

Highlights from CMS Medicare Advantage Industry Conference

On October 19, 2009 CMS held a Medicare Advantage Industry Conference in Baltimore, during which they presented a number of new compliance issues for the coming year. A few highlights from the conference:

Marketing surveillance activities for 2010 would include secret shoppers at events and individual appointments, use of clipping service, marketing material and website review, calls to agents/brokers and calls to shopping event coordinators. A surveillance database has been created and CMs will use it to track issues. Plans will have three days to respond to issues from the time they are notified. Three vendors have been contracted by CMS for the surveillance program.

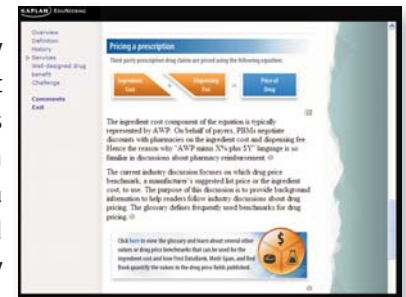
Call center monitoring, which is outsourced by CMS to a vendor, will continue to occur during the winter and summer. Areas to be addressed for 2010 include

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New Course...Introduction to Pharmacy Benefit Management

The Pharmacy Benefit Management Institute (PBMI), has worked with Kaplan EduNeering to develop a new course entitled Introduction to Pharmacy Benefit Management, which introduces the aspects of drug benefit design and management. The course will be of value to PBMs and organizations, such as Medicare Advantage plans that contract with PBMs.

The course is available to KnowledgeWire subscribers, and can also be purchased directly from the PBMI web site for \$50 (for PBMI members, the charge is \$45). Visit www.pbmi.com, click "Education" tab, then select "Online Training," to take the course directly. Another course, Introduction to Specialty Pharmacy Management, will be added in early 2010.



CMS Audit — Part 2

Note: This is the second in a series of articles regarding the audit process that CMS follows in their review of health plans. The first article in this series dealt with disclosing delegation relationships to CMS and the requirements for a sound delegation oversight program.

When CMS conducts an audit they use four major sources of information:

1. Documents provided by the health plan or plan sponsor being audited.
2. Review of specific cases (e.g., grievances, organization determinations, sales representative files, and contracts.)
3. Onsite interviews of health plan or plan sponsor executives and staff. This can also include a Board member and participating providers.

4. Information obtained directly by CMS – IRE/QIO contacts, communications from beneficiaries, state regulators, media, reports submitted by plan to CMS.

Approximately eight weeks before they intend to come onsite for an audit the plan will receive the "Audit Letter" from an administrator at the CMS Regional Office (RO). The Audit Letter serves as a guide for the rest of the review process. The letter and related attachments include:

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CMS Audit — Part 2

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- The dates during which CMS intends to complete the onsite portion of the audit.
- A list of CMS audit team members. Depending on the scope of the audit this is typically four or five individuals. Most are from the regional office, but CMS will borrow reviewers from other offices and if needed use consultants.
- A list of elements to be included in the audit. A full MA-PD audit could include as many as 300 unique elements. During audits conducted during CMS 2009 has limited the audit scope to approximately 200 elements. The RO has some latitude in selecting which elements to include.
- If included in the audit, CMS will provide directions on how to submit QIP and CCIP documentation to an external vendor for review.
- A tentative agenda for onsite interviews and a list by job title of who may be interviewed.
- A list of required documentation. CMS will indicate what documents need to be provided in advance and which only need to be available for the onsite portion of the audit. During 2009 CMS appears to be requiring a greater portion of the documents in advance as compared to prior years. CMS will allow two weeks for submission of documents from the date of the Audit Letter. CMS believes that all of the documents they are requesting should already exist and therefore will not allow extra time for their creation. All documents sent to CMS must also be available onsite for their review.
- A list of all Universes that CMS will require from the health plan/plan sponsor and if applicable, its delegated entities. More on this in a moment.
- Instructions regarding the flow of documents and information. The instructions in terms of both form and content must be followed for a successful start to an audit.
- Instructions regarding logistic requirements for the auditors (i.e., number of rooms.)

As can be seen from the list, a CMS audit is a large project and should be managed as a project. A common practice is for the organization's Compliance Officer to serve as overall project manager and CMS contact point

person. A best practice is to organize and use a steering committee composed of the organization's top executives.

Where in the Universe?

An important aspect of a CMS audit is Universes, sampling and case review. In the Audit Letter CMS will provide guidance and instructions as to which elements will require Universes. In a full MA-PD audit there could be as many as 40 elements requiring Universes.

