Best Practices & Annual Report

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Overview

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  - Cross-Year Results
  - Why IDS Conditions?
  - Audit Results by Audit Timing
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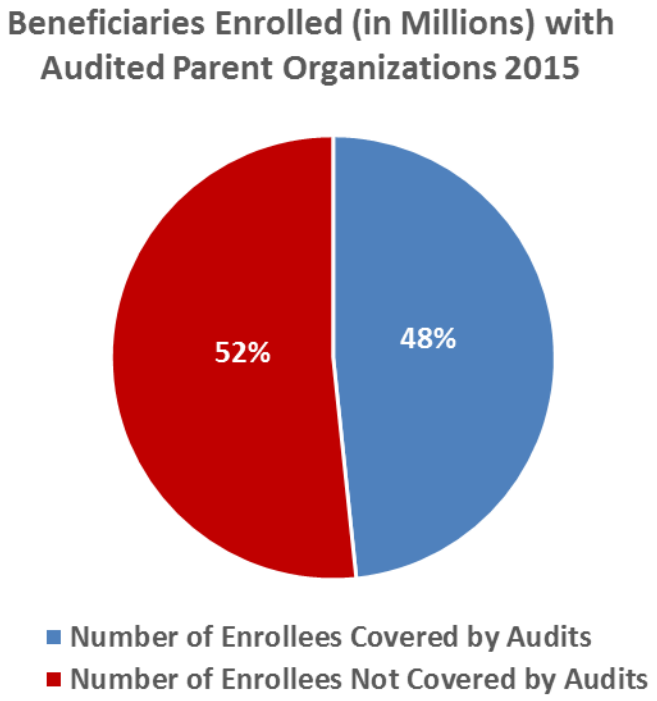
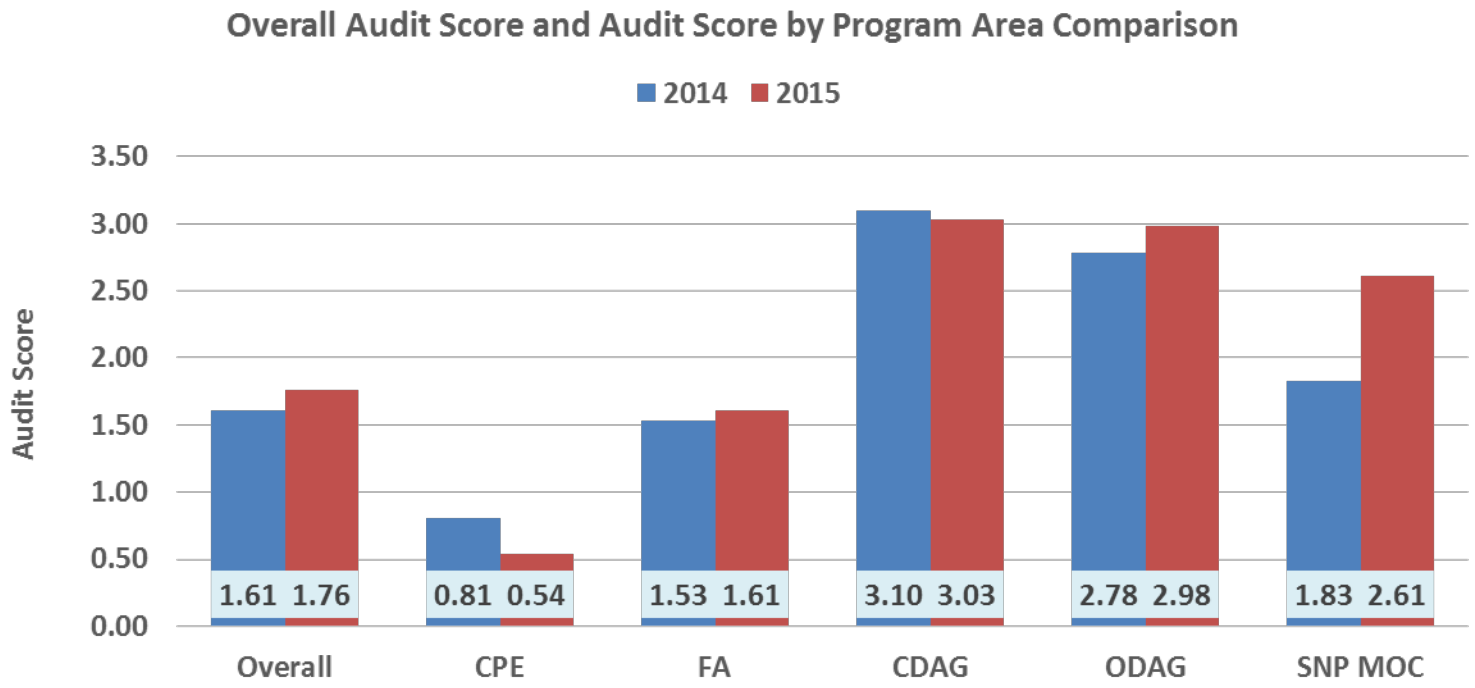
  - 2015 Most Common Conditions
  - Enforcement Actions
- Job Aids

Audit Landscape

- CMS began a new audit cycle in 2015.
- Just under 50% of Medicare beneficiaries were covered by 2015 audits.



