2017 Program Audits

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Fatima Mohamed: Good morning, everyone. My name is Fatima Mohamed and alongside me is Angelique Morris. We'll be discussing the 2017 audit process.

We'll first walk through, at a high level, the phases of an audit timeline and then highlight significant changes and improvements CMS has made to the process as a result of feedback we've received from the industry. Every year we evaluate the feedback we get through our Audit Survey, the Mailbox, and other forums. We do our best to make changes that both improve the audit process and reduce the burden on sponsors that we audit.

In addition, my colleagues Doreen Gagliano and Marie Gutierrez will be discussing helpful information regarding universe submissions and record layouts.

The 2017 Audit Process Timeline -- Program audits are conducted in four phases: the Audit Engagement and Universe Submission phase, the Audit Fieldwork phase, the Audit Reporting phase, and the Audit Validation and Close Out phase. Each phase consists of key milestones, which will be outlined in the following slides. As you can see, the entire audit process from start to finish extends about one year.

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Phase I is known as the Audit Engagement and Universe Submission Phase. We've highlighted three important milestones that occur during this phase: the engagement letter issuance, the universe submission, and universe integrity testing.

The issuance of the engagement letter marks the beginning of the audit. Within 15 business days of the engagement letter date, sponsors must submit all requested universes to CMS, following the instructions outlined in the engagement letter instructions and attachments. Within one week of the receipt of universes, CMS conducts universe integrity testing to verify the accuracy of submitted universes. To conduct this test, CMS selects samples of cases in the universe and matches the information to the sponsor's live systems. CMS conducts these tests virtually via webinar.

Some enhancements or changes to the audit process and universe phases were: the engagement letter modifications; the creation of the audit submission checklist with the issuance of the engagement letter; changes to the reporting for the pre-audit issue summary, which includes sponsor disclosures; and a note that all universes will be submitted in HPMS and not SFTP. We'll be discussing these enhancements in more detail in the following slides.

In highlighting Phase I significant changes, the engagement letter content has been improved. CMS improved the engagement letter process by transmitting all critical information through the engagement letter.

There is no longer an engagement letter follow-up e-mail. We have also created several materials that reside in HPMS that will assist sponsors in understanding the audit process. These materials include the 2017 Program Audit Process Overview. This is also posted publicly on our CMS Oversight and Enforcement website. The On-site Information and

Request document has also been included and then lastly, the Audit Submission Checklist.

The Audit Submission Checklist – As I said, new in 2017, it is meant to provide the compliance officer and organization an organized list of all audit deliverables due to CMS by audit fieldwork. It is attached directly to the engagement letter. It also identifies universe periods and due dates. It identifies the method and location of submission, and then it allows compliance officers to easily track submissions.

As an example, we'll briefly walk through a snapshot of the Audit Submission Checklist. The checklist displays the audit specific engagement letter and entrance conference dates at the top. Please note that this checklist has been modified to show you examples of deliverables in each program area.

Starting from left to right, the "Level Association in HPMS" and "Upload File Type" columns both identify the location that the specific request should be uploaded to. All documents should be uploaded to HPMS, again. We will no longer be using SFTP when uploading universe files. I should also note that CSV files will not be accepted at this time.

The "Audit Request Type" column gives sponsor insight into the type of request such as universe files, questionnaires, or other documentation.

The "Audit Submission Name" column is the actual naming convention CMS would like for sponsors to use when uploading requests. One thing to note for universe request types, HPMS will automatically rename the file upon upload. So the naming convention is only important for supplemental file types.

The "Universe Period" column identifies the time periods of data that CMS needs for the respective universe. These dates will vary from audit to audit.

Lastly, CMS has identified the due dates for each request in the far right column.

Another significant change made within Phase I was to the Pre-Audit Issue Summary. Only sponsors' disclosed issues are reported in the Pre-Audit Summary. CMS is no longer requiring the disclosure of self-identified issues that have not been previously reported to CMS. A disclosed issue is one that has been reported to CMS prior to the receipt of the audit engagement letter. Issues identified by CMS through ongoing monitoring, account management, or oversight activities during the plan year are not considered disclosed.

Sponsors must provide a description of each disclosed issue, as well as the status of correction and remediation using the Pre-Audit Issue Summary. This template is due within five business days after the receipt of the engagement letter. So when CMS determines that a disclosed issue was promptly identified, corrected, or is actively undergoing correction and the risk so the beneficiaries has been mitigated, CMS will not apply the ICAR condition classification to that condition.

