2017 Program Audit & Enforcement Report

Greg McDonald, CM

Allison Conaway, CM

Kaye Rabel: I am very happy to introduce our next speakers who will provide an overview of the results of the 2017 audit program, program audits. From the Division of Analysis, Policy and Strategy, please welcome Greg McDonald. And from the Division of Compliance Enforcement, Allison Conaway.

[Applause]

Greg McDonald Hi everybody, my name is Greg McDonald, and along with Allison I'm going to be talking today about our 2017 Program Audit and Enforcement report which we also call our annual report. I'll be going over the progress that we've made so far during our second audit cycle, audit results and audit trends. And then Allison will walk you through the enforcement actions we imposed as a result of the non-compliance that we discovered.

Our agenda is as follows; first, we're going to take a look at the audit landscape, we will then move into audit scoring broken down a few different ways, then we'll take a look at cross-year results which is audit results from 2016 to 2017, we'll then take a look at most common ICARs we saw in audits last year, and then as I mentioned Allison will take us throughout our enforcement actions. If we have time at the end and I suspect that we probably will, we'll be happy to answer any questions that you might have.

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Okay, as many of you know, we began our second audit cycle in 2015. Just as a bit of background info, our first audit cycle ran from 2010 through 2014, and just one other thing cycle and wave are kind of synonymous for purposes of what we're talking about here. From 2015 through 2017, we audited 84 sponsors that are still in operation. In truth we audited a few more than that, but some of them are no longer around either because they were acquired by another organization, or terminated their contracts. We currently plan to audit 33 sponsors this year, which when you add those to the 84 I mentioned a moment ago, takes us to 117 that will still currently be in operation. Those 117 sponsors represent just under 60% of the sponsors that currently operate Part C and Part D contracts.

Here we see the percentage of beneficiaries that we have audited thus far in our second audit cycle. The first three years, so 2015, 2016, and 2017 we audited sponsors that cover about 93% or so of Medicare beneficiaries and we project that by the end of this year that number is going to be around 96% or so. So we're talking in total about 44.3 million beneficiaries there abouts. You may notice a discrepancy between the percentage of sponsors we've covered and the percentage of beneficiaries that we've covered. We do make an effort to audit the largest sponsors during each audit cycle and we do this, you know, not to pick on anybody but just primarily to give ourselves the best chance we can of having our audits reach as many beneficiaries as possible. And we'll see in a little bit here actually a breakdown of enrollment size of those sponsors that we audited last year.

Which is this slide. This slide shows audit scores broken down by enrollment size. You'll see that there are three groups, you could think of these let's just say as the small, medium and large size groups. And these three buckets that we have them split into mirror the enrollment bands that we use in ODAG and CDAG to determine the look back periods for the universes that we collect in advance of the field work for those audits. And what you'll see here is that there's an inverse

relationship between audit performance or audit score and enrollment size. That is to say the larger size sponsors, which are on the far right hand side of the chart, have average on average lower audit scores than the ones farther over to the left. Now this is not any kind of longstanding or consistent trend, if you were to look at our 2015 audits for example, so the audits we presented on in 2016, the medium sized group, so the group in the middle, had actually on average the best audit scores and if you look at what we presented last year, which were our 2016 results, the medium sized group, excuse me, had actually on average the highest audit scores. So, there is a bit of fluctuation from one year to the next when it comes to audit performance broken down by enrollment size. As I was alluding to a minute ago, the n's below the buckets here actually indicate the number of audits, or the number of sponsors essentially, that were included that fit into that different enrollment size. So you can see that 21 of the 39 audits that we conducted were of sponsors that had below 50,000 enrollees as far as enrollment is concerned, whereas on the larger end there were only four that actually had over a quarter million.

Here we see audit scores broken down by program experience. We define program experience essentially as the amount of time that the sponsor's oldest contract has been around. So we're not talking about any kind of average or anything like that. It's just how old is your oldest contract? And what you see here is that sponsors that have been around for longer, actually tend to fare better on audit than ones that haven't been around for so long. And we've run this analysis, I believe this is the third time, and this is a trend that actually has been in contrast to the previous slide, this is a trend that actually has been pretty consistent. And I think there are probably two basic explanations for this. The first is that if you've been around for longer, you've had more time to familiarize yourself with guidance and operationalize that guidance. And the second reason is that some of these sponsors that have been around for a number of years have undergone one or possibly more CMS audits. So they've had a chance to be told essentially what their deficiencies are and then hadthe opportunity to focus their time and attention and resources to

remediating those deficiencies; which you'd like to think would help farther on down the road if and when you're audited again.

