DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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To: All Medicare Advantage Organizations (MAOs), Prescription Drug Plan (PDP) Sponsors, and 1833 & 1876 Cost Plans

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Subject: 2018 Readiness Checklist for Medicare Advantage Organizations, Prescription Drug Plans, and Cost Plans

The Centers for Medicare & Medicaid Services (CMS) is reminding organizations of critical Medicare Part C and D requirements for the Annual Election Period (AEP) and coverage beginning January 1, 2018. A 2018 Readiness Checklist for operational Medicare-Medicaid Plans (MMPs) will be issued separately.

The Contract Year (CY) 2018 Readiness Checklist summarizes key operational requirements as established in statutes, regulations, manual chapters, Health Plan Management System (HPMS) memos, and other sub-regulatory guidance. Organizations should review this checklist and take the necessary steps to fulfill these requirements for the 2018 benefit year.

Two years ago CMS moved from requiring organizations to submit readiness attestations to strategic conversations between sponsors and Account Managers, with a goal of more open and direct conversations about preparedness and process improvements. The feedback was positive, with sponsors preferring this approach because it gave them an opportunity to explain, seek clarification, or express concern. As a result of this feedback, CMS added an appendix that lists points of contact for specific subject matter. We are using the same communication and feedback process again this year. Organizations must notify their account manager(s) of any requirements that are at risk or technical assistance needed to resolve any issue. CMS account managers will follow up with organizations regarding their self-assessments prior to the new year, at which time we invite you to share suggestions for improving the process.

For additional information regarding the checklist, please refer to the appropriate CMS guidance, contact your account manager, or contact the subject matter expert identified in Appendix A.

Note: Unless otherwise indicated, requirements that apply to Medicare Advantage Organizations also apply to 1876 Cost Plans. Part D sponsors refers to all organizations offering Part D.

CY 2018 Medicare Advantage Organization, Prescription Drug Plan, and Cost Plan Readiness Checklist

Contents

A. New Medicare Cards (formerly the Social Security Number Removal Initiative (SSNRI)) – Medicare Advantage Organizations and Part D Sponsors

The Centers for Medicare & Medicaid Services (CMS) is removing Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare cards which will be issued to beneficiaries no earlier than April 2018. There will be a transition period where CMS will accept either the HICN or the new MBI when organizations are submitting data to the agency. The transition period will begin no earlier than April 1, 2018, and run through December 31, 2019. All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to be ready to submit or exchange the MBI by April 1, 2018. Stakeholders may submit either the MBI or HICN during the transition period.

(HPMS memos 9/29/2016, 11/18/2016, 5/2/2017, *Medicare Managed Care Manual*, Chapters 2 and 7D, Medicare Prescription Drug Benefit Manual, Chapters 3 and 4)

B. Individuals with Disabilities – Alternate Formats – Medicare Advantage Organizations and Part D Sponsors

Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, audio, etc.) to individuals with disabilities upon request. (HPMS Memo dated August 30, 2017, and Section 504 of the Rehabilitation Act of 1973)

C. Systems, Data, & Connectivity

I. Health Plan Management System (HPMS) – Medicare Advantage Organizations and Part D Sponsors

- Ensure key staff members register for the Plan Connectivity Data Module within HPMS by e-mailing hpms_access@cms.hhs.gov.
- Update your organization's contact and data information in HPMS, and ensure that your organization has a process in place to keep the data on the HPMS contact and data information pages up-to-date throughout the year. It is critical to enter and maintain contract-level contact information as it is used for other purposes within HPMS and other CMS systems, as well as in support of information displayed publicly. Refer to the HPMS contact definitions to assist you with completing the contact and information sections.

  (HPMS Basic Contract Management Manual and Contact Definitions)

II. Medicare Advantage Prescription Drug (MARx) System– Medicare Advantage Organizations and Part D Sponsors

- Review and implement guidance regarding software improvements to the enrollment and payment systems. (HPMS memos 12/20/2016, 04/11/2017, 7/28/2017 and 10/4/2017

- Ensure your External Point of Contact (EPOC) is notified of the changes regarding the Enterprise Identity Manager (EIDM) users. (HPMS memo 9/15/2017)
- An individual's access to EIDM will be locked when 60 days lapses between system logins. To unlock the account, the individual must login to EIDM, answer their challenge questions, and reset their password. (EIDM- Users Guide)
- Submit beneficiary-level opioid point of sale (POS) edit notifications within seven (7) business days of the date on the beneficiary's written advance notice and submit implementations, terminations, and modifications of opioid POS edits into MARx within seven (7) business days of the event. (Section 11 in the Medicare Advantage and Part D Plan Communications User Guide)

III. Medicare Plan Finder Data (MPF) – Applicable organization types noted below

- **Pricing Data and Pharmacy Network Files.** (Part D Sponsors) Submit timely and accurately the CY 2018 pricing data for posting on the MPF. (Office of Communications email 5/05/2017, HPMS Memo 7/07/2017)
    - Accurately identify preferred cost-sharing pharmacy arrangements in the MPF pricing files. A pharmacy may only be associated with the plan's preferred cost-sharing network if a lower differential cost sharing applies to some tiers of formulary drugs at that pharmacy than applies at pharmacies in the standard cost-sharing network.
    - Confirm pricing and pharmacy network data files for MPF are correct and accurate, and that only pharmacies under contract for 2018 are included for display. Incorrect data may result in suppression from the MPF, and/or applicable compliance actions.
- **MPF File Pre-Submission Quality Assurance Testing.** (Part D Sponsors) Perform quality assurance activities prior to submitting MPF files to CMS. Sponsors may be subject to Part D program compliance and enforcement actions as a result of MPF suppressions or inaccurate data submissions.
    - If your organization receives an outlier notification for your 2018 pricing and pharmacy data which was previously a known exception in 2017, your organization must re-confirm that the data continue to be accurate. If you do not confirm these data, your organization's pricing data may be suppressed on the MPF.
    - MPF submissions must be complete and accurate in all respects, and sponsors are solely accountable for any errors in their MPF data, regardless of how they come to CMS' attention. Because of the critical role the MPF plays in providing beneficiaries with reliable information about their drug plan options, CMS will suppress the display of a sponsor's plan information as the result of any identified inaccuracy or failure to respond to a CMS inquiry about a data submission.
- **MPF Communications Website.** (Part D Sponsors) Ensure your organization has access to the MPF Communications website and has authorized new users. Updates and announcements relating to the quality assurance (QA) process are posted on the MPF Communication website, https://PartD.ProgramInfo.us/User_Security.

