DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

Date: September 10, 2012

To: All Medicare Advantage Organizations and Prescription Drug Plan Sponsors

From: Gerard Mulcahy, Acting Director
Program Compliance and Oversight Group

Subject: Best Practices and Common Findings from 2012 Program Audits

In the course of conducting audits and best practices reviews, the Centers for Medicare & Medicaid Services (CMS) has had the opportunity to observe and learn from Medicare Advantage (MA) organizations and Part D sponsors demonstrating excellent operations and achieving strong results. In other instances, we have identified program areas where numerous sponsors are non-compliant with Medicare rules. This memo seeks to share with all MA and Part D sponsors the best practices and lessons learned through the course of conducting audits and best practice reviews during the first half of 2012.

As part of our process to improve oversight in 2012, CMS conducted best practices reviews of key operational areas at all six of the 5-star MA-PD Sponsors. CMS rates MA plans on a scale of one to five stars, with five stars representing the highest quality plans. Five-star plans are those that have demonstrated excellent performance based on the rating methodology used. These best practices reviews aimed to accomplish several key objectives:

- Reviewing high performers to identify best practices to share with other sponsors to drive improvements in performance and better outcomes across the industry.
- Understanding the structure and outcomes of high performing plans to establish reasonable benchmarks for overall industry performance.
- Testing and fine tuning CMS oversight tools in an environment of expected compliance.
- Utilizing the results of these reviews to demonstrate that there is a correlation between a high star rating and high performance in areas deemed to be important to ensuring beneficiary access to services.

In addition, CMS conducted an analysis of results stemming from program audits to identify findings that are common amongst sponsors.

Our audits reviewed Part D formulary administration; Part D coverage determinations and appeals, and grievances; Part C and D agent and broker oversight; Part C organization determinations and appeals, and grievances; Part C access to care; Part C and D enrollment and disenrollment; the Part D late enrollment penalty (LEP); and Part C and D compliance program effectiveness. Attachment A shares best practices and common pitfalls for each of these areas. We hope that sharing these common findings will help all sponsors to focus their internal

monitoring efforts and help ensure these common findings are corrected. Sponsors that implement the best practices can expect to achieve even greater success.

Attachment A: Best Practices and Common Findings from CMS Reviews and Audits, January – July 2012

PRESCRIPTION DRUG FORMULARY ADMINISTRATION

Best Practices

1. **E-prescribing**
   Electronic medical records (EMRs) are used to streamline the flow of clinical information, enabling beneficiaries to leave the pharmacy with the appropriate medications more frequently. EMR systems increase the availability of clinical information to prescribers, pharmacists, and those making coverage decisions, resulting in real time informed decisions on providing the appropriate covered drug. Some features noted in sponsors' EMR systems include:
   - A clear transfer of necessary information at the time of prescribing, including (1) presenting the doctor with a listing of plan approved (formulary) medications and dosing regimens that are covered under the approved benefit, (2) identifying the specific medications or regimens that require prior authorization or coverage determination, and (3) providing the doctor with the processes and criteria necessary to request an exception to a drug not approved (non formulary) by the plan.
   - Educational messaging to prescribers describing preferred medication options offered by the plan, and the best overall value for members. This messaging reduces the need for communication between pharmacists and physicians at the point of service, which helps the beneficiary leave the pharmacy with the appropriate medications more frequently.
   - Pharmacist involvement in the programming and use of the EMR system when reviewing cases, which increases communication among a beneficiary's team of health care professionals.

2. **Transitioning new and existing members**
   Maintaining the same transition process for new and existing members was found to ease administration, as all beneficiaries are treated as newly enrolled for the purposes of meeting CMS transition requirements. Since it is not always possible to determine if a beneficiary has previously received a particular medication (due to circumstances such as physician samples and incomplete on-line records), providing new beneficiaries with the protections of the transition policy allows them to receive a transition fill and the information necessary to request an exception for future dispensing. Some features noted in effective transition programs include:
   - Identifying the presence of existing medications by looking back across the multiple strengths and dose forms of the medication to account for any dosing adjustments.
   - Utilizing a look-back period that is long enough to identify the presence of prescriptions that were obtained for an extended day supply, through providers such as mail service pharmacies.