Finally, we have audit scores broken down by tax status. Here again you can see there are three different categories; we have sponsors that offer, excuse me, for-profit contracts only, non-profit contracts only, and then a mix of both types. You'll notice that the sponsors that offer only for-profit or non-profit make up a sizeable majority of the 39 audits that we actually conducted last year. And what you'll notice is non-profit sponsors fared on average the best; that is to say their audit scores were the lowest on average. Followed closely by the sponsors offering a mix of both types, then followed by sponsors offering only for-profit contracts. With the exception of last year, so 2016 audits, the ones that we reported on last year at our conference, and every year that we've run this analysis and it's been a number of years now, non-profit sponsors have actually fared the best on audit. I want to say last year it was a mix, the mixed group that had the lowest average score. But here again we returned to something that we've seen a number of years now since we've been running these analyses.

Here we see cross year results, so this is 2016 versus 2017. And we have all of the program areas that we actually audited in both of these years, as well as you can see on the far left hand side of the chart there, the overall audit scores. So we have CPE which is compliance program effectiveness; we have FA, which is Part D formulary and benefit administration; we have CDAG which is Part D coverage determinations, appeals and grievances; ODAG which is Part C organization determinations, appeals and grievances; and then finally, SNP-MOC which is special needs plan model of care. And what you'll notice is, is that in every single individual program area, except for CPE, you actually see a decline in audit score from 2016 through 2017. So an improvement in performance. The area with the largest increase in performance or decrease in scores, was SNP-MOC where the average score dropped by over a point, or about 55%. The smallest decrease in score or

improvement in performance was in FA. And again, you also see a decrease in the average score overall, not just in individual program areas. In CPE we see an increase in score, but this is not really attributable to a decline in performance. In 2017 we actually changed the way, I believe this was alluded to earlier, we changed the way that we audited CPE, so instead of having seven elements, we had three. And with the way that we calculate audit scores, both in terms of individual program area and overall, if you do something to the number of elements that you evaluate, even if the number of conditions that you have is the same and the severity of the things that you see on audit is the same, if you change the number of elements, the score will change just mathematically, because that's the way that it works. So if you reduce the number of elements that you're talking about from seven to three as we did here, the score all things being equal, aside from that the score will go up. And so that's what you see here. If we had actually continued to audit CPE the way that we had before, that is to say with seven elements instead of three, the score actually would have been 0.25 and not 0.59. So even there you would have seen as in the other areas, you would have seen an improvement in performance or a decrease in score.

And then finally we have, finally for me anyway, we have the conditions that resulted in ICARs the largest number of times in our 2017 audits as well as the program areas that they're actually associated with. On the far right hand side there in the farthest right column you'll see the number of separate times that particular condition was cited as an ICAR last year. So for instance, with the first one we have a CDAG condition that was cited 22 times, we did 39 audits last year in CDAG as well an FA, 33 in ODAG. And then it kind of goes on down from there. As you may notice, all of the conditions are in CDAG. FA and ODAG. And this is really the case because ICARs are rarely if ever cited in CPE or SNP-MOC anymore given how we currently define ICARs. Many of the conditions that are listed here have appeared in common conditions listed over the years and those common conditions lists are actually the 2017 versions anyway, actually are in the annual report itself. So that's something that's

probably worth taking a look at. The conditions that were cited as ICARs the largest number of times in our 2017 audits were, and I'll read these quickly; sponsor misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries; sponsor failed to properly administer its CMS-approved formulary by applying unapproved utilization management practices; sponsor did not auto-forward coverage determinations and/or redeterminations, standard and/or expedited, that exceeded the CMS required timeframe to the Independent Review Entity, IRE, for review and disposition; sponsor did not demonstrate sufficient outreach to providers or enrollees to obtain additional information necessary to make appropriate clinical decisions; and then finally, sponsor did not notify enrollees, and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited organization determination requests. So that concludes my portion of the presentation, I will now turn it over to Allison who will walk us through the enforcement actions that we imposed. Thank you.

