Frequently Asked Questions (FAQs)

2018 Audit Conference FAQ Document

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Please note: We received questions other than the ones listed in this document. Many of the questions were out of scope for the session and were not included in the list. If you feel that you still have an outstanding question, please email the appropriate contact.

Session 1 - New Approach to 2019 Audits and Universes
Marie Gutierrez and Doreen Gagliano

Session 1 - New Approach to 2019 Audits and Universes

	Question	Response
1	Why did you create a new universe in CDAG to evaluate processing and classification of requests?	We received questions from the Industry around which universe should include unprocessed cases. This new universe is intended to be a catch-all for such cases. For example, cases that are inactive, or resulting in something other than an approval or denial. It will also include cases that the sponsor deems to be: invalid, unprocessed, dismissed, withdrawn or cancelled.
2	Why did you add a supplemental questionnaire in Formulary Administration?	By collecting this information up front, auditors can provide better instructions to sponsoring organizations during the universe follow-up call. Specifically, these questions direct the data that is to be included in the New Enrollee universe, and other questions are later used to select samples and to better understand plan operations prior to initiating field work.
3	MMP CCQIPE and SARAG protocols were not included in the 2019 draft release and when we contacted the program audit inbox, we were told that the "2019 MMP data request document will not differ much from the 2018 protocols." We strongly encourages CMS to reconsider this strategy. The 2019 ODAG and SNP CCQIPE drafts drastically restructure these protocols, therefore leaving the two MMP protocols as is in 2019 would cause them to significantly differ from their counterparts, increasing the already substantial extra workload these protocols cause for MMP sponsors. It would be ideal to use the same protocols on all contracts, including MMPs, but if that is not possible, MMP protocols should align as closely as possible with other protocols.	Thank you for your comment. Please submit your comment per the instructions in the Federal Register Notice for the proposed Medicare Parts C and D Program Audit and Timeliness Monitoring Data Requests (CMS-10191; OBM control number: 0938-1000) is published at: https://www.govinfo.gov/content/pkg/FR-2018-04-02/pdf/2018-06645.pdf.

Session 1 - New Approach to 2019 Audits and Universes
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	Question	Response
4	Will CMS consider eliminating certain elements from the universe layouts similar to the Part C and Part D Reporting requirements?	It is our intent to redesign our information collection tools to maximize efficiency and reduce burden on the industry. Wherever possible, we simplified data collection by combining record layouts to better reflect plan operations. We also adjusted the scope of the data we were collecting based on past audit experience and to ensure we were only collecting the volume of data necessary to conduct our analyses. We listened to stakeholder feedback and removed data points from our collection that created unnecessary burden for sponsoring organizations. And, we clarified other data points in response to the questions you sent via our Parts C and D Audit mailbox, as well as questions and feedback received from audited sponsors and lessons learned from auditors and other stakeholders.
5	What is the CMS expectation on the length of time recorded calls need to be kept for audit purposes?	CMS record retention requirements for contracted health plans are established by the Medicare Drug and Health Plan Contract Administration Group (MCAG). To confirm record retention requirements, you may send an email to their mailbox at: https://dpap.lmi.org.
6	What is CMS looking for when conducting the Call Log audit? Plans seem to have different interpretations and to the intent and methodology of the audit. Some say it is missed CDAG opportunities, while others say it is more general in nature.	The purpose of the Call Log portion of our audits is to determine if an incoming call was classified correctly and subsequently processed, if it was a request for coverage.

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	Question	Response
7	Please explain how to determine and apply thresholds to all ODAG tables outside of claims when calculating the failure rate within each universe for both timeliness and effectuation. There are timeliness requirements for all tables but only claims provide a threshold (i.e. 95%).	The requirement that a Medicare health plan pay 95% of clean claims within 30 days is found in Manual guidance, Chapter 13, section 40.1. The other timeliness thresholds that you are referring to are internal audit thresholds and not shared with the Industry.
8	In the description section 2018 Program Audit Data Request Part C Organization Determinations, Appeals, and Grievances (ODAG) Table 1, columns ID O and P from the 2018 Audit protocols it states, "If multiple attempts were made to notify the enrollee orally, enter the date of the last good faith attempt within the notification timeframe." Can you provide clarification if CMS expects plans/delegates to execute multiple attempts, to meet the "good faith attempt" requirement? And if so, how many attempts are required?	Your question is outside of the scope of this presentation. Any questions related to examples of Part C policy implementation should be directed to the Part C policy mailbox at: Part_C_Appeals@cms.hhs.gov.
9	Regarding timeliness of standard reconsiderations and grievances, should MCOs treat the date of receipt as day 1 or the next day as day 1? Example if a standard grievance is received on January 1st, is the date of resolution due on 1/30 or 1/31?	Your question is outside of the scope of this presentation. Any questions related to examples of Part C policy implementation should be directed to the Part C policy mailbox at: Part_C_Appeals@cms.hhs.gov.

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	Question	Response
10	For Medicare Advantage plans can we make a determination on an urgent/emergent inpatient admission? For example if a member is admitted through the emergency room into inpatient status, if the member does not meet medical criteria for inpatient status but would meet observation status can we either advise the provider to change the status from inpatient to observation or deny the inpatient admission if provider is not willing to change to observation status?	Your question is outside of the scope of this presentation. Any questions related to examples of Part C policy implementation should be directed to the Part C policy mailbox at: Part_C_Appeals@cms.hhs.gov.
11	Can you please give me a definition and examples of when you would have a withdraw and dismissal for an organization determination	Please refer to Chapter 13 of the Medicare Managed Care Manual for requested definitions. Any questions related to examples of Part C policy implementation should be directed to the Part C policy mailbox at: Part_C_Appeals@cms.hhs.gov.
12	Regarding the 2018 and 2019 Program Audit Protocols Call Logs - does the call log on ODAG require inclusion of calls placed to delegated FDRs who may take calls regarding an authorization or denial letter sent a member due to plan model "Delegated Providers" who are responsible for this part of Utilization Management	Yes, per the 2018 record layout for Part C Call Logs: Include all calls received by your organization (or delegated entity) that relate to your Medicare Part C line of business and are from beneficiaries or their representatives (i.e., calls to your customer service line).