3. **Updating prior authorizations (PAs) efficiently**
   The updating process of PAs on file is conducted in such a way that the PA can be extended into the next plan year without disruption to the beneficiary. Some features noted in sponsors' process include:
   - Generating a report of all prior authorizations in the system that are set to expire at the end of the plan year to determine if notification letters should be sent to the prescriber to request extending the duration.
   - Sending out a renewal letter along with an updated PA form to the prescriber prior to the end of the year via the pharmacy benefit manager (PBM).

4. **Effective communication across all levels**
   Communication occurs primarily among four parties: the beneficiary, sponsor, pharmacy, and PBM. Effective communication and coordination among these parties results in proper adjudication and administration of the CMS approved formulary. Some features noted in sponsors' communications processes include:
   - Routine review of rejected claim reports by the sponsor and PBM, followed by time to discuss with each other any unexpected findings and communicate any necessary corrections to the benefit configuration.
   - Directing calls placed to customer service regarding medications to the pharmacy department. This results in medication questions being answered by staff that have experience with pharmacy claims and are knowledgeable in pharmacy benefit matters (e.g. clinical pharmacists or certified pharmacy technicians), rather than generalist customer service representatives (CSRs).

5. **Formulary inclusion and alterations**
   Effective management of the CMS-approved formulary allows for timely beneficiary access to clinically appropriate medications. Sponsors often discovered that ensuring formulary edits were effectively tested prior to implementation, through the use of comprehensive quality assurance protocols, enabled them to implement the formulary with fewer errors occurring at the point of service, and reduced the need for alterations and changes. Another feature noted in sponsors' formulary protocols includes attempts to maintain formulary consistency for beneficiaries across years and during the year, which ensures that beneficiaries have continued access to their medications.

Common Findings

In the area of Formulary Administration, sponsors must ensure that beneficiaries receive the Part D drugs they are entitled to consistent with CMS guidance. Several sponsors were unable to properly administer the CMS approved formulary and comply with transition requirements. CMS observed the following findings:

1. **Unapproved system edits**
   Sponsors utilized unapproved or inappropriate point-of-sale system edits, including:
   - Unapproved quantity limits.
   - Unapproved prior authorization edits.
   - Inappropriate maximum cost edits that were not established based upon usual and customary pricing for products at standard dosing regimens.

2. **Transition fills**
   New and continuing enrollees were denied transition fills for non-formulary drugs, protected class drugs, and drugs subject to utilization management restrictions during their transition period. The following examples are transition errors observed during the audits:
   - Failure to provide a required transition supply of formulary medications to beneficiaries during their transition period.
   - Failure to pay an eligible transition claim due to the utilization of incorrect transition logic.
   - Failure to properly administer the CMS-approved formulary by incorrectly applying edits. For example, one sponsor programmed its system to look for a prior fill of the same National Drug Code (NDC), as opposed to a broader Generic Product Identifier (GPI) level, resulting in inappropriate rejections of transition eligible fills.

PART D COVERAGE DETERMINATIONS, APPEALS, AND GRIEVANCES

Best Practices

1. **Timeliness**
   Sponsors ensured timeliness in their decision making by tracking and overseeing their coverage determinations, appeals, and grievances. Additionally, by providing notification to pharmacies of coverage determination decisions and appeal decisions within an hour of a decision, sponsors enable pharmacies to dispense drugs accurately and timely. Some features noted include:
   - Automated system notifications to remind sponsors when a decision on a coverage determination or redetermination must be made to ensure sponsors remain engaged in outreach and conscientious of deadlines.
   - Placing an Interactive Voice Response (IVR) message phone call to inform beneficiaries of the decision of their pending coverage determination or appeal. This system is a unique best practice due to the fact that a call is made for every decision for every beneficiary and not just the expedited and/or protected class drug coverage determinations and appeals.
   - Providing a standardized form for network prescribers to use when prescribing drugs that could be paid by either Part B or Part D. This form, which is available for each of the drugs on the formulary requiring prior authorization to determine payment under Part B or Part D, includes all of the guidelines for when a drug is typically covered under Part B vs. D. Using this form provides pharmacies with

necessary information used to immediately assess which benefit the drug should be processed under, expediting the approval process and allowing beneficiaries to have access to these medications almost immediately.

- Pharmacy department management performing a retrospective review of all coverage approvals to ensure authorization in the claims processing system is entered timely and appropriately. This ensures that any and all issues are mitigated before a beneficiary receives an inappropriate rejection at the point of sale, and also provides coaching opportunities for the sponsor's staff.
- Continuing education of staff to identify problems concerning coverage determinations, and enabling them to immediately update errors in authorization rather than routing them to other departments.