Now I'll turn it over to Angelique Morris to discuss Phases II through IV.

Angelique Morris: Thank you, Fatima.

As Fatima stated, I'm going to discuss Phase II through IV of the audit process. Phase II encompasses Weeks 7, 8, and sometimes 9, and is referred to as the Audit Fieldwork Phase.

Fieldwork begins with an entrance conference conducted virtually via WebEx. The auditor in charge will lead the conference, review the schedule, and discuss expectations for the weeks ahead with the sponsoring organization. The sponsor will also have an opportunity to make a presentation about his organization during the call.

After the entrance conference, the virtual webinar will begin. CMS customarily conducts the audits of each operational area virtually via webinar, with the exception of the Compliance Program Effectiveness; and this is the CPE Program. The review is conducted at the sponsor's location during the last week of fieldwork. Several enhancements have been made to the CPE protocol and will be discussed in depth during the next presentation.

At the conclusion of the audit fieldwork phase, which is after the on-site CPE review, CMS will issue a preliminary draft report one hour prior to the exit conference where the audit team, broken down by operational areas, will discuss the preliminary results of the audit. During the exit conference and discussion of the preliminary draft report, CMS will not be reporting any condition classification. The meeting will consist primarily of the overall preliminary findings and outstanding documentation. CMS prohibits the recording or taping of any audit activities.

Some significant changes to Phase II – CMS has extended the time frame from one business day to two business days for submission of supporting documentation for non-compliant or pending case samples. Documentation may be in the form of screenshots, member letters, case notes.

When attempting to determine the cause for non-compliance found during an audit, CMS will request a root cause statement from the sponsor. We

have extended the time frame from one business day to two business days for the submission of this information.

An impact analysis must be submitted, as requested by CMS. The impact analysis must identify all beneficiaries subjected to, or impacted by, the issue of non-compliance and all applicable contracts. CMS has extended the time frame from 5 to 10 business days to complete the requested impact analysis. The 10-business-day period will not begin until the conclusion of the first week of fieldwork, which is marked by the status call.

Fieldwork will be extended to three weeks when a Medicare Medicaid Plan or MMP Plan is included in the scope of the audit. Because MMPs will have separate protocols in 2017, additional webinar-based reviews must occur and extend the fieldwork phase from two to three weeks.

Week 3 will conclude with an on-site audit of the Compliance Program. The MMP audit protocols will be discussed more in depth during a presentation today. As I previously stated, the Preliminary Draft Audit Report will be produced in HPMS and will be available one hour prior to the exit conference.

Now we're going to talk about Phase III, which is known as the Audit Reporting phase and occurs between Weeks 9 and 21.

During this phase, we have the notification of the Immediate Corrective Action Required, which is the ICAR. CMS notifies the sponsor of any conditions requiring immediate corrective action after the issuance of the Preliminary Draft Report but prior to the issuance of the Draft Report. The sponsor is responsible for submitting corrective action plans, or CAPs, for each ICAR condition identified. The ICAR notification will be sent via e-mail from the auditor in charge.

In addition to the ICAR e-mail, the sponsor will receive notification from HPMS regarding the Draft Report. The Draft Report is inclusive of condition classifications and audit scores to the sponsor approximately 60 days after the exit conference. The sponsor will have the ability to respond to the Draft Report and submit comments 10 business days after the receipt of the Draft Report, so you have up to 10 business days. And then the final report issuance- CMS will respond to the sponsor's comments and update the audit score, if applicable; and we have a target issuance space of 10 business days after receipt of the sponsor's comments to the Draft Report.

Some significant changes to Phase III -- Submission of Corrective Action Plans, or CAPs, for individual conditions is completed directly in HPMS now. While the Program Audit Consistency (PACT) Teams are not new in 2017, the PACTs have continued to evolve and have become more sophisticated by developing tools that assist with decision-making, tracking condition classification, and dealing with complex subject matters and audit policy issues. PACTs are comprised of CMS subject matter experts within each program area and ensure consistency in classification in all audits.

For Phase IV, which is known as the Audit Validation and Close Out Process, this occurs between Weeks 22 and 48. Upon CMS acceptance of all CAPs, the auditor in charge will send a formal e-mail, which will confirm the acceptance of the CAPs and kickoff the validation process. The validation review may be conducted by CMS, or a sponsor may be required to hire an independent auditor to validate the corrections. CMS will advise sponsors at the time of issuance of the Final Audit Report if an independent auditor is required to validate corrections of the conditions noted or if CMS will conduct the validation internally.