IV. User Group Calls – Medicare Advantage Organizations and Part D Sponsors

Ensure key staff registers for the CMS Part C & D User Calls at https://www.mscginc.com/registration/. Participants should call fifteen minutes before start time to ensure timely access to the call.

V. Patient Safety Analysis Website – Part D Sponsors

- Access the monthly Patient Safety Reports via the Patient Safety Analysis Website to compare your performance to overall averages and monitor progress in improving Part D patient safety measures over time.
- These actionable reports include contract-level patient safety reports for expanded analyses and information and detailed beneficiary-claim level and outlier reports. Be advised, sponsors are required to use the website to view and download the reports, respond to outlier notices, and should be engaged in performance monitoring. (HPMS memo 4/07/2017)
- New sponsors for 2018 – Your organization will receive log-on credentials directly from the Patient Safety Analysis Website contractor, and you will begin reviewing these reports in spring of 2018.

VI. Overutilization Monitoring System – Part D Sponsors

- Ensure your organization's Medicare Compliance Officer authorizes users to access the Overutilization Monitoring System (OMS), available via the Patient Safety Analysis Website. At least one user from each contract must have access to Summary and Confidential Beneficiary Reports to view and respond to beneficiary-level overutilization issues.
- Review and act upon OMS quarterly reports and send response to CMS within 30 days of the report. For additional information, the OMS User Guide is available on the Patient Safety Analysis Website under Help Documents. (see *Improving Drug Utilization Controls in Part D* at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html)

VII. Risk Adjustment Data Submissions – Including Risk Adjustment Processing System (RAPS) and Encounter Data (EDS) – Medicare Advantage Organizations

- Medicare Advantage Organization (MAO) payment is primarily based on data submitted to CMS. In order to receive proper payment, MAOs and other entities must be certified to submit data through both the EDS and RAPS.
- Information about becoming certified to submit data, guidance regarding data submission to CMS, and other resources can be found on the Customer Service Support Center (CSSC) website, https://www.csscoperations.com, as well as memos available on HPMS. Register for monthly Risk Adjustment for EDS & RAPS User Group webinars through https://tarsc.info/.

  Assistance with data submission can be obtained by emailing csscoperations@palmettogba.com, or by calling 1-877-534-2772.

- Checklist items for EDS and RAPS submission are as follows:
  - Enroll to submit data through CSSC,
  - Subscribe to receive email updates,
  - Perform certification requirements,
  - Be familiar with guidance contained on the CSSC website, and
  - Begin submission of production data within 4 months of contract effective date.

VIII. Prescription Drug Event (PDE) Requirements – Part D Sponsors

- Establish access to the Part D Payment Process Support Website. (HPMS memo 2/16/2016 and 10/12/2016)
- Submit original PDEs within 30 days following Date Claim Received or Date of Service (whichever is later).
- Within 90 days:
  - Resolve rejected PDE records and re-submit following receipt of rejected record status from CMS, and
  - Submit adjustments and deletions following discovery of issue requiring change.

  (HPMS memo 10/06/2011)
- Establish access to the PDE Analysis and PDE Reports websites. (HPMS memo 4/13/2017)
- Have procedures in place for analysis of recurring reports so that PDE data maintained by CMS (which are the basis for Part D Payment Reconciliation) and the organization's internal records correspond. CMS reports include:
  - Drug Data Processing System (DDPS) Cumulative Beneficiary Summary,
  - PDE Accounting Report,
  - P2P (Plan to Plan) Reports,
  - Coverage Gap Invoice Report,
  - Part D Potential Exclusion Warning Report and Part D Exclusion from Reconciliation Report, (HPMS memos 1/06/2014, 4/16/2014 and 2/23/2017),
  - Payment Reconciliation System (PRS) reports (HPMS memo 6/23/2017).

IX. Electronic Enrollment Mechanisms - Medicare Advantage Organizations and Part D Sponsors

- Organizations developing and offering electronic enrollment mechanisms made available via an electronic device or secure internet website must apply CMS' enrollment guidelines for electronic enrollment mechanisms, including:
  - Submit all materials, web pages, and images (e.g. screen shots) related to the electronic enrollment process for CMS approval per established processes for the review and approval of marketing materials and other enrollment request mechanisms.

- Comply with CMS' data security policies, at a minimum. https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS- Information-Technology/InformationSecurity/Information-Security- Library.html

- Sponsors retain complete responsibility for following enrollment policies, and appropriate handling of any sensitive beneficiary information provided as part of the online enrollment, including those facilitated by downstream entities.
- From the point at which an individual selects the plan of his or her choice on the third-party website and begins the online enrollment process, CMS holds the organization responsible for the security and privacy of the information provided by the applicant and for the timely disclosure of any breaches.
- CMS must be notified in a timely manner of security and/or privacy breaches, should they occur.