2. **Complete/Detailed Documentation**

   The ability to provide complete and detailed documentation allows the sponsoring organization to act swiftly in documenting and resolving all cases. Documents and cases are researched, categorized, and documented from start to finish. Some features noted in sponsors' documentation policies include:

   - Utilizing a detailed and clear letter to beneficiaries that includes a complete case history along with the dates of any verbal correspondence and an outline of the issue and the grievance resolution process. This practice provides the beneficiary with a more in depth account of the proceedings of the case's resolution process.
   - Utilizing a cross-functional, internal database that is fully integrated with other internal systems to allow the sponsor's staff to document, track, and trend all coverage decisions, appeals, and grievance cases. This gives personnel across all departments immediate access to all necessary information, including a beneficiary's medical history, to quickly and efficiently process coverage determination and appeal requests, and grievance cases, which in turn allows beneficiaries to receive a decision quickly.
   - Providing operational departments with a detailed trending report that identifies issues discovered in the grievance department. Each of the respective departments is responsible for investigating the root cause and mitigating the systemic issue(s) that are likely to recur. This process has been shown to mitigate potential issues with beneficiary access before additional beneficiaries are negatively impacted.

3. **Effective Communication**

   Effective communication and coordination among all parties associated with a sponsoring organization reduces the number of coverage determinations, appeals, and grievances by coordinating a more complete and efficient response to beneficiaries. Members are able to contact prescribers, pharmacies, and the sponsors without complication. Prescribers are able to communicate with ease amongst beneficiaries and pharmacies. Some features noted in sponsors' communication policies include:

   - Identifying and taking responsibility, with an apology, for the causes of the grievances at hand. The CMS model grievance response does not require the plan to verbally take responsibility for the grievance cause, whereas this best practice illustrates the plan's true responsibility to the beneficiary.

- Repeated attempts to contact prescribers through both phone calls and faxes when requesting additional information. Tracking of outreach attempts and documentation of results allow sponsors to better assess their outreach efforts and success rates.
- Utilizing a "5 point of contact" method for requesting information for coverage determinations and appeals. This method includes sending letters to the prescriber (1) and patient (2), as well as making phone calls to the patient (3), prescriber (4) and pharmacy (5). This approach is more expansive than the requirement to solicit necessary information from the prescriber.

4. **Electronic Medical Records**
   EMRs allow for immediate access to members' medical records, allowing for more accurate and timely clinical decisions.

Common Findings

In the area of Part D Coverage Determinations, Appeals, and Grievances, several sponsors lacked adequate systems and processes for timely and accurate communication with beneficiaries about coverage determinations, appeals, and grievances. Several sponsors also lacked adequate processes for effective internal communication among departments responsible for processing coverage determinations, appeals, and grievances. Sponsors must ensure coverage determinations, appeals, and grievances are handled in a meaningful and timely manner. CMS observed the following findings:

1. **Noncompliance with Adjudication Timeframes and Processing**
   Sponsors were untimely in effectuating determinations, including:
   - Coverage determinations were not processed within 24 hours of receiving an expedited coverage determination request and/or within 72 hours of receiving a standard coverage determination request.
   - Expedited coverage requests were inappropriately downgraded to standard coverage requests to meet CMS' timeliness requirements.
   - Payments were not made to beneficiaries within 14 days of receiving a standard request for reimbursement.
   - Redeterminations were not processed within 72 hours of receiving an expedited request and/or within 7 calendar days of receiving a standard request.
   - Insufficient outreach to prescribers or beneficiaries to obtain additional information necessary to make appropriate clinical decisions.

2. **Noncompliance with Notification Requirements**
   Sponsors' communication with beneficiaries was inadequate, including:
   - Failure to provide beneficiaries with written notification of coverage determinations and redeterminations.
   - Failure to provide beneficiaries with notice of the plan's decision within 24 hours of an expedited coverage determination request and/or within 72 hours of a standard coverage determination request.

- Issuance of denial letters that either did not include correct information or did not include adequate rationale specific to the individual case.

3. **Improper Classification and Processing of Requests**
   Sponsors misclassified coverage determinations, redeterminations, and grievances. CMS observed the following findings, which resulted from a lack of internal controls, and training:
   - Redeterminations were inappropriately classified as coverage determinations.
   - Coverage determinations were classified and processed as grievances.