Allison Conaway — Thank you Greg. Thank you Greg. Now that we've covered 2017 program audits, we will now take a look at the enforcement actions imposed as a result of non-compliance discovered in 2017. So starting with an enforcement actions overview MA plans, PDPs, PACE organizations, and cost plans that when we have determined that enrollees were adversely impacted or when there was substantial likelihood that enrollees were impacted, by a plan's significant failure to comply with CMS requirements, these plans may receive an enforcement action. These enforcement actions include civil money penalties or CMPs, intermediate sanctions, and for-cause terminations. The Medicare – I work in the Medicare Part C and D Oversight and Enforcement Group, Division of Compliance Enforcement and we are responsible for imposing these types of actions. I along with my colleagues featured in the picture here, work in the Division of Compliance Enforcement, and just so you know we don't always carry these serious looks on our faces.

So DCE receives enforcement actions referrals based on non-compliance primarily detected through CMS routine audits, ad hoc audits, monitoring and surveillance activities. In calendar year 2017 we received 93 referrals for enforcement actions and almost half were due to Medicare Part C and D program audits. The other basis for the enforcement action referrals were due to failure to set accurate and/or timely annual notice of change/evidence of coverage documents, one-third financial audit non-compliance, failure to make timely decisions related to Part D coverage determinations appeals and grievances identified through routine monitoring activities with the independent review entity, non-compliance discovered during PACE audits, and failure to maintain an adequate medical loss ratio for three consecutive years as determined by reviews of self-disclosed medical loss ratio data.

So DCE imposed 24 CMPs and three intermediate sanctions during calendar year 2017 and early 2018. As a result of non-compliance discovered during 2017 program audits and other monitoring efforts conducted by CMS. So 18 of those actions were imposed for 2017 program audit failures. The remaining enforcement actions were issued for failures involving inaccurate ANOC/EOC documents, untimely Part D decisions, 2017 PACE audit failures, and failure to meet statutory medical loss ratio requirements.

DCE imposed $2.9 million in CMPs for 2017 referrals, approximately $2.5 million of those CMPs were imposed for 2017 program audit failures. And then the remaining were imposed for inaccurate ANOC/EOC documents, untimely Part D decisions, and for 2017 PACE audit failures. The average CMP amount was approximately $120,000. The highest CMP amount was approximately $1.3 million and the lowest CMP amount was $3,600. So please note that the sponsors CMP may not reflect overall performance. The majority of CMPs are based on the number of enrollees that are impacted by non-compliance and also a CMP may be higher for sponsors with larger enrollment or where a violation affects a higher number of enrollees.

As stated earlier, 18 of the 24 CMPs were imposed for Medicare Parts C and D program audit failures. The number of CMPs we imposed were slightly increased in 2017, while the combined dollar amount of CMPs decreased. So this was attributable to a smaller number of violations per CMP and a smaller enrollment size per sponsor. So the average enrollment size of a sponsor in 2017 was around 240,000 compared to 650,000 in 2016.

Three sponsors were placed on intermediate sanction in 2017. Two of them – two of the actions were based on 2017 PACE audit non-compliance, and one action was imposed for medical loss ratio inadequacies. These organizations are currently working on implementing their corrective action plans and CMS will validate correction before they are released from their sanctions. Another organization was released from an enrollment and marketing sanction after they were able to demonstrate compliance by successfully passing validation exercises. And there were no for-cause terminations as a result of 2017 non-compliance.

So this concludes the overview of 2017 enforcement activities. For more information, please feel free to access the recently released annual report in HPMS and on our website. So now I'll turn it back over to Kaye, thank you.

Kaye Rabel: Thank you. We do have time for questions. So if you have a question please make your way to the center – the mic in the center of the room, state your name and let us know where you're from.

Since we don't have any in-house questions, we did receive some questions from our webcast participants one of which is "Are you going to start a new audit cycle in 2019 or continue another year in cycle two?"

Greg McDonald: The plan is to start a new audit cycle which would be our third audit cycle at the beginning of next year. We, I think we communicated that in an

HPMS memo that went out fairly recently, I would say probably within the last couple months or so.

Kaye Rabel: Okay. Thank you. Okay and we do have an in-house question.