(Medicare Managed Care Manual Chapter 2 and Medicare Prescription Drug Benefit Manual Chapter 3, Section 40.1.2 – Electronic Enrollment)

D. Reporting

I. Healthcare Effectiveness and Data and Information Set (HEDIS®), Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – Medicare Advantage Organizations and Part D Sponsors

Prepare to submit HEDIS, HOS, and CAHPS measures to the appropriate entity by the specified due date. (HPMS memo 8/14/2017)

II. Part C and Part D Reporting Requirements – Medicare Advantage Organizations and Part D Sponsors

Prepare to collect data on all Part C and Part D (as applicable) reporting requirements; conduct appropriate data validation; and submit data to CMS according to the requirements. (https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html)

III. Reporting and Returning Sponsor Identified Overpayments - Medicare Advantage Organizations and Part D Sponsors

Every organization offering a Medicare Advantage (MA) plan and/or Part D benefits is required to report and return to CMS any overpayment it received no later than 60 days after the date on which the organization or sponsor identified the overpayment. (HPMS memos and email notifications 2/18/2015, 8/28/2015, 12/29/2015, 6/07/2016, 9/22/2016, 4/25/2017, 6/01/2017)

IV. Fiscal Soundness - Medicare Advantage Organizations and Part D Sponsors

Annually, use the Fiscal Soundness Module in HPMS to submit independently audited annual financial statements and 2018 quarterly financial statements. The CMS Fiscal Soundness Reporting Requirements, relevant HPMS memos, and other important information is available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/FSRR.html

E. Contracting, Subcontractor Provisions, and Oversight

I. Any Willing Pharmacy (AWP) Contracting Requirements – Part D Sponsors

- To comply with the Any Willing Pharmacy requirement, a Part D plan sponsor must make standard terms and conditions available for all Part D plans it offers. For those terms to be reasonable and relevant, they must identify for the pharmacy the plan(s) to which they apply, and the offer must include language that obligates the Part D sponsor to include the pharmacy in the identified plan(s) upon the pharmacy's acceptance of the terms and conditions.
- CMS expects Part D sponsors to:
  - Have standard contracting terms and conditions readily available for requesting pharmacies no later than September 15 of each year for the immediately succeeding benefit year, and
  - Provide the applicable standard terms and conditions document to the requesting pharmacy within two business days of receipt of the request.

  (HPMS memo 8/13/2015)

II. Offshore Subcontracting – Medicare Advantage Organizations and Part D Sponsors

For organizations with offshore subcontractor* arrangements, ensure the HPMS Offshore Subcontracting module is up to date regarding the functions offshore subcontractors perform within 30 calendar days of signing an offshore contract. (HPMS memos 7/23/2007, 9/20/2007, and 8/26/2008)

* *Offshore subcontractor* is defined as a first tier/downstream/related entity located outside of the one of the fifty U.S. states, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

III. Changes to First Tier/Downstream/Related Party (FDR) Contracts for Key Part C and Part D Functions - Medicare Advantage Organizations and Part D Sponsors

- Notify your CMS Account Manager at least 60 days prior to the effective date of the new contract.
- CMS recommends that sponsors making pharmacy network changes provide both those pharmacies whose network status is changing, and enrollees using those pharmacies, with notices of changes specific to their situation.
- Part D Sponsors – If making Pharmacy Benefit Manager (PBM)/ Processor changes:
  - Take all steps per the *Medicare Prescription Drug Manual Chapter 5, Section 50*, if making changes to the PBM contracted to maintain your organization's pharmacy networks.

- Update all members' 4Rx data prior to the effective date of the PBM change to reflect the new BIN and PCN. (*Medicare Managed Care Manual* Chapter 2 and *Medicare Prescription Drug Plan* Chapter 3 *Eligibility, Enrollment, and Disenrollment*, Section IV.D.a)

- If your organization's drug pricing is based on maximum allowable cost (MAC), ensure that contracts with first tier, downstream, and related entities contain a provision: (A) Establishing regular updates of any prescription drug pricing standard used by the Part D sponsor consistent with §423.505(b)(21); and (B) Indicating the source used by the Part D sponsor for making any such pricing updates. See 423.505(i)(3)(vii).

F. Customer Service

I. Customer Service Call Centers Operation – Medicare Advantage Organizations and Part D Sponsors

- Staff all toll-free beneficiary call centers appropriately to handle increased call volume from October 1 to February 14, which includes the AEP. Plans/Part D Sponsors must operate a toll-free call center for both current and prospective enrollees open during usual business hours, which CMS considers to be seven (7) days a week, at least from 8:00 A.M. to 8:00 P.M., according to the time zones for the regions in which your organization operates. Call centers must be able to provide free interpreter services for Limited-English Proficient (LEP) beneficiaries. (*Medicare Marketing Guidelines,* Section 80)
  - From October 1 to February 14 - Current and prospective enrollees must be able to speak with a live customer service representative. Your organization may use alternative technologies on Thanksgiving and Christmas.
  - From February 15 through September 30, your organization may use alternative technologies to meet the customer service call center requirements for Saturdays, Sundays, and Federal holidays.

II. Limited English Speaking Beneficiaries – Medicare Advantage Organizations and Part D Sponsors

- All plan sponsors' call centers must have interpreter services available to call center personnel to answer questions from non-English speaking beneficiaries. This requirement is in place regardless of the percentage of non-English speaking beneficiaries in a service area.

- Inform callers that interpreter services are "free." Interpreters should be available within a prescribed time after reaching the Customer Service Representative (CSR). Please refer to the annual call center monitoring memo released each fall for more detail.

- Make the marketing materials identified in the *Medicare Marketing Guidelines* sections 30.6, 30.7, 30.10 and the Part D Transition Letter(s) available in any language that is the primary language of five (5) percent or more of a plan sponsor's plan benefit package service area. Additionally, plan sponsors must place translated versions of these materials on the plan's website. (Excluding Employer Group/800 series-only

contracts).

(*Medicare Marketing Guidelines,* Sections 30.5, 80.1, 100.1, and Appendix 3; 42 C.F.R. §§ 422.2264(e), 423.2264(e)); HPMS memo 7/20/2017)

III. Customer Service Staff Knowledge of Medication Therapy Management (MTM) – Part D Sponsors

Ensure customer service representatives are familiar with the plan's Medication Therapy Management (MTM) program, including eligibility criteria and additional information required to be available on a dedicated Medication Therapy Management Program page linked from the Medicare drug plan website, and how to direct beneficiaries to the plan's MTM program page. The 2018 MTM program annual cost threshold increased to $3,967. (*Medicare Marketing Guidelines*, Section 100.2.1*,* HPMS memo 04/07/2017, Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information).