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	Question	Response
13	Can you confirm the exclusions from table 1: Standard and Expedited Pre-service Organization Determinations (OD) Record Layout include pre-service concurrent outpatient services? (Example enrollee is receiving home physical therapy. the plan receives a pre-service request for additional visits). Is this example of a pre-service concurrent reviews to be included in table 1?	Your example appears to be a request for an extension of previously approved services which would be excluded from table 1: Standard and Expedited Pre-service Organization Determinations (OD) Record Layout as it exists as of May 2018. Please note, however, that the Record Layouts (as included in the Data Request documents) are still going through the PRA process and are subject to change until they have been approved by OMB.
14	CMS stated the changes to the audit universes will provide better transparency for sampling. The CDAG draft protocols has less details about which sample cases will be selected than the 2018 Protocols. Where will plans be able to find the sampling methodology?	Please note, for 2019, the Program Audit Protocols are separate from the Data Requests that are currently out for public comment in accordance with the PRA process. The CDAG Data Request document (currently going through the PRA process right now) is limited to data collected for purposes of conducting the audit and is not intended to include sampling methodology. Sampling methodology will be included in each program area Protocol document. Protocol documents are not currently subject to PRA but our intent is to post the protocols to the CMS website by the Fall of 2018. The public will be afforded the opportunity to provide comments at that time. Then, the final version of the documents will be (re-)posted to the CMS website after public comments are processed and considered.
15	Please confirm when the comments are due. There was a conflict between the HPMS e-mail and the supporting statements document.	Comments must be received by June 1, 2018. Please refer to the following Federal Register notice for submission instructions: https://www.govinfo.gov/content/pkg/FR-2018-04-02/pdf/2018-06645.pdf.

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	Question	Response
16	CMS is requiring plans to implement Opioid Drug Management Programs for 1/1/2019. Appeals related to this program are to be processed as Part D Redeterminations. Should these appeals be included in the 2019 CDAG Audit Universe, Table 4: Standard and Expedited Redeterminations? If so, will changes be required for this record layout?	Cases meeting the definition of a Part D appeal must be included in the applicable CDAG universe. Please provide any recommendations for changes to the applicable record layout using the directions listed with the federal register notice: https://www.govinfo.gov/app/details/FR-2018-04-02/2018-06645/context
17	It was mentioned that the Program Audit Process Overview and Protocols would be posted to the CMS website. When does CMS expect these to be posted? Will there be an opportunity for public comment on these documents as well?	Our intent is to post the documents to the CMS website by the Fall of 2018. Although these documents are not subject to the PRA process, the public will be afforded the opportunity to provide comments at that time.
18	Can you give us an estimate as to when we can expect a final version of the 2019 protocol? Will there be a 2nd draft released first?	Our intent is to post the protocols to the CMS website by the Fall of 2018. Although these documents are not subject to the PRA process, the public will be afforded the opportunity to provide comments at that time. Then, the final version of the documents will be (re-)posted to the CMS website after industry comments are processed and considered. Please note, for 2019, the Program Audit Protocols are separate from the Data Requests that are currently out for public comment in accordance with the PRA process.

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	Question	Response
19	In the Draft Audit Protocols Part C ODAG Program Audit Request Table 3 instructions states: Each request must be listed as its own line item in the submitted universe (i.e., if the request includes more than one service, enter each service in a separate row). For clarification are you asking us to include a separate row that represents each claim item even when there is multiple lines on a claim?	If a claim has more than one line item, include all line items from that claim within a single row in the universe.
20	Could CMS release the audit process documents in advance of 2019, preferably in time for this comment period or the second comment period this year? Our organization found that reviewing and commenting on the data collection tools alone gave us an incomplete picture and that the process documents would be helpful for providing feedback to CMS and for preparing in advance for next year.	Our intent is to post the documents to the CMS website by the Fall of 2018. Although these documents are not subject to the PRA process, the public will be afforded the opportunity to provide comments at that time. Please note that the compliance standards as reflected in the current protocols remain unchanged; these same compliance standards may be used as reference and in preparation for next year.
21	Hello, I do not see any changes mentioned to SARAG universe. Will that remain the same in 2019?	The MMP protocols will be redesigned to better align with the Part C and Part D protocols once they are finalized.
22	It was mentioned FA universe will be subject to data integrity review. This is a universe of rejected claims and the data is many a times incorrect and that is why it was rejected. What exactly will CMS be reviewing as part of the data integrity review of this universe?	Data integrity testing in FA will be conducted via webinar with sponsors to ensure universe data has not been filtered. However, the approach has not been finalized as CMS is still piloting this process with a limited number of sponsors in 2018 to better inform the testing process.

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	Question	Response
23	How will the combining of expedited and standard universes impact the size of the data integrity and audit samples?	The number of samples selected for data integrity and for review during the audit will remain the same. But please keep in mind, the data request documents are going through the PRA process and are subject to change until they have been approved by OMB.
24	When does CMS expect the 2019 Program Audit Protocols and Document Requests to be finalized? These redesigns will require significant adjustments to current data extractions. Plans need to develop a timeline to ensure preparedness for any audits taking place in 2019.	Our intent is to post the updated protocol documents to the CMS website by the Fall of 2018. Although these documents are not subject to the PRA process, the public will be afforded an opportunity to provide comments at that time. Then, the final version of the documents will be (re-)posted to the CMS website after industry comments are processed and considered. Please note that the compliance standards as reflected in the current protocols remain unchanged; these same compliance standards may be used as reference and in preparation for next year. Finalization of the Data Requests (that are subject to PRA) is based on OMB-approval.
25	Will the data that will be collected for the 2019 Timeliness Monitoring Project (data collected Q1 2019) be requested in the 2019 data collection formats or the 2018/2017 data collection formats?	Data collected for the 2019 Timeliness Monitoring Project will be requested in the 2018/2017 data collection formats.