The sponsoring organization has 150 calendar days from the date of the CMS acceptance of the sponsoring organization's CAPs to undergo a validation to demonstrate correction of all audit deficiencies, as outlined in Appendix A of the Final Audit Report.

To begin the sponsor validation audit process, CMS holds a kickoff call with the sponsor one to two days after the CAPs are accepted. When the Validation Audit Work Plan has been completed, it must be sent to CMS to review and approve prior to conducting the audit work.

Lastly, the results of the Validation Audit are sent to CMS for review to determine if sufficient correction of audit conditions have occurred and if the audit can be closed. Later this year, CMS will plan to conduct an industry listening session to give feedback on how the independent auditor process has been working and what improvements CMS can make to the process to make it more efficient for all parties involved.

I'm now going to turn over the presentation to my colleagues Marie Gutierrez and Doreen Gagliano, who will discuss helpful information regarding universe submission and record layout.

Marie Gutierrez: Thanks, Angie.

Angelique Morris: You're welcome.

Marie Gutierrez: Good morning, everyone. My name is Marie, and Doreen and I will be providing clarifying guidance regarding record layouts to ensure proper universe submissions. We'll be focusing on commonly-asked questions we've received from the Parts C & D Mailbox, and those encountered during audits about certain record layouts; specifically, it pertains to the following program areas: Part C organization determination appeals and grievances, so that's ODAG; Part D coverage determination appeals and

grievances, which is CDAG; formulary administration, FA; medication therapy management, MTM; and special needs plan model of care.

Let's start with the ODAG Program area. There are 14 record layouts. The 14th record layout is new, and that's the call logs; and that's new in 2017. Actually, some of you may have seen that in prior audit years as we used that as a supplement to grievance universes; but in 2017, it is a required record layout.

We'll start by discussing clarifying guidance that applies to Record Layouts 1 through 13. So we'll talk about call logs lastly.

For ODAG Record Layouts 1 through 13, the instructions state to include all requests processed as…and "processed" means the way the sponsor handled the request. For example, if a request came in as an Expedited Pre-Service Organization Determination Request, but the sponsor processed it as a standard case, then it must be included in the standard pre-service organization determination universe and not the expedited pre-service organization determination universe. So really, put it in the record layout the way you, the sponsor, processed the case and not necessarily the way the request came in.

Some of the record layouts explicitly state to exclude withdrawn cases. This applies to ODAG Record Layouts 1 through 13, so please do not include withdrawn cases in any of these record layouts.

In regard to the "Date written notification provided" field, we still get some questions about this; and "provided" means when the notification left the sponsor organization or its delegated entity. For example, it's the date the letter was mailed; it is not the date the letter was generated. If a mail vendor is used, it is the date the notification left the mail vendor. If the

sponsor sends it via U.S. mail, it's the date the notification left the sponsor organization.

Along the same lines, in regard to the "Date paid" field, paid or issued payment means when the payment left the organization. This applies to our payment organization determination, DMR, and payment reconsideration universes. So if a payment vendor is used for an electronic payment, it is the date the electronic payment left the organization as the organization already had set that payment in motion. If the sponsor sends a check via mail vendor, it's the date the check left the mail vendor. If the sponsor sends a check via U.S. mail, it's the date the check left the organization.

Let's talk about "AOR receipt date." That applies to our pre-service organization, pre-service reconsiderations, and grievance record layouts. So if the AOR is required but not yet received at the time of the universe submission, the case must be excluded from the universe because it's not yet a valid request.

So for our pre-service record layouts – that's 1, 2, 5 and 6 – oral notification is valid by speaking with the enrollee or authorized representative directly; leaving a voicemail with instructions to contact the plan for additional information about the decision; or by making a good faith attempt to contact the enrollee or the authorized rep.

Let's define "good faith attempt." That would be calling the enrollee's preferred number without actually speaking with them, and the good faith attempt must be properly documented in the sponsor's system to qualify as a good faith attempt. This policy applies to both oral approval notifications and oral denial notifications followed by a written denial notice.

Our Tables 1 and 2, the SOD and EOD record layouts explicitly state to include all supplemental services, such as dental and vision; but this language is omitted from record layouts 3 and 4, which is our claims and DMR record layouts. Supplemental services must be included in record layouts 3 and 4, as well as record layouts 1 and 2.

Here's our new record layout, Table 14 Call Logs; and the protocol states to use the name of the first tier downstream and related entity that processed the dismissal. So please use the name of the FDR that processed the call and not the dismissal.

At this time, I'd like to pass it on to Doreen, who will talk about CDAG, FA, and MTM.