IV. Pharmacy Technical Help Desk Call Centers – Part D Sponsors

Ensure pharmacy technical support is available at all times when any network pharmacy is open. Sponsors that have pharmacy networks with 24-hour pharmacies in their networks must operate their pharmacy technical help call centers 24 hours a day, including Thanksgiving and Christmas.

V. Complaints Tracking Module – Medicare Advantage Organizations and Part D Sponsors

Resolve at least 95% of Complaints Tracking Module (CTM) complaints designated as "immediate need" within two calendar days, complaints designated as "urgent" within seven days, and resolve at least 95% of all CTM complaints designated without an issue level within 30 days. Plan sponsors are urged to make interim contact with beneficiaries if their complaints will take more than seven days to resolve. (HPMS memo 2/6/2015, 12/30/2015)

G. Marketing Consistent with the Medicare Marketing Guildelines - Medicare Advantage Organizations and Part D Sponsors

Market consistent with the CY2018 Medicare Marketing Guidelines (HPMS memo 7/20/2017)

I. Individuals with Disabilities - Anti-Discrimination – Medicare Advantage Organizations and Part D Sponsors

Provide basic services and information to individuals with disabilities, upon request. (*Medicare Marketing Guidelines*, Section 30.4, HPMS memo 9/9/2014)

II. Formulary – Part D Sponsors

Ensure your organization's formulary is updated on the website when changes are made, and that only approved formularies are marketed. (*Medicare Marketing Guidelin*es, Section 60.4)

III. Referencing Star Ratings in Marketing Materials - Medicare Advantage Organizations and Part D Sponsors

- Provide the overall Star Ratings information to beneficiaries through the CMS standardized Star Ratings information document, which must be distributed with any enrollment form and Summary of Benefits (SB) document.
- Ensure that any references to Star Ratings comply with the 2018 requirements.
- Plans/Part D sponsors are not permitted to display or release their Star Ratings information until CMS releases the Star Ratings on Medicare Plan Finder.
- Plans/Part D sponsors must clearly identify which contract year their Star Ratings references.

(HPMS memo October 2017, *Medicare Marketing Guidelines*, Sections 30.10)

IV. Websites – Medicare Advantage Organizations and Part D Sponsors

- Ensure that your organization's website and all electronic Information and Communications Technology (ICT) is accessible to people with disabilities. Monitor website compliance with Section 508 standards and remediate any identified issues. (Section 508 of the Rehabilitation Act (29 U.S.C. 794d))
- The ANOC/EOC, Provider and/or Pharmacy Directories, Formulary and Utilization Management Documents, and Multi-Language Insert must be posted on the website by September 30 for the upcoming contract year (*Medicare Marketing Guidelines*, Section 100.2.2)
- Provider and Pharmacy Directories are expected to be accurate, updated at least monthly, and contain, among other things, a provider's ability to accept new patients. (*Medicare Managed Care Manual*, Chapter 4*,* HPMS memos 8/16/2016 and 1/17/2017)
- MAOs, PDPs, and their third-parties' websites that market their products are expected to meet applicable CMS marketing requirements.

(Medicare Marketing Guidelines, Section 100*)*

V. Agents and Brokers – Medicare Advantage Organizations and Part D Sponsors

Implement Agent/Broker compensation rates, submissions, and training and testing requirements. (HPMS memo 5/30/2017)

VI. Access to Preferred Cost Share Pharmacies – Disclaimers – Part D Sponsors

- Include the appropriate marketing disclaimer language for plans with limited access to Preferred Cost Sharing Pharmacies. (HPMS memo 8/16/2016)
- All marketing disclaimers can be found in the *Medicare Marketing Guidelines*, Appendix 5.

H. Enrollment/Disenrollment and Premium Billing

I. Timing of Annual Enrollment Period (AEP) – Medicare Advantage Organizations and Part D Sponsors

- The AEP begins on October 15 and ends on December 7. An enrollment/disenrollment election type "AEP" cannot be used after the end of the AEP.
- Submit non-AEP enrollments for January 1 effective dates beginning October 03, 2017. Beneficiaries must have a valid election period for a non-AEP enrollment for requests received after the December 7 deadline.
- Submit certain enrollments (e.g., employer group enrollments and enrollments made during an individual's Initial Coverage Election Period (ICEP)) for January 1 effective dates beginning October 3, 2017. Enrollments received after December 7, 2017 may not be processed as AEP elections. Beneficiaries must be eligible for a valid Initial Election Period (IEP) or Special Enrollment Period (SEP) for requests received after the December 7 deadline.
- If your plan does not offer a visitor/travel benefit to retain enrollees when they are outside of their service area for six (6) to twelve (12) months, then ensure that you disenroll beneficiaries who are absent from the plan's service area for six (6) months. (*Medicare Managed Care Manual* Chapter 2, Section 50.2.1*,* and HPMS memo 4/30/2010)
- Properly process notifications from CMS of reinstatement for good cause for Part D-Income Related Monthly Adjustment Amount (IRMAA) cases. Upon disenrollment for failure to pay Part D-IRMAA, CMS will make all decisions about reinstating beneficiaries on the basis of good cause.
- Establish a process to receive *Good Cause Requests* for disenrollments for failure to pay plan premiums. Organizations are responsible for all aspects of the good cause process, including receiving requests, making good cause determinations, notifying the beneficiary, collecting payment, and submitting the reinstatement requests to the Retroactive Processing Contractor. Reinstatement criteria are narrowly defined. (*Medicare Managed Care Manual* Chapter 2, Section 60, and *Medicare Prescription Drug Benefit Manual* Chapter 3, Section 60)

II. Medicare Advantage Disenrollment – Medicare Advantage Organizations

The Medicare Advantage Disenrollment Period (MADP) begins on January 1 and ends on February 14. During this time, or during the AEP, MAO enrollees may disenroll from a Part C plan and return to Original Medicare and may also enroll in a stand-alone PDP.