Session 1 - New Approach to 2019 Audits and Universes
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	Question	Response
26	Reviewing the CPE Audit Protocols we came upon a questions which we are seeking clarification. We want to know CMS' definition of Activity Completion Date (Column K, I and I of tables 1, 3 and 4, respectively). We would like to know what date should be presented in these columns: • The date the audit field work concluded and conditions identified throughout the audit were communicated - that is when the Final Audit Report is issued by Compliance? Or The date were all of the CAR/ICAR as presented in the Final Audit Report were validated? Which is a much later date depending on the CARR.ICAR. Based on the data universes layout it is our interpretation that the date that we should include is the date that the Final Audit Report. However we are challenging our interpretation and would like further guidance of what date should we populated in these fields. Appreciate your guidance.	Your interpretation is correct. Activity Completion Date is the date audit field work concluded and conditions identified throughout the audit were communicated (which could also be the date the final audit report is issued by compliance based on how your process is designed).
27	Will the new approach start a new audit cycle in 2019?	Yes, 2019 is the start of audit cycle #3.

Session 2 - Enforcement Analysis Process
Ann Levinstim

Session 2 - Enforcement Analysis Process

#	Questions	Response
1	How does CMS determine which beneficiaries to mitigate and which beneficiaries to include an aggravating factor for?	To determine which beneficiaries are mitigated, we look at a number of different factors for various conditions. The easiest one to identify is if a beneficiary has received their medication the same day. However, sponsors have provided us with additional information that has assisted us making determinations on which beneficiaries to mitigate. That is why we are conducting more sponsor outreach. As for the aggravating factor, determining which beneficiaries receive an aggravating factor depends on the type of aggravating factor. For example, for a prior offense it would be all beneficiaries affected by the violation. For the expedited factor, it would be all beneficiaries that had an expedited request. For formulary, the most common aggravating factor is the delay and denial of medications that generally require access to prescription drugs within 24 hours in order to treat acute conditions or maintain the therapeutic treatment of non-acute conditions. This number can change depending on the types of drugs impacted in the IA. We continually review each IA to determine whether a drug is generally considered critical.
2	Do CMPs count against the Star Ratings?	For any CMPs issued starting in 2017, those will not count for Star Ratings purposes. However, Past Performance points are still impacted. The organization receives one Past Performance point for each CMP issued. Those points factor into the ability to apply for a service area expansion.
3	Will CMS be including details about which sponsor's received a CMP on Plan Finder?	As stated in the CY2019 Call Letter, CMS decided not to include a CMP icon on Plan Finder. However, CMS may consider alternate approaches to communicate CMP information to beneficiaries.

Session 2 - Enforcement Analysis Process
Ann Levinstim

#	Questions	Response
4	Long-standing SNP audits have demonstrated sponsor deficiencies that impact very vulnerable beneficiaries, yet there has not been any related enforcement actions so far. Please advise when CMS will include SNP results in enforcement actions.	At this point a determination on timing has not been made but it is something being evaluated.
5	Plans want to be transparent but the result of self-reporting is often enforcement actions that directly affect the Star rating. As previously stated, plans cannot be perfect with everything so we are interested to know, In the calculation of a CMP what is the weight placed on self-reporting by the plan?	When determining whether a CMP is issued, CMS does give some weight to self-reporting by the plan, but more importantly is whether the plan was able to self-identify the issue quickly and remediate the beneficiaries quickly. If an issue was not discovered quickly or not remediated quickly and that resulted in a number of beneficiaries being impacted, there is some risk that self-reporting may result in enforcement or compliance actions. However, CMS may likely discover the issue anyway (through complaints or audits), and self-reporting builds a strong relationship and trust with CMS which is very important for the long term relationship. In addition, enforcement actions no longer impact a plan's Star Ratings starting with actions impose in 2017.
6	Is the $200 penalty per delay per date of fill for a prescription? Or is it per prescription?	CMS imposes a $200 penalty on each enrollee impacted by the failure. Therefore, even if the enrollee had multiple prescriptions denied inappropriately for the same root cause, that enrollee would only be counted once for CMP purposes.

Session 2 - Enforcement Analysis Process
Ann Levinstim

#	Questions	Response
7	Please advise if it is possible for a plan to have no findings or observations on an OFM audit (1/3 Audit) but still receive a CMP? In other words, is there a threshold for imposing a CMP post-OFM Audit? The process for OFM Audit referral for a potential CMP is not clear to plans, so any additional information is welcomed. Thank you,	No, the audits must have a finding or observation in order for DCE to take an enforcement action against the sponsor. However, given that 1/3 financial audits are conducted at a contract/PBP level and not at the parent organization, one contract may show a finding for a particular failure and the other contract may not due to auditor criteria. However, we would consider an enforcement action on both contracts if it shows a systemic failure across all contracts impacted. DCE/OFM developed criteria for the types of findings that would warrant a referral for an enforcement action which was published in an HPMS memo. *See June 28, 2017 HPMS Memo Re: 2017 One-Third Financial Audit Civil Money Penalties.* As last year was the first year that DCE started to receive referrals, we expect that our criteria will start to refine to narrow the scope of referrals.
8	Are these same $$ amounts being applied to PACE programs? What would be the consideration regarding how this could significantly negatively impact the financial viability of a small PO?	The PACE regulations do not support a per enrollee penalty for CMPs. Therefore, CMPs are calculated on a per determination basis. Therefore, one failure can result in a fine up to $37,396. Therefore, fines would not be as significant on PACE organization as a whole.

Session 2 - Enforcement Analysis Process
Ann Levinstim

#	Questions	Response
9	Can you please define violation of a "clear requirement" and "substantial likelihood" of adverse effect?	"Clear requirement" means that there is a regulation or manual guidance that clearly supports the failure. If there is any question as to the interpretation of the regulation or manual guidance, DCE will discuss with SMEs to see if CMS has clearly communicated the interpretation of the requirement. "Substantial Likelihood" of adverse effect, means that there is direct beneficiary effect that is attributable to the failure. For example, a sponsor inappropriately denying claims can have a direct effect on enrollees because providers can bill those enrollees for the denied claims. Therefore, there is a "substantial likelihood" that beneficiaries are adversely impacted. On the other hand, a compliance program failure may very well result in some beneficiary impact, however, the impact is tenuous to the failure and would not be considered the "substantial likelihood" of adverse effect.