4. **Grievances**
   Sponsors were noncompliant in their handling of Part D grievances. The findings observed included:
   - Failure to resolve grievances in a thorough (e.g., not pursuing fraud allegations) and/or timely manner.
   - Failure to provide the beneficiary with notification that explains how the plan sponsor's disposition of the grievances addressed the beneficiary's concerns.
   - Inadequate processes or systems to track and manage grievances.

PART C ORGANIZATION DETERMINATIONS, APPEALS, AND GRIEVANCES

Best Practices

1. **Timeliness**
   Routinely processing pre-service requests well in advance of deadlines helps to reduce the number of reconsiderations and appeals. A software system that auto-populates dates and sends reminders to staff helps the organization reduce the number of reconsiderations and appeals.

2. **Electronic Medical Records (EMR)**
   EMRs create greater efficiency for patients, providers, and payment systems, increase access to clinical data and information, and improve safety. The ability to access the EMR remotely at any time facilitates timely, deliberate, and informed determinations needed to provide appropriate, covered services. Providers' access to more current and complete beneficiary information should have a positive impact on beneficiary services and continuation of care.

3. **Effective Provider Outreach**
   Effective provider outreach allows necessary clinical documentation to be collected quickly and completely. Some features include:
   - A standard protocol of providing verbal and/or written outreach to the provider and/or the beneficiary in cases where additional clinical documentation is necessary to reach an appropriate decision.
   - The use of a provider website to submit pre-service requests.
   - Following up with the provider by fax and phone several times to obtain the information needed.

- The use of a Provider Relations Department to investigate a provider appeal for non-payment. This reduces the time spent by clinical staff on non-clinical appeal matters.
- Extensive outreach to obtain the waiver of liability or authorized representative form which resulted in fewer dismissals. This promotes timely submission of the waiver so the cases can be processed.
- Direct communication between the sponsor's personnel and the provider's personnel. This benefits the sponsor's network by allowing direct contact without having to leave messages through customer service and/or provider relations for callbacks.

4. **Effective Beneficiary Communication**
   Clear and regular communication among all parties involved in a coverage decision, appeal, or grievance resulted in an abbreviated timeframe for resolution. Some features noted in the sponsors' communication include:
   - Calling beneficiaries to acknowledge receipt of an appeal and briefly going over the case with them. This could help the sponsor better understand the reason for the beneficiary appeal and may help resolve appeals more quickly.
   - An open communication process for the beneficiary to get in direct contact with the sponsor's utilization management staff. This feature allows beneficiaries access without going through customer service.
   - Issuances of appointment of representation (AOR) forms are preceded by member calls to explain the contents and necessity. This process helps both the beneficiary and organization to obtain the AOR form when it is needed.
   - Customized grievance letters result in delivering more meaningful information to the beneficiary.

Common Findings

In the area of Part C Organization Determinations, Appeals, and Grievances, organizations were often noncompliant, predominantly in the areas of clinical decision making, timely processing and notification of decisions, and in classification and processing of grievances. Organizations must ensure coverage decisions, appeals, and grievances are handled appropriately in order to avoid beneficiary harm due to delayed or denied access to services. CMS observed the following findings:

1. **Making Clinical Decisions**
   Sponsors were not accurate and clear in the communication of their coverage decisions, including:
   - Failure to follow Medicare coverage guidelines. Specifically, failure to provide the required denial rationale for adverse coverage decisions (i.e., not adequately stating the specific reasons for the denial in the Notice of Denial of Medical Coverage (NDMC) and Notice of Denial of Payment (NDP)).
   - Failure to reimburse for services provided by out-of-network providers that were coordinated through contracted providers.

- Lack of due diligence in soliciting appropriate documentation,including completed appointment of representative (AOR) and/or waiver of liability (WOL) forms, or requiring such documentation when it was not required.
- Failure to gather all necessary information and/or to provide reasonable opportunity for the parties to present evidence needed for making a decision.

2. **Noncompliance with Adjudication Timeframes and Processing**
   Sponsors were untimely in organization determinations and appeals, including:
   - Failure to timely process requests and notify the enrollee of the plan's decision.
   - Failure to effectuate the IRE's favorable decisions within the required timeframes.
   - Expedited coverage requests were inappropriately downgraded to standard coverage requests to meet CMS timeliness requirements.