III. SEP for Enrollment into a 5-Star Plan – Medicare Advantage Organizations and Part D Sponsors

Beneficiaries may enroll in a plan awarded an overall 5-star rating for 2018, provided the beneficiary is otherwise eligible for that plan. An individual may only use this SEP one time between December 8, 2017 and November 30, 2018. 5-Star plans must be prepared to accept all valid enrollment requests made using this SEP. (*Medicare Managed Care M*anual Chapter 2, sec. 30.4.4; *Medicare Prescription Drug Plan Benefit Manual* Chapter 3, sec. 30.3.8)

IV. Enrollment Processes and Notices – Medicare Advantage Organizations and Part D Sponsors

Electronic enrollment mechanisms via a third-party website or non-plan owned electronic device, mechanism, or software are permitted.

V. Online Enrollment Center – Medicare Advantage Organizations and Part D Sponsors (Excluding MSA, 800-Series-Only, and Medicare-Medicaid plans; Optional for SNPs, RFB, and 1876 cost plans; Required for PDP and MA-PD)

- Establish and maintain a process to download enrollments at least once daily from the Online Enrollment Center (OEC) unless your organization is prohibited from participating in the OEC. (*Medicare Managed Care Manual* Chapter 2, sec. 40.1.2; *Medicare Prescription Drug Plan Benefit Manual* Chapter 3, sec. 40.1.2.)
- The OEC uses Coordinated Universal Time (UTC) which is four hours earlier than Eastern Daylight Time. Calculate the application date on enrollments received via the OEC to be 11 hours earlier than the time and date CMS "stamps" on the request. Use the adjusted application date to determine eligibility for election periods and proper effective date for coverage. (Administrative Console site on the OEC AND email to plans, April 8, 2016)

VI. Retroactive Enrollments – Medicare Advantage Organizations and Part D Sponsors

- Submit enrollments and disenrollments directly to MARx following the "current calendar month" cycle. Organizations can submit enrollments and disenrollments for the current calendar month and for the calendar month prior to the current calendar month, using the User Interface (UI) or in batch submissions. Enrollment into, or disenrollment from, EGWP plans may be submitted via the UI or in batch for the current calendar month minus three months.
- Prepare systems and processes to support the submission of retroactive enrollment and disenrollment corrections that cannot be accomplished within the Current Calendar Month cycle to the retroactive processing contractor (Reed & Associates). These requests must be made appropriately and timely. For more information, please visit www.reedassociates.org.

Medicare Managed Care Manual Chapter 2, Section 60.4, *Medicare Presciption Drug Benefit Manual* Chapter 3, Section 60.3

I. Late Enrollment Penalty (LEP) and Creditable Coverage – Part D Sponsors

I. Charge the correct LEP for beneficiaries based on CMS LEP reports (Medicare Prescription Drug Benefit Manual, Chapter 4, Section 40)

Process LEP changes, refunds due to error, or LIS redeterminations timely. Changes are reported in the Monthly Premium Withhold Report Data File, LEP report, and Transaction Reply Report (TRR). Plan sponsors need to review the reports for changes and effectuate timely. (*Medicare Prescription Drug Benefit Manual* Chapter 4, Sections 40.2 and 60.3, and HMPS memo 7/14/2014)

J. Benefits Administration & Beneficiary Protections - Medicare Advantage Organizations and Part D Sponsors

I. Benefits and Beneficiary Protections

- MAOs, as specified in §422.111(b)(12), implement systems and processes necessary to provide for the generation of Part C EOBs for all plan members. EOB templates and instructions are available at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketingModelsStandardDocumentsandEducationalMaterial.html.
- Ensure MA provider networks meet network adequacy standards. (§*42 CFR 422.112*(a)(1))
- Part D Sponsors must ensure that their retail pharmacy networks meet the access criteria established under 42 C.F.R. § 423.120(a). Sponsors must ensure that their retail pharmacy networks have a sufficient number of pharmacies that are able to dispense drugs directly to patients (other than by mail-order) to ensure convenient access requirements have been met.
- Regional Preferred Provider Organizations must ensure they pay non-contracted providers at least the Original Medicare payment rate in those portions of their service area where they are meeting access requirements by non-network means. (*Medicare Managed Care Manual* Chapter 4*, Section 10.2*)
- MA and other health plans must ensure their organization and its contracted hospitals and critical access hospitals (CAHs) implement the provisions of the NOTICE Act. Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services as an outpatient for more than 24 hours. See the final at: https://www.federalregister.gov/articles/2016/08/22/2016- 18476/medicare-program-hospital-inpatient-prospective-payment-systems-for- acute-care-hospitals-etc

II. Billing and Anti-discrimination Rules Applicable to Dual Eligible Enrollees - Medicare Advantage Organizations

- Remind network providers about billing rules applicable to dual eligible beneficiaries as required under 42 C.F.R. §422.504(g)(1)(iii). Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. QMB billing prohibitions may also apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. The prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low Income Subsidy copayments still apply for Part D benefits. (Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; 42 C.F.R. §422.504(g)(1)(iii))
- Organizations should verify procedures to ensure that MA providers do not discriminate against enrollees based on their payment status, e.g., QMB. Specifically,

MA providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. (*Medicare Managed Care Manual*, Ch. 4, Section 10.5.2)

III. Coverage Gap Discount Program (CGDP) – Part D Sponsors

- Sponsors should be prepared to repay manufacturers for negative invoice amounts caused by PDE adjustments. Such amounts are included in quarterly invoices and must be paid to manufacturers via the CGDP portal within 38 days of invoice receipt. (HPMS memo 1/22/2014)
- Part D Sponsors should make sure that the data displayed in HPMS is the most current information and reflects the correct personnel listed for the following fields:
  - HPMS field "Third Party Administrator (TPA) Liaison" for the TPA Primary Contact role
  - HPMS field "Coverage Gap Discount Program (CGDP) Payment Contact" for the TPA Payment Initiator role (if different from the Primary Contact).
- Ensure your organization updates the appropriate Bank Account Change Form on the TPA Website if there have been any changes to the accounts used for sending or receiving payments. Also validate any debit blocks and velocity filters which may be in place. These data are collected and maintained outside of the Automated Plan Payment System (APPS). The Bank Account Change Form can be found under the EFT Information line on the TPA web site (http://tpadministrator.com).