Session 3 - Sponsor's Insights Related to Compliance Program Effectiveness Audits
Vernisha Robinson-Savoy
Debbie Aznar, Peg Fry, Pam Wood

Session 3 - Sponsor's Insights Related to Compliance Program Effectiveness Audits

#	Question	Response
1	Which audit activity the do you find most challenging as it relates to a CMS CPE audit?	There are 4 activities that present challenges to sponsoring organizations as it relates to a CMS CPE audit are: Submitting accurate universe submissions to CMS: Working with your FDRs to obtain data or information for audit; Preparing and presenting CPE tracer sample cases; Keeping staff engaged and motivated throughout the CMS audit process
2	How do you track progress of your compliance activities and oversight?	We utilize a compliance tool that allows us to enter things into a system and create dashboards and monitoring reports to track activities.
3	For new plans starting in 2019, when would you expect the first CPE audit, first quarter of 2020 for 2019 program?	We need the sponsor to be a little more specific. Are you referring to the internal annual CPE audit conducted by the sponsor? If so, the sponsor has the discretion to determine when in the calendar year to conduct their CPE audit.
4	Can Debbie say which Compliance tool she used?	The compliance tool that our organization is using is through Armor Medicare Solutions. I've provided their website below for your reference, along with a quick description of some of the functionalities that the software offers. https://www.armormedicaresolutions.com Assignment, tracking and reporting automation for: 1. HPMS memo 2. Audit/Monitoring and Compliance Due Date Calendar 3. Condition/Issue/Risk remediation 4. Marketing material development 5. CPE Universe automation 6. CTM Please feel free to reach out if you need any additional information.

Session 3 - Sponsor's Insights Related to Compliance Program Effectiveness Audits
Vernisha Robinson-Savoy
Debbie Aznar, Peg Fry, Pam Wood

#	Question	Response
5	Why is CMS not taking into account the CMS calendar when scheduling these audits? For example, I would like a plan that will be audited in May, when the staff needs to work on the 2019 Bid.	CMS takes into account many factors when scheduling program audits. However, to fit in the number of audits on schedule each year, it is difficult to avoid all other CMS activities when putting the schedule together. We encourage sponsoring organizations to work with their assigned Auditor-In-Charge whenever conflicts arise once an audit engagement letter is received.
6	Many of you mentioned that you engrain regulatory specialists within the operational departments. How does this work with operational departments that are off-shore?	Organization- specific question. Please refer to Debbie Azar (Health Sun), Pam Wood (Express Scripts) and Peg Fry (Blue Cross Blue Shield of TN)
7	Please provide verification on the intent around the CPE (Compliance Program Effectiveness) Internal Monitoring Record Layouts per the Part C and D CPE Audit Process and Data Request pdf, section "Appendix, Table 4". The CPE Universe, whose purpose is to evaluate the sponsor's performance with adopting and implementing an effective compliance program, implies that the oversight activities populated on the CPE universe is the monitoring being performed by a stand-alone, non-biased party outside of the business operational areas being monitored, like the Compliance Dept. Can we get confirmation of this assumption and clarification that CMS expects such oversight and reporting and not self-auditing results performed by the actual business unit performing the primary/operational function? Thank you	This is a question for Session 1 - New Approach to 2019 Audits and Universes

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests

#	Question	Response
1	We have members call us to express some dissatisfaction with the plan or our benefits, but have indicated they do not want to be contacted further about the grievance. Do we still process as a grievance and send the enrollee a response?	All grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response. In this case, the enrollee is not requesting a written response. The plan must document the specifics of the complaint/grievance, their response to the complaint/grievance and the date and time the grievance was received and resolved. In this case, it should also be noted that the enrollee does not wish to be contacted further about this issue.
2	How should a coverage request that was classified as a grievance be handled?	If the plan misclassifies a coverage request as a grievance and later discovers the error, the plan must notify the enrollee in writing that the issue was misclassified and will be handled as a coverage request.
3	Can CMS please provide best practices to plans in how to address calls or requests regarding Tier Exception for LIS Members?	Does not apply to this session. For questions related to addressing calls or requests regarding Tier Exception for LIS Members, please contact PartD_Appeals@cms.hhs.gov.
4	With the upcoming revision of Chapter 13 and 18, as stated by CMS in the 2017Fall Conference, will CMS consider the distinction between the grievances referred for review and investigation versus the grievances handled in the Call Center? This distinction will help members understand the nature of their complaint and it will also help plans handle these grievances according to their complexity.	No. Grievances that are resolved during a call received in a Call Center are still to be counted and reported the same as grievances that require additional review and investigation.

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests
Angelique Morris and Staci Paige

#	Question	Response
5	I would like you to ask; Scenario: Beneficiary calls in upset. We identify their complaint as a potential grievance. We give them requested information and resolve their concern. We ask them, “Have I resolved your concern?” They respond, “Yes”. Do we still need to offer them a grievance? Do we need to classify and process the call as a grievance?	The member services representative would not have to offer to file a grievance, as it was already resolved. When a grievance is received and resolved during the same call, it would be entered and reported as a grievance.
6	Scenario: A beneficiary calls in upset, and we identify their complaint as a potential grievance. After listening to and addressing their complaint, we ask them if they would like to file a grievance. They say, ‘No.’ Would we still want to process and categorize this as a grievance, or can it be a resolved inquiry?	Given then information you have provided, it sounds as though this was a grievance that was addressed during the call. If a complaint is received and resolved during the same call, it would still be entered and reported as a resolved grievance. If the member services representative hears the complaint but does not resolve the issue and explains the grievance procedures and the enrollee states they do not want to file a grievance, the plan would document the call and note that the enrollee did not want to file a grievance.
7	The concept of "oral good faith attempts" is a very recent clarification on oral notification requirements for Part C Organization Determination Appeals and Grievances. To ensure clear understanding of CMS' expectations, I would like to request a clarifying HPMS memo to assist health plans with establishing procedures that conform to the spirit of the previously circulated guidance.	Thank you for this feedback. We will take this request into consideration.