3. **Grievances**
   Sponsors misclassified organization determinations, appeals, and grievances. We observed the following:
   - Failure to address all of the beneficiary's complaints in the written or verbal notification.
   - Failure to provide the beneficiary with notification that explains how the plan sponsor's disposition of the grievance addressed the beneficiary's concerns.
   - Failure to correctly classify beneficiary concerns (i.e., classifying appeals as grievances).
   - Failure to provide beneficiaries with Quality Improvement Organization (QIO) rights for quality of care grievances.

COMPLIANCE PROGRAM EFFECTIVENESS

Best Practices

1. **Tracking & Monitoring Systems**
   Sponsors have monitoring systems in place to detect excluded providers that provide care and/or medication to enrollees, monitor operational compliance, and assess contractor risks. Tracking systems have been implemented to track the status of corrective action plans (CAPs) and Medicare Prescription Drug Integrity Contractor (MEDIC) referrals. These systems also have the ability to assign measures such as priority levels, metrics, scoring, and produce reports. Some features noted within sponsors' systems include:
   - Integration with an external reporting hotline and allowing potential fraud, waste, and abuse (FWA) tips to be uploaded into the case tracking system.
   - Controlling access rights to the system to ensure cases are handled properly by the appropriate person.
   - Establishing protocol that cases may not be closed without the completion of a corresponding CAP.
   - Both compliance and operational staff monitoring progress toward established goals.
   - Systems being updated continuously with data from multiple sources, such as hotlines and investigations.

- Audits being conducted of areas in which the tracking and monitoring system shows no deficiencies to ensure metrics are effective.
- CAPs are automatically created when metric targets are not achieved.
- A systematic approach to receiving, interpreting, and disseminating CMS communications to staff.

2. **Data Collection and Sharing**
   Sponsors collect data from various sources and analyze the data to identify abnormal relationships and/or aberrant patterns that may be indicative of fraud, waste, or abuse (FWA). Sponsors' data collection efforts include:
   - Accessing data from various sources to identify patterns.
   - Extensive utilization of idea sharing/generation between departments in order to identify FWA.
   - Extensive promotion and advertising of the compliance/FWA reporting hotline.

3. **Staff Development and Training**
   Well-trained and knowledgeable staff are better equipped to assist beneficiaries. CMS noted the following features in effective training and development programs:
   - A user-friendly intranet site providing a structured environment for creating, disseminating, and tracking policies and procedures; promoting a corporate culture of compliance; and providing an efficient source for employees to obtain answers to frequently asked questions.
   - Training for first tier, downstream, and related entities (FDRs) through web-based modules, providing greater oversight of FDRs.
   - Knowledge checks within training modules to identify areas with low pass rates that would signify additional training is necessary.
   - A Code of Conduct (COC) with links to supporting policies (e.g., whistleblower, conflict of interest) as well as to important websites such as the organization's internal fraud, waste, and abuse (FWA) website. These features allow for direct access to the most current policies and procedures, provide high visibility of these documents, and increase the familiarity and openness of the compliance and FWA program of the sponsor. Making materials accessible and user friendly can increase the employees' likelihood of reporting non-compliance issues.

4. **Prompt Responses to Beneficiaries**
   Sponsors maintain a dedicated hotline for FWA calls staffed with pharmacy certified Customer Service Representatives who are able to immediately address questions and concerns about pharmacy claims edits and related issues with the beneficiary on the call.

Common Findings

In the area of Part C and D compliance program effectiveness, CMS identified areas of concern with respect to some of the sponsors' compliance programs. CMS observed the following findings:

1. **Training**

Sponsors failed to demonstrate the establishment and implementation of its required training and education between the compliance officer and the organization's employees, governing body members, and FDRs.

2. **Monitoring, Auditing, and Compliance Risk**
   Sponsors did not have an effective system for monitoring, auditing, or identifying compliance risks, including:
   - Failure to have an effective process in place for identification of compliance risks.
   - Failure to follow up on previous internal audit findings to ensure that the identified issues have been resolved.
   - Failure to establish and implement appropriate oversight over delegated entities.

3. **Prompt Response**
   Sponsors failed to establish and implement procedures for fully investigating, reporting, and timely remediation of compliance and potential FWA issues.