IV. Formulary – Part D Sponsors

- Ensure your organization properly administers CMS' transition policy as outlined in 42 CFR § 423.120 (b)(3). (*Medicare Prescription Drug Benefit Manual* Chapter 6, Section 30.4 and HPMS memo 8/19/2016).
- Biosimilars may be added to plan formularies at any time as a formulary enhancement. Formulary changes involving the addition of the biosimilar and removal of the reference biological product will generally be considered a non-maintenance change. These formulary changes will be evaluated, as are all non-maintenance changes, on a case-by-case basis, and allowed if the formulary continues to meet the formulary review standards with the corresponding addition of the biosimilar. Because biosimilars are not interchangeable with the reference biological product, CMS expects that Part D sponsors' Pharmacy and Therapeutics (P&T) committees will review newly approved biosimilars in accordance with section 30.1.5 of Chapter 6 of the *Medicare Prescription Drug Benefit Manual*. (HPMS memo 3/30/2015)
- Apply a daily cost sharing rate whenever certain prescriptions (depending on the drug dispensed) are dispensed by a network pharmacy for less than a month's supply in accordance with 42 C.F.R. § 423.153(b)(4)(i).
- Update MAC drug prices at least every seven days and to disclose all individual MAC drug prices to be updated to the applicable pharmacies in advance of their use. In addition, the disclosure must be made in a manner that enables the pharmacies to validate prices. (42 CFR §§423.501; 423.505(b)(21))

- A P&T committee must clearly articulate and document processes to determine that the requirements under paragraphs 42 C.F.R. § 423.120(b)(1)(i) through (iii) have been met, including the determination by an objective party of whether the disclosed financial interests are conflicts of interest and the management of any recusals due to any conflicts.

V. Mail-Order and Auto-Ship Refill Programs – Part D Sponsors

- Prescription drug plans offering mail-order benefits must provide access to urgently needed medications. Inform beneficiaries of their options when requesting rush orders. The required steps must be included in all beneficiary marketing materials that relate to mail-order benefits.
- Ensure your organization follows the mail-order auto ship guidance:
  - Part D sponsors should require their network retail and mail pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery. Such confirmation is unnecessary when the beneficiary personally initiates the refill or new prescription request.
- Two exceptions to the 2014 Call Letter auto-ship guidance, authorizing automatic deliveries without prior beneficiary consent are available to plan sponsors agreeing to meet the conditions stated in the applicable Exceptions to the Auto-Ship Policy memos:
  - Part D sponsors interested in offering automatic deliveries of new prescriptions (as described in the 12/12/2013 memo) are no longer required to request an exception to the auto ship policy from CMS. Instead, the exception will remain available to all Part D plans, without the need to specifically submit a request. Plans are permitted to start or continue automatic shipments, provided they meet the conditions detailed in the memo.
  - Employer Group Waiver Plan (EGWP) sponsors interested in offering automatic deliveries of refill prescriptions (as described in the 10/28/2013 memo) may do so and are not required to request an exception to the auto-ship policy from CMS.
- If a beneficiary has experience using mail-order home delivery, or other automatic shipment programs under the plan, sponsors do not need to establish an additional opt-in procedure to acquire explicit consent to fill initial scripts.
- If a beneficiary has had no previous experience using mail-order, home delivery, or other automatic shipment programs under the plan, then a new prescription for that beneficiary is not eligible for auto ship, and your organization should receive consent from the beneficiary before that prescription is filled.

  (HPMS memos dated 10/28/2013, 12/12/2013, 03/21/2014, 9/22/2014 and Calendar Year 2014 & 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letters)

VI. Quality Improvement (QI) Program, Chronic Care Improvement Program (CCIP), and Quality Improvement Project (QIP) – Medicare Advantage Organizations (excludes non-network PFFS/MSA, Cost plans, PACE)

- The QI Program (inclusive of the CCIP and the QIP) must meet the applicable requirements for the services that it furnishes to MA enrollees, as specified at 42 C.F.R. §422.152 and detailed in Chapter 5 of the *Medicare Managed Care Manual* and the *QIP and CCIP Resource Document*.
- 2018 changes (HPMS memo & FAQs dated 8/18/17):
  - The current QIP will become the newly designated CCIP. The newly designated CCIP will continue to focus on the topic: Promote Effective Management of Chronic Disease. The newly designated CCIP also will continue to serve as the vehicle to improve care and health outcomes for enrollees with chronic conditions. MAOs that have a QIP in progress, now the newly designated CCIP, must continue with their current project.
  - The newly designated QIP must aim to improve health outcomes and/or enrollee satisfaction and address one or more of the CMS Quality Strategy Goals.

  (HMPS memo dated August 18, 2017)

VII. Improving Drug Utilization Controls – Part D Sponsors

- Implement processes and procedures to comply with the drug utilization management (DUM) requirements of 42 C.F.R §423.153 *et seq*. to prevent overutilization of prescribed covered Part D drugs. (CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and http://www.cms.gov/Medicare/Prescription- Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html)
- Implement retrospective drug utilization review criteria to identify enrollees who are at risk of adverse events due to opioids, so that their cases may be subject to further clinical review. (Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information).
- Submit beneficiary-level point of sale (POS) drug edit information for identified opioid overutilizers to MARx. As stated in section A.II, submissions should be completed within seven (7) business days of the date on the beneficiary's written advance notice, the date of the POS edit implementation, termination, or a type of opioid POS edit modifications. (Plan Communications Users Guide, Section 11, Reporting Identified Drug Overutilizers, available on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS- Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html.)
- Ensure your P&T committee develops specifications for your plan to implement either a soft and/or hard formulary-level cumulative morphine equivalent dose (MED) POS safety edit(s) to prospectively prevent opioid overutilization. (Calendar Year (CY) 2017 and 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter).