Doreen Gagliano: Thank you, Marie.

For the CDAG program area, we actually have 16 different record layouts; and the 16th this year in 2017 is our new Call Log record layout, which is unique to all the other ones. We will start by discussing some clarifying guidance around record layouts 1 through 15.

For record layouts 1 through 15, all the CDAG universes, you will want to enter and ensure that you submit the cases based on the date that they were processed or should have been processed. We get this question a lot in our Audit Mailbox, and we wanted to provide clarity around that. That means that you would submit all cases based on the way that you handled it. For example, if a case came in and was a request for an expedited coverage determination but you processed it as a standard coverage determination, then you would enter it and list it in the standard coverage determination record layout, not the expedited.

For record layouts 1 through 8, we have instructions that state you should submit the case based on the decision that was rendered or should have been rendered. Sponsors should submit all cases that were decided, or should have been decided, during that particular universe period that has been identified in your engagement notice. Therefore, these may be cases that were received prior to the universe review period; those would also be included because it's based on when your decision was rendered.

For CDAG record layouts 1, 2, 4, 5, 8, 14, and 15, we're going to talk about oral notice…again, another question that we get a lot. So the date the oral notification was provided to the enrollee would be when you have a valid outreach attempt – so speaking with the enrollee or their authorized representative directly or, as Marie said in ODAG, making a good faith attempt. A good faith attempt would be calling the enrollee at their preferred phone number without actually speaking with them and the good faith attempt must be properly documented in the sponsor systems.

For CDAG record layouts 1 through 10 and 14, in the field that is titled "Date written notification provided to enrollee," this term, again, means when the letter left the sponsoring organization or delegated entity's establishment by U.S. mail, fax, or electronic communication. Just as Marie said in ODAG, please do not enter the date that the letter was generated internally. But, let's say you send it to a vendor and it was not mailed out for two or three days after that; that would be the date that we would want to see in the record layout, the date that it actually left the establishment.

CDAG record layout Tables 6 through 8, under the field name or the description of "Was the request denied for lack of medical necessity," we would like you to please insert whether the initial coverage determination request was denied for lack of medical necessity.

For record layouts 6 through 8 again, the field name, "If it was denied for lack of medical necessity, was the review completed by a physician," we would like you to indicate whether the redetermination review was completed by a physician. This is just providing clarifying guidance to make sure that you're entering information correctly in that record layout for those.

For CDAG record layout Table 16, so our new Call Log, we would like you to include all Part D calls that were received by your organization or your delegated entity from an enrollee or their representative, and if it was received or transferred to your member customer service line. Do not include prescriber calls in Part D call logs, and do not include non-Medicare lines of business or sales calls.

Next we're going to move to Formulary Administration Record Layouts. There are five different record layouts that we want to provide some clarifying guidance on. For FA Tables 1 through 3 and 5 – so this is all the record layouts except for PDE – the field name "Enrollment Effective Date" and "Effective Disenrollment Date" – both the effective disenrollment and enrollment dates should be reported at the plan benefit package level. The enrollment and disenrollment dates submitted in the rejected claims universes should be relevant to the contract and the plan ID of the beneficiary at the time of each claim.

In the new member universe, a separate record should be entered each time a beneficiary is enrolled and considered a new member. The enrollment and disenrollment dates for each of these records should also be relevant to the associated contract and plan IDs submitted by the sponsor for that beneficiary.

For FA Tables 1 through 3, the "Reject Reason Code" and "Pharmacy Messaging," if both reject codes and pharmacy messaging exist for a

rejected claim but the exact association between them cannot be identified, the organization is permitted to enter the individual reject code in the "Reject Reason Code" field, followed by all the messaging for that claim in the "Pharmacy Message" field. This should be repeated for all reject codes appearing for that rejected claim. When pharmacy messages for a rejected claim exist without a reject code, the organization should enter "N/A" in the "Reject Reason Code" field, followed by the messaging for that claim in the "Pharmacy Message" field.

For FA Tables 1 through 3, the "Patient Residence" and "Pharmacy Service Type," values should reflect what was submitted by the pharmacy on the claim for these particular fields. While this may typically be an NCPDP value, other values included on the claim would also be accepted.

For FA Tables 1 through 4, the "NDC" field description should be populated in the format that was provided in the NCPDP Data Dictionary. The rejected claims universe should include the NDCs that were submitted on that claim, regardless of whether the NDC was determined to be invalid after processing. NDCs should include the 11-digit value, as submitted by the pharmacy and, when applicable, should remove special characteristics separating the labeler, product, and trade package size. In the event a multi-ingredient compound does not include at least one Part D-covered drug, populate the NDC field with 11 zeros to remain consistent with the 11-digit NDC drug code.