AGENT/BROKER OVERSIGHT

Best Practices

1. **Training of Agents & Brokers**
   Well-trained and knowledgeable agents/brokers are better equipped to assist beneficiaries. CMS mandates that agents and brokers of plans must pass their Medicare Training with a score of 85% or higher. Thorough broker interview processes and higher than standard requirements of testing-90% in some instances-ensure that a plan is operating with the highest quality personnel. Some features noted within sponsors' agent and broker training include:
   - Online training, incorporating interactive quizzes throughout the training module, followed by a final examination. The interactive system of quizzes ensures that agents/brokers are completing all parts of the training and periodically assesses agents/brokers' knowledge on different areas. This helps the sponsor make sure that agents/brokers understand all key information they must provide to beneficiaries and increases the likelihood that agents/brokers retain all the information they learn during training.
   - Providing each agent/broker with a direct point of contact at the plan that s/he can reach out to with questions. Providing the agent/broker with a direct contact ultimately reduces beneficiary confusion and complaints.
   - A comprehensive training program including a ride-along process between a compliance manager and new agent/brokers to make sure they are providing the correct information to the beneficiary and answering any questions they may have to increase their performance.
   - An agent/broker performance monitoring process that includes ride-alongs for seasoned agents occurring bi-annually. This practice helps ensure that agent/brokers are following the most up-to-date Medicare marketing guidelines and providing beneficiaries with quality service.

- In-person coaching and training for agent/brokers is used in conjunction with the CMS mandated Medicare Training, constituting a robust training program that adds to agent/broker performance.

2. **Thoroughness of Outbound Enrollment Verification (OEV) Procedures**
   Best Practices noted to enhance the OEV process include:
   - OEV letters being sent to all beneficiaries instead of just to those beneficiaries the plan was unable to reach by phone, decreasing beneficiary confusion and helping to ensure required information has been provided.
   - OEV calls being reviewed by the organization on an ongoing basis for quality assurance. This review of OEV calls enables the sponsor to verify that agents/brokers are giving correct information to beneficiaries on a timely basis and also allows the sponsor to correct any issues it discovers with agents/brokers not providing beneficiaries with the correct information.
   - Utilizing an OEV checklist that is very detailed and provides excellent documentation assists sponsors in tracking OEV activities. Features of such checklists include describing the date on which the application was received, the dates on which the calls were made, and the disposition of each call.
   - Utilizing a spreadsheet or other tracking mechanism that provides member services with the 15-day threshold in place for OEV call attempts, to ensure compliance with CMS required timelines.

3. **Maintaining Current Information**
   To ensure the best service is rendered to beneficiaries, information within the sponsors' systems must be updated as often as possible. Keeping the most recent information on file allows for quicker processing and better outcomes for plan members. Some features noted within sponsors' information updates include:
   - The establishment of an agent/broker advisory board of seasoned agent/broker committee members to provide up-to-date market information. An informational resource such as this greatly improves a plan's ability to provide high quality service to beneficiaries.
   - Quarterly broker meetings to assist in keeping current with the broker population and the beneficiaries they serve. This level of broker monitoring is unusual and provides valuable information to the plan that would help to ensure beneficiaries are receiving quality service.

4. **Complaint Management**
   Complaints are received, documented, addressed, and resolved in a timely fashion. When initially received, complaints are timely forwarded to the appropriate assigned operational areas to ensure the appropriate level of knowledge is applied. Throughout the review process, reviewers note the date of the complaints, the operational area to which the complaint was sent, and the date of resolution. The sponsor fully investigates complaints to make the beneficiary whole in a timely fashion. The system also enables the sponsor to discover and analyze any trends within the complaints so that appropriate action can be taken.

Common Findings

In the area of Part C and D agent & broker oversight, most sponsors were compliant with the requirements for training/testing and licensure/appointment. However, many sponsors failed the requirements for outbound enrollment verification (OEV) calls and the complaints process. CMS observed the following findings:

1. **OEV Calls**
   Sponsors failed to meet the requirements for OEV calls, including:
   - Failure to demonstrate that the OEV call script was communicated completely to the beneficiary.
   - Failure to provide the beneficiary with the correct cancellation date and/or failure to facilitate the beneficiary's cancellation in a timely manner.
   - Failure to provide proof of the required three OEV calls and/or send an OEV letter upon the first unsuccessful attempt.

2. **Complaints**
   Sponsors conducted incomplete investigations, as not all allegations against the agent were reviewed and followed up on by the plan. Sponsors also closed large numbers of complaints indicating "unable to substantiate," without documenting adequate investigation of the complaint.