Most of the transaction oriented elements require multiple Universes. These include topic areas such as grievances, appeals, organizational determinations, enrollment and disenrollment. For enrollment and disenrollment, CMS will pull most Universes themselves from MARx. The other topic areas requiring Universes include marketing materials, sales representatives, medication therapy management, credentialing, and provider contracts. If the plan delegates functions, CMS may request Universes from both the plan and each delegated entity. For example, if the plan directly credentials some providers and they also contract with an IPA who credentials their own providers CMS will likely request two Universes.

Universe requests normally require six months of data looking back at least one month. For example, if you received your CMS Audit Letter in late November 2009, the Universe period would likely be May 2009 through October 2009.

An organization will have two weeks to create and submit their Universes after receiving the Audit Letter. Failure to correctly submit a Universe will lead to a deficiency finding from CMS and a corrective action plan (CAP.) Errors in multiple Universes could lead to CMS having concerns about the integrity of the plan's information system. This could bring many elements into CAPs and call into question the plan's quality management program.

As a best practice plans should make sure they can pull valid Universes prior to receiving an Audit Letter from CMS. Many plans use the structure of CMS Universes to support their internal audit process and their auditing of delegated entities. Plans that wait until they get the Audit Letter are more likely to end up with a number of CAPs.

In the next article in this series we address sampling and case documentation.

Highlights from CMS MA Conference

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interpreter availability, TTY/TDD functionality and information accuracy. During 2009 all of these areas had room for improvement. This is particularly true for TTY/TDD functionality, which met standard only 1 out of 4 times.

Assessing network adequacy: For 2011 applications a new method of assessing network adequacy will be implemented. CMS will be setting standards by county and by specialty for number of providers, maximum travel time and maximum travel distance. The standards will vary by county type – rural, micro, metro

and large metro. To support the new requirements the HSD tables are being redesigned and a new automated tool is being established to review the tables.

While applicants will be able to request exceptions from the requirements, CMS intends the exceptions to be limited in number and cause (e.g., no providers in area that meet distance requirement.) While this new process will initially only be used for applicants, it points to a direction that could be used for audits in the future.

CMS Delays External Data Audits Requirement Until 2011

In the 2010 Call Letter released in March 2009, CMS announced that they would begin requiring all Part C and Part D sponsors to obtain external data validation audits beginning in 2010.

In early September 2009 CMS released draft requirements for the validation process and related tools. Comments on the draft requirements were due to CMS by September 23, 2009. Based on the comments CMS announced on November 23, 2009 that they would delay the reporting of external audits until 2011.

There are currently 28 measures that Part C and Part D sponsors are required to report to CMS. For 2010 eight of those measures were going to require external audit. CMS is updating the Part C and Part D reporting requirements and will announce next year those items requiring external audit reporting in 2011. Within a few years all

reported measures will require external audit.

While changes are likely when CMS releases their final data audit requirements, the base requirements are not likely to substantially change. With these new requirements in mind, some plans are lining up external auditors and completing pre-audit activities. The CMS audit reporting delay provides plans time to work with their external auditors during 2010 to insure the correct reporting of information.

Not unlike a financial audit conducted by a CPA firm, a number of documentation steps and verification activities can occur prior to finalizing measures. If done with enough lead time the pre-audit work can improve measures and prevent qualified opinions.

Eight Audit Measures Initially Selected for 2010

Part C

- Benefit utilization
- Grievances
- Organization Determinations/ Reconsiderations
- Agent Compensation Structure

Part D

- Grievances
- Coverage Determinations and Exceptions
- Appeals
- Drug Benefit Analyses or Medication Therapy Management Programs

Significant Regulatory Changes Planned for 2010

On October 9, 2009 CMS released a proposed rule that would make revisions to the Medicare Advantage (Part C) and prescription drug benefit program (Part D). The detail was published in the Federal Register dated October 22, 2009, and is entitled “Medicare Program: Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Proposed Rule”. CMS accepted comments on the proposed rule until December 8, 2009.

The regulations that are impacted by the changes are 42 CFR Parts:

- 417 - Health Maintenance Organizations, Competitive Medical Plans and Health Care Prepayment Plans
- 422 - Medicare Advantage Program
- 423 - Voluntary Medicare Prescription Drug Benefit
- 480 - Acquisition, Protection and Disclosure Quality Improvement Organization Review Information

The changes are intended to strengthen beneficiary protections, improve plan payment rules and clarify various program participation requirements.

Below is a summary of the proposal that addresses CMS' eight specific goals.