FA Tables 1 through 3 and 5 – when you're determining "new" versus "continuing" enrollee status for the purpose of the universe submission, there may be a difference among sponsors in determining new enrollment status for beneficiaries that change plans and contracts under the same organization from year to year during a contract year. So organizations should identify such members as new versus continuing for purposes of

universe submission based on their internal policies and procedures. After receipt of a program audit engagement letter, organizations will have the opportunity to discuss their approach to help ensure complete and accurate universe submissions.

Moving on to MTM Record Layouts, we have two different record layouts in the MTM area. For MTM record layout Table 1, "MTM Eligibility Date" vs. "MTM Enrollment Date," the reason for the two separate fields for MTM eligibility and enrollment dates is because although systems could be developed to auto-enroll beneficiaries into MTM immediately after they have been flagged as eligible, this does not always occur in practice.

MTM record layout Table 1 continued -- the field name, "Was the enrollee residing in a long-term care facility," sponsors should use the patient residence code on the submitted drug claims to determine that information.

And for the "Number of Comprehensive Medication Reviews (CMRs) offered," as noted in the field description of the number of CMRs offered in order to count as a CMR offer, it must have been received by the MTM Program member. Returned mail or incorrect phone numbers do not count as an offer. For audit purposes, if a CMR offer is successfully delivered, it may be counted regardless of whether response was received or an action was initiated by the beneficiary or the AOR.

For the "Number of CMRs administered" vs. "Number of written CMR summaries," a CMR summary may either be provided immediately following a CMR or distributed separately within 14 days of the CMR. Therefore, the CMR administration and written summary dates may be different.

For the "Enrollment Effective Date," if there is only one enrollment date within the audit period or the enrollment date is outside, which would be before the audit period, enter the last effective enrollment date in the field. If multiple enrollment dates exist within the audit period, enter the first enrollment date that occurred within that audit period.

All right, we can go ahead to the next one here.

For the "Number of TMRs performed," targeted medication reviews, or TMRs, conducted by the sponsor no less than quarterly for all beneficiaries enrolled in the MTM Program; and these assessments could be person-to-person, or they could be system-generated.

Now I'll turn it back over to Marie.

Marie Gutierrez: Great, thanks, Doreen.

Now let's talk about SNP-MOC, which has two record layouts and eight documentation requests. I will discuss clarifying guidance that applies to a record layout and some of the documentation requests.

For SNP-MOC record layout Table 1, enrollees that switched from one plan to another during the review period should be included in the SNP-E, so that's Table 1 record layout, as separate entries. In such instances, the members will appear in the SNP-E universe for each contract or plan in which they were enrolled over the duration of the 13 continuous months.

In regard to the HRA during the current audit period, enter "No" if the HRA was not filled out and returned by the member. Sponsors will have the opportunity to provide information on their outreach efforts during case review to satisfy compliance.

For the "Cumulative Dollar Amount of Parts C and D Claims Paid" field, enter the amount the sponsor paid. Do not include the member's cost sharing amount. So it's basically the cumulative dollar amount paid by the sponsor.

Next we'll look at some documentation request clarifications. This one is specific to models of care. Please submit your original approved models of care and any redlined updates to the originally submitted MOCs. This will help auditors understand the improvements and changes that you have made to models of care.

About the HRA submission related to the HRA tool, submit the one CMS reviewed and approved during your MA application or SNP proposal review process. Do not submit additional tools that may be used internally by the sponsor.

Policies and Procedures related to Enrollment and Eligibility Verification -- please include information related to State agency eligibility verification and enrollment.

Include the care coordination policies and procedures that contain outreach provisions for HRA administration or individual care plan development if not addressed in your MOC.

Performance Monitoring Reports – include quality improvement committee reports, corrective action plan progress reports, and any reports presented to stakeholders, senior leadership, and the Board.

Now, this next slide is our general universe clarifications. The first bullet talks about when the sponsor does not have any cases that meet the record layout request. In that scenario, the sponsor should upload the

universe template with a sentence attesting that they do not have such data as requested.

The second bullet is about coverage request that is received prior to the enrollee being effective in a plan. In that scenario, use the plan ID that was in place at the time of the enrollment effective date.

