2013 Program Audits
Best Practices and Common Findings

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Presentation Overview

- 2013 Best Practices and Common Findings HPMS Memo
- Top 5 common conditions for each program area
- Recurrent conditions from previous years highlighted

2013 Program Audit Areas

- Part D Formulary and Benefit Administration (FA)
- Part D Coverage Determinations, Appeals, and Grievances (CDAG)
- Part C Organization Determinations, Appeals, and Grievances (ODAG)

2013 Program Audit Areas (cont.)

- Compliance Program Effectiveness (CPE)
- Special Needs Plans Model of Care (SNP MOC)
- Part C and D Outbound Enrollment Verification Calls (OEV)

Best Practices: FA

- Concurrent DUR logic alerts pharmacists when beneficiary has claims for 4 or more prescribers or 4 or more drugs from the same therapeutic class.

Best Practices: FA (cont.)

- Claims look-back for immunosuppressant therapy when claim submitted for oral corticosteroids; if no history of immunosuppressants, then claim pays automatically under Part D.

Common Findings: FA

1. Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.
2. Sponsor failed to properly administer its CMS-approved formulary by applying unapproved utilization management practices.

Common Findings: FA (cont.)

3. Sponsor failed to properly administer the CMS transition policy.
4. Sponsor improperly effectuated a prior authorization or exception request.
5. Sponsor failed to provide a continuing beneficiary a transition supply of a non-formulary medication.

Best Practices: CDAG

- Sponsor makes payments for Direct Member Reimbursement (DMR) claims on a daily basis.
- Sponsor reviews all Part B vs. Part D rejections from previous day and begins coverage determination process if one has not already begun.

Best Practices: CDAG (cont.)

- Automated claims look-back process for 180 days for medications with PA for new starts only (PA Type 2).

Common Findings: CDAG

1. Denial letters did not include an adequate rationale or contained incorrect information specific to the denial.
2. Sponsors did not demonstrate sufficient outreach to the prescriber or beneficiary to obtain additional information necessary to make an appropriate clinical decision.

Common Findings: CDAG (cont.)

3. Sponsor misclassified a coverage determination (CD) or redetermination (RD) as a [grievance][customer service inquiry].
4. Sponsor did not notify the beneficiary or their prescriber, as appropriate, of its decision within 72 hours of receipt of a standard CD request, or for an exceptions request, the physician's or other prescriber's supporting statement.
5. Sponsor made an inappropriate denial when processing a CD.

Best Practices: ODAG

- Sponsor supplies a health care manager to beneficiaries that do not seem to understand authorization/reconsideration processes to assist with clarifying treatments/processes.

Best Practices: ODAG (cont.)

- Sponsor records 100% of CSR calls to allow for comprehensive review and to improve classification issues.
- Reconsideration requests for SNF admissions are automatically expedited.

Common Findings: ODAG

1. Sponsor did not make the payment decision within 60 days after the receipt of the organization determination (OD) request.
2. Sponsor did not notify the beneficiary or the provider, as appropriate, of its decision within 14 calendar days of receipt of a standard OD request.

Common Findings: ODAG (cont.)

3. Denial letters did not include an adequate rationale, or contained incorrect information, specific to the denial.
4. When Sponsor denied a request for payment from a non-contracted provider, the remittance advice/notice did not state the specific reason for the denial nor did it provide a description of the appeals process.
5. Sponsor did not demonstrate sufficient outreach to the provider or beneficiary to obtain additional information necessary to make an appropriate clinical decision.

Best Practices: CPE

- Employee security access badges have contact information for the compliance/fraud, waste and abuse (FWA) hotline on the back.
- Sponsor automated the process of checking the HHS Office of Inspector General (OIG) and General Services Administration (GSA) Excluded Parties List System (EPLS).

Best Practices: CPE (cont.)

- Sponsor has process for HPMS memo distribution by functional areas, with follow-up process for operational owners responsible for implementation of new guidance.
- Detailed training on roles/responsibilities and CMS requirements for governing body members.

Best Practices: CPE (cont.)

- Online monitoring tool to track/manage corrective action plans (CAP).
- Internal Medicare FWA prevention program developed to engage employees and delegated entities in FWA detection and prevention.

Common Findings: CPE

1. Sponsor did not review OIG and GSA exclusion lists for any new employee, temporary employee, volunteer, consultant, governing body member and/or FDR prior to hiring or contracting; nor monthly thereafter.
2. Sponsor did not provide evidence that it audits the effectiveness of the compliance program at least annually and that the results are shared with the governing body.

Common Findings: CPE (cont.)

3. Sponsor did not provide FWA training directly to its first-tier, downstream and related entities (FDRs) or provide them with FWA training materials.
4. Sponsor did not provide the evidence that general compliance information was communicated to its FDRs.

Common Findings: CPE (cont.)

5. Sponsor did not distribute its standards of conduct and policies and procedures to employees who support the Medicare business, within 90 days of hire, when there were updates to the policies and procedures, and annually thereafter.

Best Practices: SNP MOC

- Model of Care set standard of performing the health risk assessment (HRA) within 30 days of enrollment.
- “Embedded Nurse” program included a nurse as part of the interdisciplinary care team to aid in individualized care plan (ICP) implementation, assist in member assessment and care coordination.

Common Findings: SNP MOC

1. Sponsor administered the initial HRA to a beneficiary more than 90 days after their enrollment.
2. Sponsor did not administer the comprehensive annual reassessment within 12 months of the last risk assessment.

Common Findings: SNP MOC (cont.)

3. Sponsor did not provide evidence that it had an ICP for the beneficiary.
4. The ICP does not address issues identified in the HRA.
5. Sponsor did not provide evidence of ICP implementation through care or case management notes.

Best Practices: OEV

- All OEV calls are recorded, including calls that may be incomplete or cutoff, and messages left for the beneficiary.
- Repeat OEV calls to beneficiaries are made on separate days and at varying times of the day.

Best Practices: OEV (cont.)

- Call center program requires CSRs to correctly and completely go through the call script before the user screen can advance to the next page.
- OEV letters sent to every beneficiary after the first call attempt, regardless of outcome.

Best Practices: OEV (cont.)

- Rapid disenrollment and cancellations are communicated to Enrollment and Sales and Market Departments for lessons learned purposes.

Common Findings: OEV

1. Sponsor did not comply with CMS regulations for completing OEV calls and supplying its beneficiaries with accurate information.
2. Sponsor mailed an [incomplete] [and] [inaccurate] OEV verification letter.

Common Findings: OEV (cont.)

3. Sponsor could not produce evidence that at least three OEV calls were made.
4. Sponsor could not produce evidence that the OEV letter was sent to the beneficiary.
5. Sponsor did not mail the OEV verification letter within the 15-day requirement.

Conclusion

- Excellent best practices observed
- Many lessons learned in 2013
- Submit questions or feedback to part_c_part_d_audit@cms.hhs.gov (part_c_part_d_audit@cms.hhs.gov)

Questions?