Daily duties distraction
- Labor
  - Remediation staffing
  - Back fill to maintain daily tasks
  - Attrition – Fatigued staff

Poor Performers

Civil Money Penalties	Intermediate Sanctions	Both Actions
May reduce Star rating	Reduces Star rating to 2.5	Increased Past Performance Points
	Decreased enrollment	Sullied reputation
	Loss of employees	Loss of profits
		Investment of time by senior leadership

It Rolls Downhill — Be Prepared For Changes

Let's Collaborate

Medicare Advantage Downstream Contracting Addendum

Medicare Advantage First Tier Entity-Downstream Provider Contract Addendum
May 1, 2013

This Medicare Advantage First Tier Entity-Downstream Provider Contract Addendum ("Addendum") is entered into by _____ ("First Tier Entity") and _____ ("Downstream Provider"), and is intended to add contract language required by the Centers for Medicare and Medicaid Services, "(CMS") for participation in the Medicare Advantage ("MA") program.

CMS requires that specific terms and conditions be incorporated into the Agreement between a

Medicare Advantage Downstream Contracting Addendum – CMS Adopte

CMS.gov
Centers for Medicare & Medicaid Services

Home > Medicare > Medicare Advantage Applications > Medicare Advantage Applications

Medicare Advantage Applications

This page provides important information on the application process for Part C Medicare Advantage plans (HMO/HMOPOS, PPO, RPPO, PFFS, MSA, EGWP and SNP). Please use the Medicare Prescription Drug link in the "Related Links Inside CMS" section below to access Medicare Prescription Drug application materials.

Medicare Contract Applications - Organizations that are interested in applying for a Medicare Advantage contract can download and complete the appropriate application.

All Medicare Advantage applicants must download the payment information form below and submit it with their application.

HPMS LISTSERVS
While HPMS plan users are automatically subscribed to the HPMS list serv, prospective plan applicants and other interested parties without access to the system may request to join the listserv's supplemental mailing list to stay abreast of the agency's communications on the Medicare Advantage (MA) and Part D programs.

To facilitate this process, CMS has implemented an online form that can be used to join one or more HPMS listservs, modify your current listserv access, or delete your current listserv access.

CMS makes additions and modifications to the HPMS listserv on a weekly basis.

CMS is also publishing HPMS memos on the CMS public website on a weekly basis. The HPMS-Memos-Archive may be found in the related links section below.

Downloads

CY 2019 Part C - MA and 1876 Cost Plan Expansion Application [PDF, 770KB]
Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance [PDF, 2MB]
HSD Reference File - 01-10-2018 [XLSX, 2MB]
Model_Contract_Amendment_080714 [PDF, 43KB]
Model_Contract_Amendment_HPMS_Memo_10_05_12 [PDF, 27KB]

Medicare Advantage Downstream Contracting Addendum – CMS Adopte

Medicare Advantage Contract Amendment

(For use with Administrative / Management Contracts and First Tier or Downstream Entity - Provider Contracts)

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

First Tier Entity - Attestation

- Intent
  - To reduce the burden on Medicare Advantage Organizations (Sponsors) and their first tier entities by providing one compliance attestation to execute.
    - First tier, downstream, related entities (FDRs)

First Tier Entity - Attestation

- Create an annual FTE Compliance Attestation Process
  - Create one attestation document
  - Create a repository that allows MAOs to audit elements of compliance programs for testing, OIG/GSA, etc.

First Tier Entity - Attestation

- Requirement
  - The Centers for Medicare and Medicaid Services (CMS) requires Sponsors communicate and monitor specific compliance and fraud, waste and abuse (FWA) requirements.
    - Title 42 of the Code of Federal Regulations, Parts 422 and 423
    - Medicare Prescription Drug Benefit Manual Chapter 9, and Medicare Managed Care Manual Chapter 21.

First Tier Entity - Attestation

- **Sponsor ultimately accountable**
  - Sponsors may contract with FDRs to perform certain functions on its behalf, the Sponsor maintains ultimate responsibility for fulfilling the terms and conditions of its contract with CMS and for meeting the Medicare program requirements, including ensuring that FDRs are in compliance with all applicable laws, rules and regulations with respect to delegated responsibilities.

First Tier Entity - Attestation

- **Standard Process**
  - **Sponsor mails, emails or uses other means to send their Compliance Attestation Form to their First Tier Entities**
  - First tier entities reviews the Compliance Attestation (legal…).
  - First tier entity signs the Compliance Attestation Form.
  - First tier entity returns completed Compliance Attestation Form per each Sponsor directions.
  - Sponsors follow up with each First tier entity that did not return the signed Compliance Attestation Form.
  - Sponsors conduct audits on the Compliance Attestation Forms.

First Tier Entity - Attestation

ICE Compliance and Contracting team created standard Compliance Attestation Form (iceforhealth.org/library/approved documents

First Tier Entity Attestation 2017
Medicare Advantage Organization (Sponsor) Compliance Program

Note: Sponsors: Please review the highlighted text and insert your required specific information, and the optional text.