The third bullet is about fields for a single case being in the same time zone. For example, if a sponsor has a system in Eastern Time and then also in Central Time, all data in a case for that single line item within that universe are to be converted to a single time zone. Let me talk through that one more time. We'll say you have a Line 10 that should reflect, we'll say, Central Time in that system; and then you can have a case in line 20 that would reflect Eastern Time – again, across that single line item case.

Lastly, if using abbreviations that are not universally recognized, please include a description.

This box we offer to you our Parts C and D audit e-mail address. If you have any questions about the protocol or our audit process, please submit your questions to the e-mail box up on the slide. We also listed our Parts C and D audit website, where you'll find the protocol and other wonderful, great audit documentation information.

That concludes our presentation. On behalf of Fatima, Angie, and Doreen, thank you for your attention.

[Applause]

Stacey Plizga: Okay, if we do have questions from our in-house guests, please step to the center aisle to a microphone; introduce yourself; and tell us where you're from.

Could we turn on the microphones in the aisle, please?

[Pause]

Michelle Juhanson: Good morning, I'm Michelle Juhanson from Perform Rx. Thank you for this very in-depth presentation on the changes themselves to the universes. It's something that we have a particular passion for. I have two questions, one related to the CDAG universes on slide 29. What I understand the clarification to mean is that on the redetermination universes, we're expected to give the information related to whether the original coverage determination was denied for medical necessity. One is a comment and one is a question.

The question is what's the justification for that? And the reason I'm asking is our comment. From an automation perspective, we're able to pull the system information that says this is what happened for that redetermination. The prior decision is not attached to that case. So as a PBM, when we recently went through the Appeals Monitoring Program, every last one of our plans was selected for the audit. That means that we're producing universes for multiple plans at the same time; that's thousands of cases. This is a field where if we follow this instruction, we would have to manually research the previous case until we can build programming to align them.

And that's a similar feedback for slide 40; and that's the MTM. Just a moment, let me get it together here. The record layout request and the clarification utilize the patient residence code on the submitted drug claims. Again, our MTM system is based on the beneficiary; and they're presumably using a high number of drugs. So are we supposed to base it on one LTC claim or more than 50% of LTC claims? Again, having to go into the claims system to look at the drug claims creates a physical and

operational challenge that would make it a manual effort for thousands of beneficiaries.

Doreen Gagliano: Okay, so I definitely understand the burden…being a PBM and having to pull that high number of data for multiple different sponsors. So to address the CDAG question first on slide 29, the reason that we ask you to identify whether that initial coverage determination request was denied for lack of medical necessity is because we need to play through the case. So if you, on page 30, were asking about the redetermination review -- so obviously if the original CD was denied for lack of medical necessity, then it helps us identify what needs to happen in the redetermination phase…so one being that it would have to be reviewed by a physician and a physician who has knowledge in that particular area of medicine that the request is coming in for or the drug. That's why we need to know the difference between those two.

Now, if it *is* burdensome and it's such a manual process, I think that we could probably talk with the auditor in charge and determine what we could list in there instead. We could potentially list "N/A," and then we would have to determine, when we go through each of the sample cases, if that was in fact denied for lack of medical necessity. So we can work with you is what I'm trying to say. Don't stress out about that. Just let your auditor in charge know what the issue is, and then we will definitely find a solution.

Michelle Juhanson: Super accommodating, thank you. Thanks very much.

Doreen Gagliano: You're welcome.

Tami Geroski: Good morning. My name is Tami Geroski. I'm with TMG Health, and my question is actually on ODAG claims, which was slide 19 as part of the presentation. The question has to do with the date paid and the date

written notification provided to the provider when you have an electronic transaction. I'm referring to EFT and ERA. I believe you specifically stated that if you have an EFT or ERA vendor that you should use the date that the transaction is given to your EFT and ERA vendor.

I just wanted to confirm that because when you give a transaction to an EFT and ERA vendor, yes, it's leaving your organization; but it could be a day or two before that EFT and ERA vendor actually effectuates that payment or that ERA. So I just wanted to confirm the date that should be used as, again, similar to the PBM, TMG is a BPO; so we're creating these universes across multiple clients and contracts. We want to make sure we're doing it correctly and consistently.

Marie Gutierrez: Thanks, Tammy. The simple answer is, yes; I am confirming that is the date. So for EFT transactions, it is the date that the sponsor put the payment in motion and sent it to its paying vendor. That said, if the sponsor is using – so for the electronic payment, if it's a check, it is the date the check left the organization and was mailed out. If they're mailing it via vendor, it is the date the vendor mailed it out. If the sponsor is using U.S. mail, it is the date that it left the sponsor because it went to the U.S. vendor.