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests
Angelique Morris and Staci Paige

#	Question	Response
8	**Withdrawn Grievances** Per the 2017 and 2018 Medicare Part D Plan Reporting Requirements Technical Specifications (see attached, p. 38), plans should exclude withdrawn grievances from reporting. We interpret withdrawn grievances as those grievances that the plan is prepared to document and act upon, inclusive of customer service calls, but the beneficiary elects not to file a grievance. Related to this, based on clarification gleaned from the 2017 CMS Fall Conference, we understand that CMS expects plans to document all instances of beneficiary dissatisfaction as a grievance. This includes instances where the plan is prepared to document and act upon the grievance, inclusive of customer service calls, but the beneficiary elects not to file one (see https://www.youtube.com/watch?v=FAL8sYANkCA&feature=youtu.be&t=7314). This scenario would appear to qualify as a withdrawn grievance. We ask CMS to please confirm if our understanding of a withdrawn grievance is correct and if not, to please clarify what constitutes a withdrawn grievance. We want to ensure we document, act upon, and report grievances in alignment with CMS expectations and requirements.	If a plan receives a complaint and the plan is prepared to process it as a grievance, but during the conversation the enrollee states they do not want to file a grievance, this would not be considered a withdrawn grievance. The plan would document the call and note that the enrollee did not want to file a grievance. A grievance would be considered withdrawn in instances where the enrollee files a grievance orally or in writing and the grievance has not been completely resolved but the enrollee contact the plan later and states he/she would like to withdraw the grievance or does not wish to pursue. The plan must clearly document that request and they may count as a withdrawn request.
9	May I get a copy of the answers to the polling questions and scenarios from this session?	Please see responses below (under question 37)

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests
Angelique Morris and Staci Paige

#	Question	Response
10	In your presentation today on a Part C example Stacie made the statement, The member does not have to say or the Customer Service Representative does not have to hear certain phrases for a coverage request to be initiated. Can you expand on that statement? I assume this also applies to appeals and grievances. On Part D, I assume this would apply to tiering exception and formulary exception words not having to be stated.	Thank you. Yes, CMS expects Medicare health plan Customer Service Representatives (CSRs) to handle certain calls as Part C coverage requests even when an individual does not directly request (i.e., specifically state) that he/she wants an "organization determination". The request for a knee replacement in scenario 6 from the presentation is an example ("Can I do that now?"). You are correct; this policy also applies to Medicare Part C appeals and grievances. Likewise, an enrollee has the right to request a Part D coverage determination with a CSR, and is not required to specifically state that they wish to initiate a coverage determination in order to do so. Please submit any future Part D tiering / formulary appeals related inquiries to the Part D appeals mailbox: PartD_Appeals@cms.hhs.gov.
11	This section is extremely helpful, especially considering how frequently misclassification leads to adverse audit findings. Would CMS be willing to publish more of these specific, complex examples with explanations on how plans should think through classification and processing? In addition, would CMS be willing to publish any best practices they've found for how plans handle concurrent processing of CDAG and ODAG case involving multiple issues?	Thank you for this feedback. We will take this request into consideration
12	In Scenario #1 it states "I received a denial notice for services I received on May 10th from a specialist" also it states, ".I don't think I should be responsible for the balance." We understood the scenario being a grievance, but based on the denial notice (which we would assume has appeal rights), wouldn't it also be a payment appeal due to this and the member disputing the balance?	If a member received a denial notice with appeal rights and calls a Medicare plan and disputes the payment due, then the plan should offer assistance to the member with appealing his/her balance due.

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests
Angelique Morris and Staci Paige

#	Question	Response
13	We appreciate all the scenarios you went through. 1) Can you provide the slides with the answers & explanations to the answers to the polling questions? 3) Supplemental benefits: Would a dispute about coverage of supplemental benefits be considered a coverage determination/appeal or would it go through the grievance process? 4) Scenario 2: The daughter is the person calling and there is no AOR on file. Why would this be considered a grievance since we need a signed AOR to proceed with a grievance?	2. If an enrollee is attempting to obtain approval for coverage of a supplemental benefit or has requested a benefit and was denied, this would be a coverage determination or appeal (respectively). Depending upon other facts related to the case, a grievance may also be initiated. 3 & 4. To clarify, the answer to polling question 7 was presuming the sponsoring organization processed the request from an enrollee, not a purported representative without an AOR on file, therefore the request would be valid and the call may be classified. We apologize for any confusion.
14	Can you give an example of a quality of service grievance?	A Medicare health plan may consider a complaint that office staff was rude as a quality of service (customer service) grievance.
15	Questions about copayment disputes: 1. If the enrollee has received a bill for a copayment from a contracted provider, calls the plan to dispute the amount, has paid the copayment, but the plan has no record of receiving a claim from the contracted provider yet, can you confirm the plan should treat this as an appeal? Would these be the same if the provider was non-contracted? 2.4. If the enrollee has received a bill for a copayment from a contracted provider, calls the plan to dispute the amount, and informs the plan the enrollee has not yet paid the copayment, can you confirm the plan should treat this as grievance? Would this be the same if the provider is non-contracted? 3. If the enrollee has received a bill for a copayment from a provider, calls the plan to complaint about the amount and indicates they cannot afford to pay the amount, can you confirm the plan should treat this as a grievance about the benefit design? 4. If the enrollee has paid the appropriate copay/cost share to a contracted provider and the member complains about the contracted provider balance bills the	1. Yes, based on the information provided, CMS expects the plan ultimately could opt to handle this case as an appeal. The plan should contact the provider (contract or non-contract) to obtain necessary documentation to complete processing the appeal. 2. If the enrollee is disputing the amount, this would be an appeal. 3. Yes, this would be a grievance. 4. Both are correct.