Date (optional) ***First Tier Entity Name: (optional)***

As part of an effective compliance program, the Centers for Medicare and Medicaid Services (CMS) and other federal and state regulators require our Medicare Advantage Organizations (MAO/Sponsor) *<and Medicaid Health Plan Sponsors* ***optional****>*, communicate and monitor specific compliance and fraud, waste and abuse (FWA) requirements to our First Tier, Downstream and Related entities (FDRs), including guidance set forth in Title 42 of the Code of Federal Regulations, Parts 422 and 423

First Tier Entity - Attestation

- **2017 Process**
  - **Sponsor mails, emails or uses portal to send the ICE standard Compliance Attestation Form to their First Tier Entities**
  - First tier entities reviews the Compliance Attestation (One).
  - First tier entity signs the Compliance Attestation Form.
  - First tier entity returns completed Compliance Attestation Form per each Sponsor directions.
  - Sponsors follow up with each First tier entity that did not return the signed Compliance Attestation Form.
  - Sponsors conduct audits on the Compliance Attestation Forms.

First Tier Entity - Attestation

- 2018 Process – Draft specifications
  - Create a database to collect the FDR attestation information
  - ICAN ICE Database agreed upon as most preferred platform Data-sharing, data-mining and report writing
  - Create auto reminders that send out to those FDR contacts listed who have not responded to the FDR Attestation

First Tier Entity - Attestation

- 2018 Process - Draft specifications
  - Utilize a checkbox format to respond with yes or no and a box for any required explanation of deficiency
  - Utilized a list of Sponsors to select
  - Electronic signature
  - Incorporate the ability to share audits across multiple Sponsors

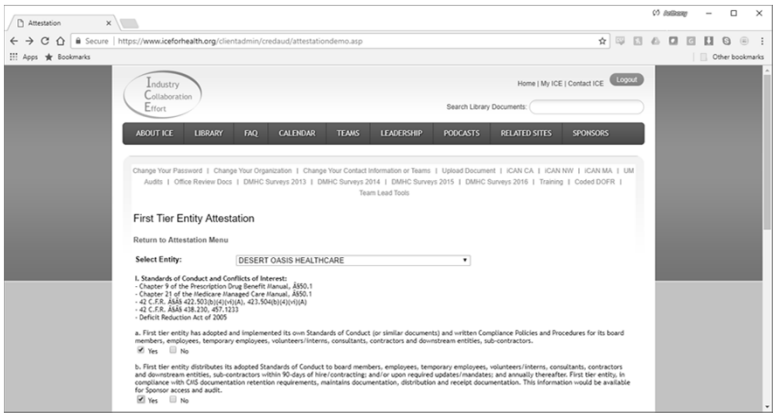
First Tier Entity - Attestation

- **2018 Process**
  - ICE emails notification of Compliance Attestation Forms
  - First tier entities electronically signs the Compliance Attestation Form and uploads to the ICE website.
  - Sponsors receive list to follow up with each First tier entity that did not return the signed Compliance Attestation Form.
  - Sponsors share audits of the Compliance Attestation Forms.

First Tier Entity - Attestation

- **2018 Process**
  - **Enhanced Access – ICE Website Integration**
  - **Enhanced Security – ICE User Account Integration**
  - **Enhanced Data Collection – ICE Database Integration**
  - **Enhanced Accuracy – Real-Time Data Validation**
  - **Enhanced Reporting & Analysis – Online Reports and Downloadable Extracts with Flexible Criteria Selection**
  - **Enhanced Communication – Automated Status Notification**

First Tier Entity - Attestation



First Tier Entity - Attestation

- *CMS Compliance elements- Shared Audits*
  - *Standards of Conduct*
  - *General Compliance and FWA Training*
  - *Monthly OIG&GSA sanction checks*
  - *Audits and monitoring of subcontractors*

First Tier Entity - Attestation

- **Encourage More Sponsors to Collaborate**

Alignment Healthcare USA
Community Health Group
Central Health Plan of California
Humana
Inter Valley Health Plan
Molina Healthcare, Inc
SCAN Health Plan
Scripps Health
Sharp Health Plan
UnitedHealthcare

Collaboration

First Tier Entity - Attestation

Let's Collaborate

- Next ICE Collaboration Projects
  - CMS Program audit training for Delegated entities
  - Standard Part C and D Reporting/Universes
  - Standard Code of Conduct Documents

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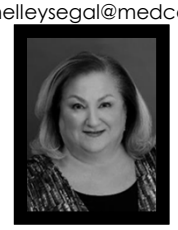

Medicare Compliance Solutions (MCS) is a well-respected, successful independent consulting practice that provides clients with high-quality service delivered in a timely, efficient, and affordable manner. Our goal is to help organizations understand and implement the CMS and State regulations in a manner that ensures compliance, provides the highest quality service to Medicare beneficiaries, and is in concert with corporate financial goals.

MCS was created in 2010 and has continually proven itself to be an industry leader for high quality solutions. MCS is strongly committed to serving the specific needs of its clients; has developed effective solutions based on decades of experience in the health plan and regulatory environments; and provides actionable insights and recommendations for optimizing performance in all Medicare Part C and D functional areas.

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