Matt McGrath: Hi, my name is Matt McGrath I'm from Perform Rx. And one quick question. When I go back to the enforcement actions in 2017 there were 93 referrals, 58 resulting in no action, just curious what's driving that? Or, are referrals coming in maybe out of an abundance of caution curiosity seeking an opinion but they're not quite certain? I'm just – it seems like a large number or high percentage actually result in no subsequent action.

Allison Conaway: Well, we – when we get referrals we, you know, as explained in previous presentation about the analysis process, we have to – we make a determination on whether enrollees were substantially impacted and whether plans substantially failed to meet CMS requirements. So, you know, if we don't come to that determination then we ultimately will not take an action. So, I mean, I guess that's pretty much where – when there were no actions taken that was the reason why, because those circumstances didn't exist.

Matt McGrath: Okay, a variety of factor then I presume it's –

Allison Conaway: Yeah.

Matt McGrath: I was just wondering if there were any trends detected, anything like that just sort of popped up. But thank you.

Allison Conaway You're welcome.

Kaye Rabel: Okay, thank you Allison. And we have one more question from our webcast participants. "You said earlier that ICARs are rarely if ever cited in CPE and SNP-MOC why is this?"

Greg McDonald: ICARs necessarily involve access to care issues and the types of things that we see in CPE and SNP-MOC are not really access to care issues, at least in the same way they are in some of the other areas, excuse me, like FA, CDAG and ODAG. That's basically the reason. I mean, we put out a memo, I keep referring everybody to HPMS, but we put out a memo in late 2015, I want to say, November or December that actually outlines how we define these things and our definition for how we define the different types of non-compliance really hasn't changed since then.

Kaye Rabel: Okay, thank you. Any other questions in-house? Okay. Well, thank you Greg and Allison for sharing information on audit enforcement actions taken.

[Applause]

Okay, if you would like to evaluate this session, take out your phones to text your response or go to the poll EV link on your device and enter A in response to the question "I would like to evaluate this question." And send your response. Remember to click on the link and follow the instructions.

What we're going to do is have a few more CMS trivia questions with Stacey before we move on to the last session of the day.

Stacey Plizga: Okay I hope you all had time to do some Googling, find some answers. Alright, our next trivia question; which president signed into law the extension of Medicare to the disabled and those with end stage renal disease? Was it President Johnson, President Nixon, President Carter or President Reagan? I'll give you a moment to select your choice. Hmm, Alright, the correct answer is B, President Nixon signed the Social Security Amendments of 1972 into law which expanded Medicare to include the disabled receiving Social Security benefits after a 24-month waiting period. And those with end-stage renal disease, ESRD, ESRD was a life-threatening disease that could be treated with very expensive kidney dialysis service.

Alright, moving on next question; President Franklin Delano Roosevelt included national health insurance in his proposed social security legislation. Is this true or false? I think we all need to brush up on our trivia. The correct answer is B, false. In 1935 FDR decided not to include national health insurance in his proposed social security legislation because of concern that opposition to it would jeopardize the entire proposal. Instead he had a task force further explore the issue.

You guys ready for another one? Alright. Okay, which president thought that health maintenance organizations, or HMO's would help contain the growth in healthcare spending? President Nixon, President Reagan, President Clinton, or D all of the above? Oh I think I gave this one away earlier. The correct answer is D, all of the above. All the presidents thought that HMOs would help to contain the growth in healthcare spending by reducing inappropriate utilization and better manage healthcare services.

And we do have another one. Who received the very first Medicare card? Was it President Eisenhower, President Roosevelt, President Truman, or President Nixon? We need music. The bars just don't want to stop moving on this one. Alright, the correct answer is oh nice job, C President Truman was the first president to propose a national health insurance plan. Subsequent debate resulted in the enactment of the Medicare program in 1965.

And one last one and then I'll quit testing your knowledge. The Health Care Financing Administration was renamed the Centers for Medicare and Medicaid services in the summer of 2001 by Secretary Sullivan, Secretary Shalala, Secretary Thompson, or Secretary Califano? Well, they do say practice makes perfect huh. The correct answer is C, Secretary Thompson announced that the Health Care Financing Administration would be renamed the Centers for Medicare and Medicaid

Services on July 1, 2001 as part of his initiative to create a new culture of responsiveness in the agency.