#	Question	Response
	member for amounts in addition to the copay/cost share, can you confirm this would be a grievance about the contracted provider's balance billing since there would be no additional member liability beyond the copay/coinsurance? If issue involved a non-contracted provider, the case would be handled as an appeal.	
16	We are seeking clarification for Scenario #2, polling question #7, did the scenario get altered by the presenter so the daughter calling in was the AOR because the scenario in the PowerPoint indicates she is not the AOR? Answer C indicates it is a quality of care grievance, reopening, and inquiry. If the family member is not the AOR and the complaint was not filed by the member or their AOR how can this be categorized as a grievance?	To clarify, the answer to polling question 7 was presuming the sponsoring organization processed the request from an enrollee, not a purported representative without an AOR on file, therefore the request would be valid and the call may be classified. We apologize for any confusion.
17	The speakers indicated if a member asks that a copayment be waived, but does not dispute the amount of a copayment, it is a grievance and not an appeal. So to clarify, if a member pays a copayment and then states that he/she should not be responsible for the copayment, it is a grievance not an appeal? The member is not disputing the amount, but does not feel he/she should have had to pay. Second, if a member receives a service, then gets an EOB and sees that he/she is responsible for a copayment and does not want to pay the copayment, it is a grievance and not an appeal? The member is not disputing the amount, but does not want to pay. Please clarify both scenarios.	For your first scenario, we would need additional information to assist with determining the appropriate classification. The enrollee is not indicating they believe the amount should be paid by the health plan. We encourage the plan to try and obtain additional information from the enrollee regarding why they want the copay waived. For the second scenario, this would be treated as a grievance because the enrollee understands that the copayment is applicable and they are responsible. For additional information, please see Section 20.2 of Chapter 13, which states: “Medicare health plans must subject complaints about co-payments to the appeals process when an enrollee believes that a Medicare health plan has required the enrollee to pay an amount for a health service that should be the Medicare health plan’s responsibility. If an enrollee expresses general dissatisfaction about a co-payment amount, then a Medicare health plan should process the enrollee’s complaint as a grievance.”

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests
Angelique Morris and Staci Paige

#	Question	Response
18	For access issues, it is clear from Chapter 13, Section 30.1.2 and Chapter 18, Section 30.4.2 that if the member is having trouble obtaining a service, item, drug(that may already be approved or does not require prior authorization) the plan should initiate an OD or CD. How should the plan code the resolution if the service, item or drug is already approved or does not require a prior authorization? Should a resolution of approved be used only if the plan is able to schedule the appointment, schedule delivery of the item or take action to allow the drug to process at the pharmacy? If the plan can resolve the issue (get the apt scheduled, delivery of the item or availability of item for pickup, drug to process at pharmacy) at the point of contact on the phone, should an OD/CD be initiated or should the OD/CD be initiated only when the issue cannot be resolved in the initial point of contact? If the plan cannot get the service, item or drug scheduled, available within the OD/CD processing timeframe, would the case resolution be denied even though the service, item, drug is approved or does not require approval?	The manner in which we expect a plan to process and report an enrollee's request depends on the facts and circumstances of the particular case as well as the dialogue between the plan rep and the caller. If the plan can resolve the issue (e.g., schedules an appointment or confirms coverage) – based on the information provided–the plan is making a favorable organization determination at the point of phone contact. NOTE: Plans are required to pay for provide or authorize a service within the timeframes set forth in regulation and manual guidance (42 CFR § § 422.618(a) (1), 422.618(b) (1), 422.618(c), 422.619(a), 422.619(b) and 422.619(c). Also, see: Ch. 13 of the Medicare Managed Care Manual, Sec. 140.) Time of phone contact? Point seems an odd word, is this a common phrase?
19	We have a clarifying question: for polling question #7, did the member file the grievance? Or was the scenario changed to say the member was the AOR? We didn't agree with the filing of a grievance because we thought it was a daughter, who was not the AOR. Thank you!	To clarify, the answer to polling question 7 was presuming the sponsoring organization processed the request from an enrollee, not a purported representative without an AOR on file, therefore the request would be valid and the call may be classified. We apologize for any confusion.

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#	Question	Response
20	We are seeking clarification about Scenario #4, polling question #10 (slide #23) - if a member calls in to inquiry about why a medication was not given because a prior authorization was required, please clarify if a plan is to provide information about the coverage determination process and member rights only, or are they to initiate the coverage determination immediately based off the question?	The plan is to provide information about the coverage determination process and initiate the request.
21	If the member calls and the issue is identified as a potential QOC issue but during the call the member does not want the involved providers contacted and withdraws the grievance in the same call, the case would be classified as a dismissed grievance but due to concerns about tracking QOC issues the plan would still open an internal review of the issues without sending a closure letter to the member. Can you confirm this is the appropriate way to handle?	If the enrollee states they do not want to file a grievance, the plan would document the call and note that the enrollee did not want to file a grievance. The plan may complete an internal review without sending a resolution letter to the enrollee.
22	In the scenarios provided in the presentation today, one of the examples stated the customer service representative should offer to file a grievance for the beneficiary. In the grievance discussion at the conference last year CMS stated that a grievance should be filed anytime a beneficiary expresses dissatisfaction regardless if they wanted the grievance filed or not. Can you please clarify if a grievance should only be submitted if the beneficiary agrees or should plans file a grievance anytime a beneficiary expresses dissatisfaction?	Depending upon the facts and circumstances of the case, when an enrollee expresses dissatisfaction, we generally expect plans to explain the grievance procedures and initiate a grievance.

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#	Question	Response
23	If a BR contacts the plan to initiate a grievance, the plan is in the process of requesting an AOR, and then the BR decides to withdraw the grievance, can the plan withdraw the grievance and use withdrawal as the reason for the dismissal of the grievance instead of dismissing due to no AOR?	There would not be a valid grievance from a purported rep if there is not an AOR on file, so nothing would need to be withdrawn or reported to CMS. The plan may classify based on their own internal tracking processes and requirements.
24	This presentation was very helpful in providing specific examples of the classification requirements. However, I did want to clarify one point that was made during the explanation of scenario #5. It was stated that additional discussion during the course of the call could change the result of the classification. Is this also true if the member initially expresses dissatisfaction but then the CSR resolves the issue during the course of the call? We have always held fast that these calls need to be classified as a grievance but following your explanation, I wonder if this would instead be considered an inquiry. Thank you for your assistance!	If a CSR resolves a grievance during the course of a call, this would still be documented and reported as a grievance. Discussions during the course of a call that could change a classification is largely referring to inquiries that could turn into grievances, coverage requests or appeals.
25	In scenario #3, polling question #9 says that the MSR offered to file a grievance and the answer was that the procedure is correct. This conflicts with the information received during the fall conference last year, when CMS advised that plans should not offer a grievance, but that a grievance should be filed for every complaint from a member. Please clarify.	Depending upon the facts and circumstances of the case, when an enrollee expresses dissatisfaction, we generally expect plans to explain the grievance procedures and initiate a grievance.