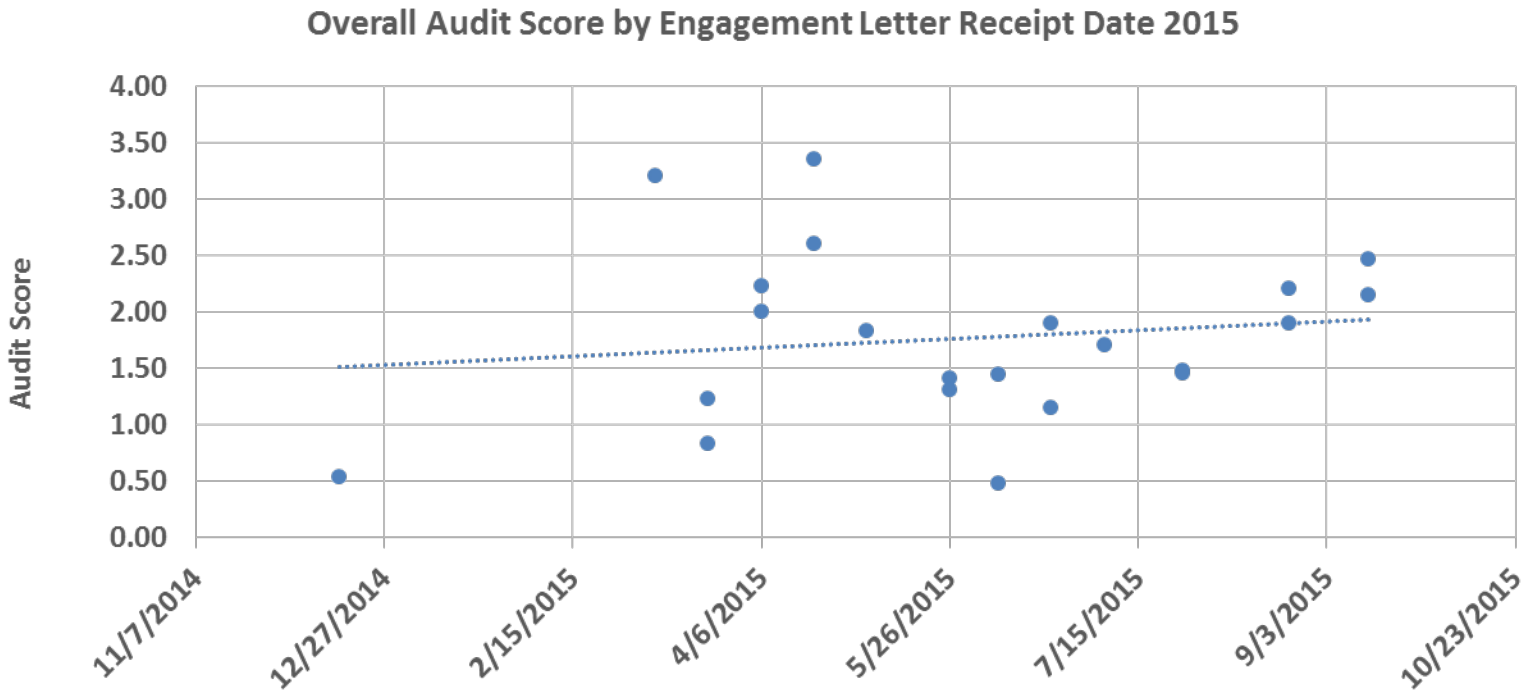
Cross-Year Results



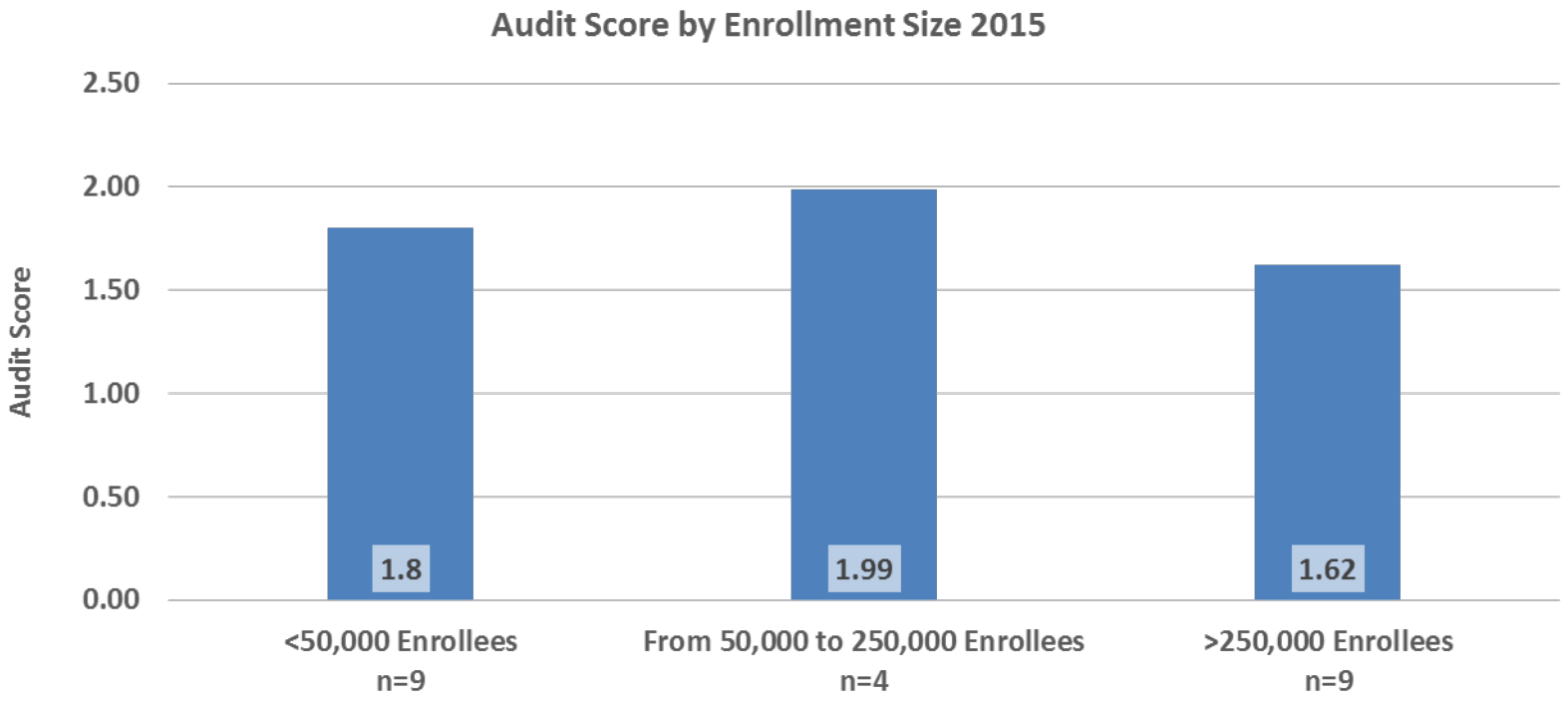
Why IDS Conditions?

- CMS chose to cite conditions for inaccurate universes for the following reasons:
  - To keep the audit process on track, time-wise
  - To hold parent organizations accountable for being able to effectively maintain and consolidate data for cases processed both in-house and by delegated entities

Audit Results by Audit Timing



Audit Results by Enrollment Size



Overview Revisited

- Annual Report
  - Audit Landscape ✓
  - Cross-Year Results ✓
  - Audit Results by Timing of Audit ✓
  - Audit Results by Enrollment Size ✓
  - 2015 Most Common Conditions
  - Enforcement Actions
- Job Aids

CPE Most Common Conditions 2015

Condition Language	Citation Frequency 2011-Present	Percent of POs Affected 2015
Sponsor did not have an effective system to monitor first tier, downstream related entities' (FDRs') compliance with Medicare program requirements.	3 out of 6	36.3%
Sponsor did not provide evidence that general compliance information was communicated to its first tier, downstream related entities (FDRs).	2 out of 6	27.2%
Sponsor did not have procedures to ensure that its first tier, downstream related entities (FDRs) are not excluded from participation in federal health care programs.	1 out of 6	27.2%
Sponsor's compliance officer or his/her designee does not provide updates on results of monitoring, auditing, and compliance failures (i.e., Notices of Noncompliance to formal enforcement actions) to: •compliance committee, •senior executive/CEO, •senior leadership, and •governing body.	3 out of 6	27.2%
Sponsor did not establish and implement a formal risk assessment and an effective system for routine monitoring and auditing of identified compliance risks.	3 out of 6	27.2%