PART C AND PART D ENROLLMENT AND DISENROLLMENT

Best Practices

1. **Timeliness**
   Sponsors reviewed the status of enrollments with missing information on a daily basis.

2. **Appropriate Use of Resources**
   A sponsor's enrollment resources include machines, systems, and personnel. Systems and policies implemented to address each type of resource maintain continuity of procedures across all levels of the organization. Developing and appropriately distributing resources is instrumental to the continued progress of sponsoring organizations. Some features noted within sponsors' use of resources include:
   - Establishing regular meetings between the customer service department and the Medicare enrollment department.
   - Cross-training staff for the ability to offer assistance to the Medicare enrollment department whenever necessary.
   - A system dedicated to managing Medicare enrollments and disenrollments that includes notes accessible by all staff. The system refreshes every 5 minutes, assuring the most up-to-date information is accessible.

   All of these practices help department members quickly and accurately resolve beneficiary inquiries, because they provide immediate access to the most current information in their systems.

3. **Communication with Beneficiaries**
   To ensure that beneficiaries are aware of all details regarding their plan and benefits at the time of enrollment, all efforts are made to maintain a reasonable level of communication. Making sure that the sponsors' beneficiaries fully understand all aspects of the benefits goes a long way toward keeping beneficiaries satisfied.

Common Findings

In the area of Part C and D enrollment and disenrollment, a significant number of sponsors were found to be noncompliant with CMS requirements for processing enrollments and disenrollments. CMS observed the following findings:

1. **Processing of enrollment or disenrollment requests**
   Sponsors incorrectly processed enrollment/disenrollment denials and incomplete enrollment requests, including:
   - Incorrect denial of an enrollment or disenrollment request.
   - Incorrect determination of the completeness of enrollment requests.
   - Incorrect enrollment of a beneficiary into a plan for which they were not eligible.

2. **Timely Processing**
   Sponsors were not timely in the processing of enrollment and disenrollment requests, including:
   - Failure to send timely and/or correct acknowledgment notices to beneficiaries.
   - Untimely processing of enrollment and disenrollment requests.
   - Untimely transmission of enrollment and disenrollment requests to CMS.

PART D LATE ENROLLMENT PENALTY

Best Practices

1. **Development & Implementation of Systems**
   Developing and putting into action systems that streamline, track, and monitor sponsor activities has helped organizations process Part D Late Enrollment Penalties (LEPs). Systems are made accessible to the necessary parties, maintained for functionality, and upgraded accordingly to assure software congruency. Some features noted within sponsors' systems include:
   - A robust visual display software system that incorporates enrollment, LEP, billing, and customer service data entries. This allows the sponsor to maintain focus on priorities and to track statuses, including reconciliations, number of uncovered months determinations, and billing and collection of LEPs and premiums. This system allows the enrollment department and customer service representatives to have the most up-to-date information regarding a beneficiary's information. Additionally, it allows for all CMS timeframes to be met.
   - An active monitoring system that allows its employees to track the status of an LEP-eligible beneficiary's application, in real time. Tracking begins at the point that the determination of the potential break in creditable coverage was made and

ends at the date that the beneficiary attested to having or to not having creditable coverage during the period in question. The system also monitors related activity occurring after the beneficiary returns the attestation, including the status of any transactions to or from CMS and any notices sent to the beneficiary.

2. **Timeliness**
   Working diligently, sponsors can enable Part D LEP Independent Review Entity (IRE) decisions to be effectuated within 4 days or less, which is 10 or more days before the required deadline. This helps beneficiaries have the correct LEP billed and collected and prevents confusion that could arise from subsequent incorrect LEP billing due to delays in processing the IRE decisions.

3. **Communication with Beneficiaries**
   Often the plan makes multiple attempts to obtain the enrollee's response to the creditable coverage attestation form, such as reminder notices concerning the last day to attest to having prior creditable prescription drug coverage are mailed to beneficiaries.

Common Findings

In the area of Part D Late Enrollment Penalty, a significant number of sponsors were found to be noncompliant with regard to complete and effective communication with beneficiaries about Late Enrollment Penalty concerns. CMS observed the following findings:

- Failure to send an approved version of the attestation request to the beneficiary within 7 days of determining his or her number of uncovered months.
- Failure to supply the beneficiary with the LEP assessment and his/her appeal rights within 10 days of receipt of the Part D LEP amount from CMS.
- Incorrect information was included in attestation letters sent to beneficiaries.