But, yes, good catch…there is a variance there; and the thinking behind that is we recognize that the sponsor put the electronic payment in motion, albeit it's to its vendor. So we do, as a policy, accept the date the electronic payment went out and left the sponsor as the payment date. Does that help?

Tami Geroski: Great, thank you very much.

Marie Gutierrez: You're welcome.

Derek Frye: Good morning, Derek Frye from the Burchfield Group. I actually have a question on the independent validation audit process. When you guys do a regular program audit, you give sponsors the samples for the webinars one hour before the webinar starts for that day for most of the sessions, other than SNP, et cetera. Is the independent validation audit, or can we follow the same process? Can we give them samples the day before? There's not a lot of clarity around that, and I just wanted to get the question out.

Doreen Gagliano: Thanks for that question, Derek. First, I just want to mention that when you are undergoing validation, your auditor in charge will be the primary point person. So I just want you to know that you will have support during that time frame; so should you have questions like this, please do direct those to them.

In regard to the IA process, most sponsors we find do follow the protocol outline when they're doing their validation. So it doesn't really matter to us how soon you get the samples; it's okay if you get them a little sooner or right on the spot. But like I said, most sponsors do go ahead and use – most IAs use the same protocol and the same timing that we do for the actual live audit. But it's not prescriptive is what I'm trying to say, which is why there's not a lot of guidance around how the IA should deliver samples or the timing.

Derek Frye: Perfect, thanks.

Mike Sneckenberger: Good morning, Mike Sneckenberger from Anthem. Staying on slide 19 from earlier – and greatly appreciate the clarifications today. Taking that initial clarification but stepping through to some later tables – Table 9 and Table 10, which is the IRA payment and the ALJ MAC requirement effectuation – more specifically, looking at the fields for completion where we have to enter whenever items were effectuated within the sponsor's

system, if that results in payments, is that looking for the date that the payment is made too? In other words, does that same clarification hold true here too, or is it when it's effectuated inside the actual system?

Marie Gutierrez: Mike, real quickly and to clarify, we want to make sure we're addressing it for the appropriate program area. Were you referring to ODAG or CDAG?

Mike Sneckenberger: ODAG.

Marie Gutierrez: For ODAG, an effectuation of the payment, specific to your question, it would be the payment date.

Mike Sneckenberger: Okay, one other quick question here regarding Table 3 in the claims universe. The instructions request to submit payment organizations based on the date the claim was paid, should have been paid, notification date of the denial, or the date the denial notification should have been sent. Around that notification date, we notify the enrollee and also the provider. So when we're pulling together the universe, if those dates are different for the notifications, which one should we leverage?

Marie Gutierrez: Please use the notification date to the beneficiary.

Mike Sneckenberger: Okay, thank you.

Marie Gutierrez: Thank you.

Britton Whitbeck: Good morning, Britton Whitbeck from Lumeris. Again, I want to agree with the commenters; we appreciate all the clarity that was in this presentation. I had a question for the ODAG universes, the field for diagnosis codes. It states that if there's a drug, that it should include both the NDC and the diagnosis code. I just kind of wanted to get clarity on the

value of inclusion on that and then kind of a comment kind of similar to the CDAG appeals cases. It involved a lot of manual intervention to identify those Part B drugs, and then often the determination is made by the plan sponsor; but the adjudication is happening in the PBM system. So we have to research those drugs to include the NDC in the ODAG universes.

Marie Gutierrez: To clarify, are you saying the NDC information is not readily available in the system?

Britton Whitbeck: Correct, in the plan sponsor system – we capture it in our PBM claim adjudication; but the diagnosis code, the ICD-10, is readily available.

Marie Gutierrez: Again, big picture…the intent of asking for that information is so we can determine and get a handle on what kind of claim that is. So, yes, ideally it would be an NCD code. If that's not readily available, you can do an ICD-9 code or a description. Again, as long as it's meeting – well, I'm sharing with you the intent and the purposes for what we use that column. As Doreen mentioned, we want to work with you and not add more work for you to do that manual lookup and stuff.

Britton Whitbeck: Excellent, thank you very much.

Marie Gutierrez: You're welcome.

Britton Whitbeck: Oh, I'm sorry, I actually had one more.

Marie Gutierrez: No, that's it (laughing). I'm just kidding.

Britton Whitbeck: There's a limit. On the dismissals universe, I appreciate the additional clarification in 2017 on the type of dismissals that should appear there and the compliance requirements. Do you know if we anticipate an

update to either Chapter 13 of the Medicare Managed Care Manual or an HPMS memo that kind of outlines plan sponsor responsibilities for the different types of dismissals?