FA Most Common Conditions 2015

Condition Language	Citation Frequency 2011-Present	Percent of POs Affected 2015
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.	6 out of 6	63.6%
Sponsor failed to properly administer the CMS transition policy.	6 out of 6	40.9%
Sponsor improperly effectuated prior authorizations or exception requests.	6 out of 6	40.9%
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved prior authorization edits.	3 out of 6	36.3%
Sponsor failed to properly post its CMS-approved formulary on its website.	1 out of 6	36.3%

CDAG Most Common Conditions 2015

Condition Language	Citation Frequency 2011-Present	Percent of POs Affected 2015
Denial letters did not include adequate rationales, contained incorrect/incomplete information specific to denials, or were written in a manner not easily understandable to enrollees.*	6 out of 6	68.1%
Sponsor did not appropriately auto-forward coverage determinations and/or redeterminations (standard and/or expedited) to the Independent Review Entity (IRE) for review and disposition within the CMS required timeframe.	4 out of 6	63.6%
Sponsor did not demonstrate sufficient outreach to prescribers or beneficiaries to obtain additional information necessary to make appropriate clinical decisions.*	6 out of 6	45.4%
Sponsor did not notify beneficiaries or their prescribers, as appropriate, of its decisions within 72 hours of receipt of expedited redetermination requests.	1 out of 6	45.4%
Sponsor misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries.*	5 out of 6	31.8%

Asterisks indicate that a given condition was addressed by the job aids released via HPMS in April 2016.

ODAG Most Common Conditions 2015

Condition Language	Citation Frequency 2011-Present	Percent of POs Affected 2015
Sponsor did not notify enrollees and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited organization determination requests.	4 out of 6	57.9%
Denial letters did not include adequate rationales, contained incorrect/incomplete information specific to denials or were written in a manner not easily understandable to enrollees.*	5 out of 6	52.6%
Sponsor inappropriately denied services to beneficiaries and/or payments to providers for services rendered to beneficiaries.	2 out of 6	47.3%
Sponsor did not notify enrollees, and providers when appropriate, of its determinations within 72 hours of receipt of expedited reconsideration requests.	2 out of 6	36.8%
Sponsor did not demonstrate sufficient outreach to providers or to enrollees to obtain additional information necessary to make appropriate clinical decisions.*	5 out of 6	31.6%

Asterisks indicate that a given condition was addressed by the job aids released via HPMS in April 2016.

SNP MOC Most Common Conditions 2015

Condition Language	Citation Frequency 2011-Present	Percent of POs Affected 2015
Sponsor did not administer comprehensive annual reassessments within 12 months of the last annual health risk assessments (HRAs).	2 out of 6	66.7%
Sponsor did not provide evidence that it developed individualized care plans (ICPs) for beneficiaries.	3 out of 6	58.3%
Sponsor did not review and/or revise individualized care plans (ICPs) consistent with its model of care (MOC) or as warranted by changes in the health status or care transitions of beneficiaries.	1 out of 6	50%
Sponsor administered initial health risk assessments (HRAs) to beneficiaries more than 90 days after their enrollment.	2 out of 6	50%
Individualized care plans (ICPs) do not address issues identified in health risk assessments (HRAs).	2 out of 6	41.7%

Enforcement Actions

- The Division of Compliance Enforcement (DCE) within MOEG took a number of enforcement actions related to 2014 and 2015 audits, as well as other instances of non-compliance discovered outside of program audits.
  - These enforcement actions included 5 intermediate sanctions and 20 CMPs totaling $10.25 million.
    - The single largest CMP was $3.1 million, and the smallest was $30,000.
    - These CMPs were issued for 83 compliance violations:
      - 12 were issued on a per-determination basis.
      - 71 were issued on a per-enrollee basis.

Job Aids

- On April 20, 2016, MOEG and the Medicare Enrollment and Appeals Group (MEAG) released a set of job aids via HPMS aimed at addressing some of the most common CDAG and ODAG conditions found on audits.
- These were published in lieu of the Common Findings and Best Practices Memo released every year from 2011-2014 and seek to:
  - Highlight some of the most common deficiencies in these two program areas;
  - Clarify existing guidance relevant to these two program areas;
  - Help organizations operationalize this guidance by giving simple, step-by-step instructions on how to correctly identify and process coverage/organization determination requests, grievances, and inquiries from beginning to end.

Questions?

Please send any remaining questions relevant to the Annual Report or Job Aids to:

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