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#	Question	Response
26	Scenario 6: When the member is requesting the knee replacement, the rep may can initiate the OD but may also suggest the member speak with the treating provider about other options. If that suggestion is made and the member indicates yes, she would do that, can you confirm no OD would be required. If the member indicates yes, should would do that but still wants to initiate the request for a knee replacement, the plan should initiated the OD.	As was done in the scenario, we would encourage the plan suggest the enrollee talk with their doctor about the specific procedure in addition to initiating the organization determination.
27	Can you provide additional information on how scenario 2 polling question 7 determines the request to look into the extra day of billing as a reopening? Is the classification of a reopening in reference to claims reporting or appeals and grievance?	New information provided that was not known at the time of the initial decision that may change the final determination may be considered good cause for reopening (see section 130.3 of Chapter 13). Also, please remember the final classification is dependent upon all of the facts and circumstances of each case. Can you please clarify your second question and send Part_C_Appeals@cms.hhs.gov.
28	Scenario 2: Since there is a quality of care grievance but also a request to waive the copayment, would the request to waive the copay be considered part of the QOC grievance or would it be considered a separate grievance?	This could be part of the quality of care grievance, since the reason for the request is based on the belief that inadequate care was provided, however, if a sponsoring organization initiates a separate grievance in addition to a QOC grievance, this would be acceptable as well.
29	Does CMS have any plans for updating chapter 13 and 18 and would the agency consider including these types of scenarios.	We are currently in the process of updating chapters 13 and 18 and will let the industry know of any planned release.

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#	Question	Response
30	For scenario 1, if the BR contacts the plan to initiate the grievance but is not with the member and wants the rep to contact the member (BR is at work, member is at home). Can the plan call the member and if contact is made get the member's permission to initiate the grievance and continue with the BR? If not member contact is made an AOR would be needed and an AOR would be needed if the BR wants a written response. Also, would the member need to be called back for the plan to communicate the resolution since the member is not physically with the BR?	The plan may document the call and contact the enrollee to notify them an AOR is needed. The plan can suggest the purported rep have the enrollee make the request in addition to sending an AOR.
31	This session was great, but I missed some of the answers. Will someone provide answers to each of the scenarios?	Please see responses below (under question 37)
32	When is Chapter 13 going to be updated?	We are currently in the process of updating chapters 13 and 18 and will let the industry know of any planned release.
33	Are you saying that scenario 1 is not an appeal because the member appears to be disputing the balance of the bill solely on the basis of the receptionist's attitude? If the member disputed the balance because she thought she should only be responsible for the co-pay, would that be an appeal?	Correct, it is not an appeal because she believes the co-pay should be waived because of how her mother was treated. She believes the amount is appropriate and if she did not have a negative experience, may not have requested the sponsoring organization waive the co-pay. For your second question, yes, that would be considered an appeal because she does not believe there should be any additional cost sharing outside of the co-payment amount.

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#	Question	Response
34	Clarification for scenario #2: In situations where a purported representative calls in but we do not have any record of a valid AOR - do we have to open the grievance and work to get a valid AOR? Would it be appropriate to open as a grievance and file an extension if needed to get a valid AOR before dismissing?	No, a grievance does not have to be initiated. Plans may begin working on the grievance but cannot send out any correspondence until an AOR is received or the enrollee makes the request.
35	If the member is upset that a provider would not prescribe a certain medication. The provider will not prescribe that specific medication. Is this a grievance and a coverage determination? If it is a coverage determination, how can it be favorable? The plan cannot force the provider to prescribe a certain medication. NOTE: This is often a case with pain medication.	If an enrollee contacts the plan sponsor to express dissatisfaction because a prescriber has made a clinical decision to not prescribe a drug, the plan would process the complaint as a grievance. A Part D plan cannot compel a prescriber to write a prescription for a drug that the prescriber does not believe is medically necessary for the enrollee. In the case of an MA-PD where there is a contractual relationship between the plan sponsor and the prescriber, the sponsor could assist the enrollee in finding another prescriber, if necessary, but whether a particular prescription is written for the enrollee is subject to the clinical judgment of the prescriber.
36	This question is related to a non-contracted provider's payment reconsideration request. If a non-contracted provider states to the sponsor verbally that they will not be providing the waiver of liability nor submitting a written withdrawal, is the sponsor able to dismiss the appeal at the time they have been verbally notified or do they have to wait the full duration of the payment reconsideration timeframe?	For dismissals involving appeals due to lack of Appointment of Representative Forms and/or Waiver of Liability Statements; or any of the reasons cited in the HPMS memo dated September 10, 2013, the plan must wait until the expiration of the applicable time frame before dismissing the case.

Session 4 - A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests
Angelique Morris and Staci Paige

#	Question	Response
37	We found the polling questions and answers and explanation of the answers very helpful. Will this information be available to plans?	**CMS Scenario Responses:** **Scenario 1** - Polling Question 1: B (see Chapter 13, Section 20.2 regarding co—payments) Polling Question 2: C - (see Chapter 13, Section 30.1.1) Polling Question 3: A (see Chapter 13, Section 20.2 regarding complaints concerning the quality of medical care received) Polling Question 4: D - (see Chapter 13, Section 20.2) **Scenario 2** - Polling Question 5: B - (see Chapter 13, Section 10.4.1) Polling Question 6: A - (see Chapter 13, Section 10.4) Polling Question 7: C - (see Chapter 13, Sections 10.1 (definition of inquiry), 20.2, 130.2, 130.3) **Scenario 3** - Polling Question 8: B - (see Chapter 13, Section 90.5) Polling Question 9: A - (see Chapter 13, Section 20.3) **Scenario 4** - Polling Question 10: B - (see Chapter 18, section 30) Polling Question 11: B - (see Chapter 18, Section 10.2, 42 CFR §423.568(a)) **Scenario 5** - Polling Question 12: A - (see Chapter 13, Section 10.1, definition of “Inquiry”) Polling Question 13: A - (see Chapter 13, Section 20.2) **Scenario 6** - Polling Question 14: B - (see Chapter 13, Section 20.2) Polling Question 15: C - (see Chapter 13, Section 20.2)