Marie Gutierrez: Off the cuff, yes, Chapter 13 update would be wonderful. We hope our sister group will – well, I know our sister group, MEAG, is diligently working on getting an update to Chapter 13.

Britton Whitbeck: Excellent, thank you again for the presentation.

Marie Gutierrez: You're very welcome. Are you sure you don't have another question (laughing)?

John Tanner: Good morning, John Tanner, Molina Healthcare. For entry of IAs and CAPs and that kind of information directly into HPMS, will we be allowed to do file uploads; or is all that going to have to be entered directly into – like in separate fields?

Doreen Gagliano: For impact analyses?

John Tanner: Mm-hmm.

Doreen Gagliano: During the live audit?

John Tanner: Yes.

Doreen Gagliano: Okay, yes, you would be able to upload those right into HPMS. There actually is a folder that identifies impact analysis.

John Tanner: Okay, good, so it will be a file. We won't have to do a separate direct entry?

Doreen Gagliano: Exactly.

John Tanner: Okay, good, thank you.

Doreen Gagliano: Yup.

Vanessa Turner: Hi, I'm Vanessa Turner from EmblemHealth. I had a quick question about the Special Needs Plan Model of Care template. I really appreciate the clarification that you should only enter in "Yes" for whether a plan conducted in HRA if the response is received. But I think Chapter 5 advises that plans can use several different mechanisms to administer the HRAs, including mail. They also seem to indicate that plans must have processes in place to address members who are resistant in responding.

I know that a lot of plans build out outreach procedures; and I noted in the past couple of years, Part C and D reporting, now direct plans require plans to report outreach attempts for members who refuse to respond to an HRA and members who it's difficult to reach. I wonder if, for future derivations of these templates, whether outreach attempts would be included in these templates as well?

Marie Gutierrez: Great question, Vanessa, and you got me. But I promise to look that up. I want to make sure I give you the right information and the current information. So I will get back to you at our Q&A session this afternoon.

Vanessa Turner: Okay, thank you.

Marie Gutierrez: Great.

Stacey Plizga: We have time for one last question. If there are more than that, please hang on to them. We will have an open Q&A session at the end of the day, where you will have an opportunity to ask more questions.

Tami Geroski: Hello, Tami Geroski from TMG Health again. One more question…and really it's a clarification on a gentleman's question just asked a few moments ago, again, on Table 3 ODAG claims and how the universe should be polled. The universe states that it needs to be polled based on the date the claim was paid or should have been paid or notification sent. I believe his question was notification to whom; and your answer was to the member. That confuses me a little bit because what if a plan is sending a monthly EOB? So it's really typically not based on the notification to the member; it's usually based on the notification to the provider. I just wanted to make sure I understood that.

Marie Gutierrez: So the monthly EOB is what goes out to the provider.

Tami Geroski: To the member…so the plan has the ability to do a per-claim EOB or a monthly EOB. Typically, in past guidance – or at least the way we understood it – the claims that need to be chosen for your universe for the scope is all based on payment to the provider and not based on the EOB to the member. I just wanted to make sure I understood your previous comment because that kind of changes everything.

Marie Gutierrez: Okay, you're right; the EOB would go to the member if it's monthly. If it's in that monthly EOB, then I would deduce that those are approvals.

Tami Geroski: They could be—

Marie Gutierrez: Denials with the appeal languages in there?

Tami Geroski: Right.

Marie Gutierrez: Then, yes, it would be that; but, Tami, I want to make sure that I am not changing everything and affecting everything on your end as well. So, as with Vanessa, I promise to answer that question at the Q&A later on this afternoon. So I'll owe you an answer.

Tami Geroski: Thank you.

Marie Gutierrez: Thank you.

Stacey Plizga: Okay, thank you for all the great questions; and like I said, we will have an opportunity later today to continue on the question and answer period.

At this time, I would like to thank our panel for the discussion on the audit process.

[Applause]

Stacey Plizga: Can we move to the polling slide, please?

It is time for our first session evaluation. Please take out your cellphones or your tablets or however you are connected via polling. You're going to respond to the question: I would like to evaluate Session 1. And if that is the case, as soon as it comes up you can go ahead and select "A."

[Pause]

Stacey Plizga: There we go. Once you select "A," you are going to get a link. Click on that link, and then you will click "Start Survey" and then respond to the questions. Please remember to hit "Finish" when you are done.