K. Low Income Subsidy (LIS) and Best Available Evidence (BAE) – Part D Sponsors

I. Low Income Subsidy Benefit Administration – Part D Sponsors, excluding plan sponsors only serving U.S. Territories

- Apply the correct CMS LIS levels to enrollees by immediately applying any updates received via the daily TRR to establish the correct premium, cost sharing, and deductible levels with the correct effective dates for prior, current, and prospective enrollees. (*Medicare Prescription Drug Benefit Manual* Chapter 13, Section 70.1)
- Reimburse LIS eligible beneficiaries, or others, who have paid or are holding receivables on behalf of the beneficiaries, any excess premiums or cost-sharing paid by the beneficiaries, including refunding of cost-sharing amounts that were paid during the period of LIS retroactive coverage. Whenever a sponsor receives information that necessitates a retroactive claims adjustment, the sponsor must process the adjustment and issue refunds or recovery notices within 45 days of the sponsor's receipt of complete information regarding claims adjustment. (*Medicare Prescription Drug Benefit Manual* Chapter 13, Section 70.3.1 and 42 C.F.R. §§ 423.466, 423.800)
- Meet CMS requirements for accepting specific forms of BAE to establish a:
  - More favorable low income copayment status of a full benefit dual eligible beneficiary and beneficiaries who applied to the SSA for the LIS (HPMS memo 08/04/2008 and 10/16/2008), and
  - A beneficiary is institutionalized or enrolled in a home community based waiver program and qualifies for zero cost-sharing.
- Provide beneficiaries access to covered Part D drugs at the reduced cost-sharing level as soon as one of the specific forms of BAE is presented.
- Implement procedures to accept BAE at point-of-sale, update systems within 48-72 hours of receipt of the documentation, and ensure correct charges of premium, deductible, and cost sharing to low-income subsidy beneficiaries. Request manual updates to CMS within 60 days if routine reporting doesn't correct for deemed beneficiaries. (*Medicare Prescription Drug Benefit Manual* Chapter 13, Section 70.5)
- Follow CMS' process for assisting beneficiaries without BAE documentation. Sponsors must develop appropriate member services and pharmacy help desk scripting to identify cases involving a situation in which the BAE policy applies, and to allow callers either to submit BAE, or request assistance with securing BAE, pursuant to CMS requirements. When assisting beneficiaries with securing BAE, Sponsors are required to use the process outlined in HPMS memo dated 2/17/2017.

II. Loss of Low Income Subsidy Data File – Part D Sponsors, excluding plan sponsors only serving U.S. Territories

- Organizations should take action once they receive the Loss of Subsidy Data File (released in December of each year) by setting organization's systems to charge the correct premium, deductible, and copayments as well as send the appropriate notification to affected beneficiaries. The only exception to this requirement is when

the organization confirms a beneficiary is awaiting a Social Security Administration determination on an LIS application and the beneficiary has been granted a grace period by the organization, if applicable. In these situations, organizations should wait until they receive the result of the SSA determination to update their systems.

- Make reasonable attempts to notify affected members to advise them of their retroactive liability for higher premiums and cost sharing when LIS status or eligibility is removed. (*Medicare Prescription Drug Benefit Manual* Chapter 13, 70.3.1)

  (HPMS memos 11/30/2009, 08/12/2014, 09/10/2015, and 07/20/2016)

III. Low Income Subsidy Deeming – Part D Sponsors, excluding only serving U.S. Territories

- Ensure your organization follows the CMS guidance for re-determination of Part D LIS eligibility for 2018. (HPMS memo 7/24/2017)
- Take appropriate actions in response to CMS deeming. (HPMS memo 7/24/2017)
- Ensure procedures are in place to submit corrections to beneficiaries' LIS deemed status to the CMS contractor, Reed & Associates, following the instructions in the *Medicare Prescription Drug Manual*, Chapter 13, Section 70.5.6.

L. Coordination of Benefits (COB) and Automatic True Out-of-Pocket Cost (TrOOP) Balance Transfer

I. Automated TrOOP balance transfer (ATBT) Process –Part D Sponsors

- Ensure that financial information reporting (FIR) processors are contracted to handle transactions for the current as well as all prior years covered under the enhanced ATBT process. (HPMS memo 7/02/2015)
- Update your organization's Business Associate Agreement (BAA) with the Part D Transaction Facilitator to reflect all upcoming contracts per the *Prescription Drug Benefit Manual* Chapter 14.

II. Hospice – Part D Sponsors

- Organizations must implement the beneficiary-level Prior Authorization (PA) requirements for beneficiaries in hospice for the following categories of prescription drugs: analgesics, antinauseants (antiemetics), laxatives, and antianxiety drugs (anxiolytics). The updated FAQ document can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html. (HPMS memo 7/18/2014, 11/15/2016)
- Organizations should utilize the standard PA form to facilitate coordination between Part D sponsors, hospices, and prescribers who serve beneficiaries enrolled in hospice. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Info-PartD.zip (HPMS memo 3/24/2015)

III. End-Stage Renal Disease (ESRD) – Part D Sponsors

- Sponsors should not pay for drugs and biologics that are included in the Medicare Part B bundled payment to an ESRD dialysis facility (as specified in section 1881(b)(14) of

the Social Security Act and in Federal regulations at Part 413). When a sponsor receives a daily TRR showing an ESRD beneficiary is receiving renal dialysis services, the sponsor must have controls in place to comply with this requirement.