Session 5 - Independent Validation Audits

#	Question	Response
1	I understand that the threshold for determining when a sponsoring organization is required to hire an independent auditing firm has been adjusted. CPE conditions are now excluded from the threshold calculation. Does this mean that correction of any CPE conditions detected during a program audit will no longer undergo validation?	No. Although we intend to exclude CPE conditions from the threshold calculation used in determining whether a sponsoring organization would be required to hire an independent auditing firm, the requirement to validate correction of CPE conditions would not be eliminated. Organizations that meets or exceeds the threshold, thus requiring an independent audit, will undergo validation of all conditions, including CPE conditions by the independent auditor. Organizations that have audit results that fall below the threshold, will undergo validation of all conditions, including CPE by CMS.
2	The timeframe for completing a validation audit has been extended from 150 days to 180 days. Are there any instances in which CMS would grant extensions beyond 180 days?	Yes. Before a validation audit begins, the causes of the program audit findings must be addressed and corrected and there must be a sufficient clean period from which to validate corrections. If the sponsoring organization needs additional time to ensure that corrections have been fully implemented, the organization should submit a written request for an extensions to their CMS validation lead. CMS will continue to consider these requests on a case-by-case basis.

Session 5 - Independent Validation Audits
Brenda Hudson

#	Question	Response
3	What level of details is expected by CMS in the IVA report?	Currently, CMS looks for certain key elements to be included in the validation audit report (e.g., identification of each condition that was included in the program audit report; the outcome of transactions or sample cases tested for each condition; description of the criteria, cause and effect of any non-compliance; and any new issues of noncompliance that were not identified in the program audit report. You may refer to a CMS program audit report for a general idea of the level of detail CMS is looking for. CMS may request further clarification, supporting documentation, etc. if there are any questions about the outcome of the validation audit. The draft IVA work plan that is included in the 2019 PRA package currently open for public comment, would require the submission of the independent auditor's validation report template. The template would be reviewed and approved at the time the work plan is reviewed and approved. However, that template and any requirements connected to it have not yet been implemented as they are subject to public comment and OMB approval under the PRA process.

Session 6 - 2017 Program Audit & Enforcement Report

#	Question	Response
1	Are you going to start a new audit cycle in 2019 or continue another year in cycle 2?	We are going to start a new audit cycle next year.
2	You said earlier that ICARs are rarely if ever cited in CPE and SNP-MOC – why is this?	ICARs typically involve access to care, and the types of non-compliance we see in CPE and SNP-MOC pertain to issues other than access to care. We published a memo at the end of 2015 that modified how we define observations, CARs and ICARs. Our definitions for the different finding types haven't changed since then.
3	Page 4 of the report mentions the new common condition of "Sponsor failed to reimburse enrollees within 60 days of making favorable reimbursement reconsiderations." We assume this means within 60 days of getting the original member request (as it states in the manual), not that one has 60 days to pay after making the favorable decision?	The condition was cited for failure to make a payment for a favorable reconsideration no later than 60 calendar days from the date of the standard reconsideration request, as outlined in Section 70.7.3 of Chapter 13 of the Medicare Managed Care Manual.
4	What enforcement actions require that beneficiaries receive information about these actions taken concerning their plans? In these instances, is the plan or CMS responsible for notifying beneficiaries?	CMS requires plans that are placed on an intermediate marketing and enrollment sanction and/or terminated to notify current and potential enrollees of the sanction and/or termination. The plan is responsible for notifying current and potential enrollees of the sanction and/or termination. CMS does provide template language that the Sponsor should use in its notification and approves the language before it is disseminated. In addition, CMS posts all enforcement action notices for public access on our enforcement website, located at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html. CMS also notifies beneficiaries about sanctioned plan sponsors on Medicare Plan Finder through the use of a sanction icon. As indicated in the 2019 call letter, CMS is currently exploring additional ways of displaying an icon or other type of notice on Medicare Plan Finder for organizations that received a CMP from CMS.

Session 6 - 2017 Program Audit & Enforcement Report
Greg McDonald and Allison Conaway

#	Question	Response
5	I have 2 claims that were paid/ finalized in our claims payment system on April 3, 2018. The provider for claim 1 has selected to receive checks and EOB via the mail. On claim 2 the provider has selected to receive checks/registries via EFT. Both claims were sent to a 3rd party vendor for printing and distribution to the provider on April 4, 2018. The provider that selected to receive their checks/EOB via the mail and his check and EOB were sent to him on April 6, 2018. The provider that selected EFT, their payment and remittance advice was sent electronically on April 5, 2018. In this scenario which date should a sponsor use to select the paid claims? The date the claim was paid in the system or the date the check/EOB or EFT was sent to the provider?	Please direct your inquiry to our audit mailbox at part_c_part_d_audit@cms.hhs.gov.
6	Thanks again for holding this conference. How can attendees get copies of the power slides for this and other sessions?	You may access the slides from the presentation at https://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives.html.

Session 7 - PACE Updates

#	Question	Response
1	What is the expected timeframe to receive the PACE Draft audit report, it seemed to vary significantly in 2017?	We are centralizing the review and generation of the draft and final PACE audit reports with the goal of releasing the draft report within 60 days of the exit conference.
2	Why is the account manager no longer a part of the PACE audit team?	While the Account Manager's interaction with the PACE plan is highly valued, to ensure there is no conflict of interest and to ensure more consistency across audits, the Account Manager will not be on the audit team, but will monitor the implementation of corrective action plans.
3	To confirm, there are no changes anticipated to the universe record layouts. Also, will CMS be making any changes to the Audit Process and Data Request guide based on the information shared today related to the 2018 changes? Can more details be shared about the desk review portion of the audit?	We do not anticipate any changes to the record layouts or any other portion of the Audit Process and Data Request document prior to 2020. This collection tool goes through the Paperwork Reduction Act process and therefore will be posted for public comments prior to CMS implementing any changes to the data collection tools.