Strengthening CMS' Ability to Distinguish Strong Part C and D Applicants and Remove Consistently Poor Performers

CMS' proposed changes and clarifications make certain that all current and potential Part C and D sponsors clearly understand and can reasonably anticipate how CMS measures performance to determine whether Part C and D sponsors are non-compliant with plan parameters.

Strengthening Beneficiary Protections

Under Part C, CMS proposes several rules including establishing new requirements for organization determinations and establishing an overall annual cap on member cost-sharing. For Part D CMS addresses proposals including transition period requirements and COB policies.

CMS also proposes to strengthen marketing requirements by distinguishing marketing materials from enrollee communication materials and requiring the use of standard marketing material language and formatting to ensure clarity and accuracy among plan documents.

Providing Plan Offerings with Sufficient Enrollment and Meaningful Differences

CMS has decided that significant differences between benefit packages must exist to ensure thoughtful choices by beneficiaries. Part of CMS' goal of streamlining and simplifying the plan election process for beneficiaries is to reduce confusion.

CMS also proposes to revise the non-renewal regulations to expressly provide grounds for non-renewal if a plan consistently attracts small numbers of enrollees.

Improving Payment Rules and Processes

CMS addresses four payment issues under the Part C program:

1. CMS outlines a new proposed dispute and appeal-rights process for risk adjustment data, validation, and audit findings that have resulted in Part C and D sponsor payment errors.
2. CMS proposes to require actuarial certification for Part C bids.
3. CMS proposes clarification on how health care prepayment plans (HCCP) and cost plans must determine acceptable administrative costs.
4. CMS proposes to update its regulations to eliminate a two-percent minimum update for all rate calculations other than end-stage renal disease (ESRD).

Improving Data Collection for Oversight and Quality Assessment

CMS has proposed four changes to the regulations in this area:

1. CMS proposes to use data collected by quality improvement organizations (QIO) to assess plan quality improvement and performance.
2. CMS proposes that beginning in 2011, Part C and Part D sponsors will have to pay for data-collection costs in the Consumer Assessment of Health Care Providers

and Systems (CAHPS) survey.

3. CMS proposes that each Part C and D sponsor hire an independent auditor to determine reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.
4. CMS proposes to amend its rules on collection and use of prescription-drug event data for non-payment-related purposes.

Implementing Other New Policies

CMS proposes two policy changes. First, under Part C, CMS proposes to revise its rules to allow beneficiaries who elect Medical Savings Accounts (MSA) as health insurance plans to pay only a pro-rated deductible if the MSA deposit is pro-rated due to enrollment after January 1 of a calendar year. Second, in the area of Part D formulary policy, CMS proposes new requirements affecting the inclusion of protected drug categories and classes on formularies following the enactment of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Clarifying Various Sponsor Program Participation Requirements

Historically, CMS has implemented operational and/or policy guidance by memoranda or manual instruction. CMS proposes a number of clarifications in the regulations to further aid Part C and D sponsors and to codify prior guidance. Topic areas include COB requirements, clarification of P&T program requirements and security of PHI.

Implementing Corrections and Other Technical Changes

CMS is implementing technical changes and corrections to several regulations including the areas of generic notice requirements, intermediate sanctions and civil monetary penalties.

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Pelorus Management Consultants

PMC serves as the subject matter experts for a number of Kaplan EduNeering's Medicare, HIPAA and compliance courses.

They also work with many Medicare and Medicaid health plans on a range of issues including start-up, expansion, training, CMS mock audits, corrective action plans, proposal responses and regulatory interaction. Beginning in 2010 PMC will serve as external data auditors to address the new CMS requirement.

More information regarding PMC LLC may be obtained from the PMC web site: www.pmcinfo.com, or by sending an e-mail to Albert@pmcinfo.com or calling 973.992.2626.

PMC consultants are prepared to help you meet CMS and state regulatory requirements and deadlines. They have done so for over 40 clients ranging from start-up health plans to national firms with millions of members.

CMS Calendar, 1st Quarter, 2010

The following are a few key CMS dates through 1st quarter 2010:

- December 31, 2009 – Annual Coordinated Election Period ends.
- January 1, 2010 – Open enrollment period begins.
- January 5, 2010 - Automated CY 2011 applications released.
- Early January 2010 - Industry training on CY 2011 applications.
- February 25, 2010 - Applications due for CY 2011.
- Late March 2010 – Call letter for 2011 released.
- To be determined – External data audits begin.
- Ongoing – CMS Audits.