- We strongly encourage sponsors to:
  - Place beneficiary-level PA requirements on the four categories of drugs that are always used for ESRD treatment; CMS removed anti-infectives from the always ESRD-related categories of drugs in the 2015 ESRD prospective payment system final rule which appeared in the Federal Register on November 6, 2014. (HPMS memo 5/12/2015)
  - Remove the beneficiary-level PA edits on the seven categories of prescription drugs that may be used for ESRD treatment. Sponsors are not expected to place ESRD PA requirements on these seven categories of drugs or take special measures beyond their normal compliance and utilization review activities. However, if it is determined through routine utilization review or otherwise that a renal dialysis service drug has been inappropriately billed to Part D, the sponsor and the ESRD facility should negotiate repayment. (HPMS memos 5/12/2015 and 11/14/2014)

IV. Drugs Available under Part A or Part B - Medicare Advantage Organizations

Organizations must coordinate all benefits administered by the plan, including drugs for which payment may be available under Part A or Part B. (42 C.F.R. § 422.112(b)(7))

V. Transition Claims Processing – Part D Sponsors

- CMS expects each sponsor to fully test how their transition policy works within its claims adjudication system, including pharmacy notification, in order to ensure that the transition policy has been programmed correctly into systems prior to the start of 2018. (HPMS memo 3/25/2010)
- Implement a transition process for current enrollees who will experience negative changes as a result of revisions to their plan's formulary across contract years (i.e., from CY2017 to CY2018). Sponsors should work aggressively to prospectively transition current enrollees to therapeutically equivalent formulary drugs or work to complete requests for formulary and tiering exceptions to the new CY2018 formulary prior to January 1, 2018. Sponsors may not use the ANOC t to effectuate the transition. (HPMS memos 3/25/2010 and 8/27/2010)
- Ensure a transition supply has been provided by closely monitor enrollees' rejected claims, among other monitoring strategies.

M. Grievances, Initial Coverage/Organzation Decisions, and Appeals

I. Part D Denial Notices – Part D Sponsors

Beginning no later than October 1, 2017, all plans offering Part D must use the revised, OMB-approved standardized Notice of Denial of Medicare Part D Prescription Drug Coverage. The revised notice must be provided to Part D enrollees when a plan issues a fully or partially adverse coverage determination. (HPMS memo 8/02/2017)

II. Staffing Requirements Related to Initial Coverage/Organization Decisions and Appeals– Medicare Advantage Organizations and Part D Sponsors

- Organizations must employ a medical director who is responsible for the clinical accuracy of all initial coverage/organization decisions and appeals that involve medical necessity. The medical director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States, or the District of Columbia. (42 C.F.R. §§ 422.562, 423.562) In addition, organizations must be staffed to satisfy the following requirements:
  - A physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, must review the initial coverage decision if the organization expects to issue a partially or fully adverse decision based on medical necessity (42 C.F.R. §§ 422.562, 423.562, 422.566, and 423.566), and
  - That a physician who was not involved in the initial denial must make the redetermination/reconsideration when the initial decision involved a determination of medical necessity (42 C.F.R. §§ 422.590(h) and 423.590(f)).

III. Appropriateness of Clinical Decision-Making – Medicare Advantage Organizations and Part D Sponsors

Organizations must ensure that clinical and administrative staff and delegated entities involved in processing initial coverage/organization decisions and appeals comply with all CMS and plan coverage rules. Organizations must demonstrate that clinical decision-making involves the consideration of the CMS-approved Explanation of Benefits, drug formulary, appropriate CMS regulations and guidance, required drug compendia, previous claims history, and all submitted clinical information. Organizations also must be able to demonstrate procedures for making and documenting requests for necessary clinical documentation from providers and prescribers when documentation is needed to properly adjudicate coverage/organization decision requests and appeals.

IV. Proper Use of Adjudication Timeframe Extensions – Medicare Advantage Organizations

Under limited circumstances, organizations may extend the adjudication timeframe for organization determinations and reconsiderations. Organizations must comply with the use of extensions per the regulatory requirements at §422.568, §422.572 and §422.590. (February 12, 2015 Federal Register, Vol. 80, p. 7912)

V. Online Appeals Training Courses – Medicare Advantage Organizations and Part D Sponsors

An organization's compliance officer, staff involved with initial coverage/organization decisions, appeals, and grievances, and customer service representatives, should be trained in Part C and Part D processes. CMS provides two optional web-based training (WBT) courses below to supplement in-house training. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html. CMS strongly suggests that compliance officers incorporate these courses into their existing in-house training and use the certificate to track course completion within the organization.

VI. Rights of Medicare C & D Enrollees – Medicare Advantage Organizations and Part D Sponsors

Part D sponsors must ensure that their organization provides immediate access to the coverage/organization determination and redetermination processes via a toll-free telephone number and website and provides access to model forms for making coverage and appeal requests.

N. Compliance and Fraud, Waste, and Abuse (FWA) Compliance Program – Medicare Advantage Organizations and Part D Sponsors

- Organizations must demonstrate that they maintain an effective compliance program which includes measures and internal controls to prevent, detect, and correct program non-compliance and fraud, waste, and abuse. 42 C.F.R. §§422.503 and 423.504. CMS strongly recommends all compliance officers and personnel routinely review and share throughout the organization information from the CMS Compliance and Audit webpage and memorandums from the HPMS. The webpage provides:
  - Useful resources to assist your organization in understanding and implementing compliance program requirements,
  - Materials CMS uses to conduct program audits,
  - Annual Program Audit and Enforcement Reports, and
  - Information pertaining to compliance and enforcement actions. https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part- D-Compliance-and-Audits/index.html.
- Organizations should use discretion when developing the criteria for determining whether an entity is a first tier, downstream, and related entity (FDR) for purposes of the compliance training requirement. Section 40 of the Compliance Program Guidelines, located in Pub. 100-18, Chapter 9 of the *Medicare Prescription Drug Manual* and Chapter 21 of Pub. 100-16, the *Medicare Managed Care Manual* has an enumerated list of factors to consider in determining whether an entity is an FDR. Also, CMS strongly encourages sponsors and FDRs to be reasonable and cooperative in identifying the compliance training vehicle. For additional information related to the compliance training requirement, please see the two HPMS memos issued on June 17, 2015, entitled *Update - Reducing the Burden of the Compliance Program Training Requirements and on February 10, 2016, entitled Additional Guidance – Compliance Program Training Requirements and Audit Process Update.*