

# FALL 2012 CMS CONFERENCE



## TRANSCRIPT

### Day 1 03: Best Practices from Testing Audit Protocols

Good morning. My name is Tawanda Holmes. I'm the Director of the Division of Compliance Policy and Operation in the Program Compliance Oversight Group. As part of our process to improve oversight in 2012, we conducted best practices reviews of key operational areas at all six 5-Star Sponsors. CMS rates Plans on a scale of one to five stars, with five stars representing the highest quality Plans. These Sponsors demonstrated excellent performance based on the rating methodology used.

The best practices reviews aim to accomplish several key objectives. One, identify best practices to share with other Sponsors to drive improvements in performance and better outcomes across the industry. Two, understand the structure and outcomes of higher performing Plans to establish reasonable benchmarks for overall industry performance. Three, test and fine tune our audit protocols in an environment of expected compliance. And finally, use the results of reviews to show that there is a correlation between a high star rating and high performance in areas deemed to be important to ensuring beneficiaries have access to services.

To share best practices, we compiled our observations, which will be released in an HPMS Memo later this week or early next week. I will be highlighting some of those observations during the next segment. In addition, we invited all six Sponsors to discuss their best practices today. We are delighted that four of the six agreed to join us. The other two desired to be here, but were unable to join us due to work priorities.

We have here today with us, Go Girl Power, Ms. Renee Wroth at Health New England. She is the Director of Compliance and Accreditation, and she will be discussing best practices, preparing for our reviews, and lessons learned. Next, Ms. Peggy Fry, who is the Medicare Compliance Officer at Martin's Point Health Care. She will discuss best practices and compliance program effectiveness. Ms. Marcella Jordan, who is the Vice President of Medicare and Compliance Programs -- she is with Kaiser Foundation Health Plan. She will discuss best practices for compliance program effectiveness and preparing for our review. And lastly, we have Ms. Dawn Thompson. She is the Director of Medicare Programs and Compliance with Group Health Cooperative -- no "Inc." -- best practices for Part D formulary and benefit administration and preparing for our review. Each will have 12 minutes to discuss their topics.

And with this, I'll turn it over to our first presenter, Ms. Renee Wroth at Health New England.

Good morning. I thought that when CMS asked me to talk about Health New England's best practices that might be difficult to do without first giving you a little bit of information about who Health New England is. So I'm just going to speak briefly about Health New England and who we are as a Plan, and then I will talk about my perception and CMS's perception of what some of Health

New England's best practices are. Then I'll also just give you a little bit about my observations on how to prepare for a Best Practice Review, as well as some lessons learned.

So Health New England is a provider owned health plan. We're located in Western Massachusetts. We're owned by the Bay State Health System. We were incorporated in 1985; and for most of our history, we've been a commercial plan with fully funded and self-funded products. It wasn't until 2009 that we entered the Medicare market. And then in 2010, we also entered the Medicaid market. We have approximately 127,000 members – and that's all lines of business. The majority of those members are commercial members. Our Medicare membership is just over 7,000 right now.

So when I think about Health New England's best practices, really they're focused around four key beliefs. We have a very strong culture of quality, accountability, and compliance. And that's throughout all levels of our organization. We have a dedicated commitment to our members, a dedicated commitment to our employees, and we're very focused on improvement at all levels of the organization. We have a unique program in our organization called an OFI Program. We encourage our employees to bring issues forward. If you walk through Health New England and walk through any area within Health New England, you will see whiteboards on the walls. And that's for our employees, regardless of what level of the organization they are in or what department they work in, to write their ideas, write their suggestions, bring to our attention areas that are going wrong or problems that they see. So we're very transparent and we make that visible.

In terms of our commitment to quality, in 1991, Health New England was the first HMO in the nation to undergo accreditation by the National Committee for Quality Assurance. In 2008, we were ranked a top 10 commercial health plan. Our status was maintained in 2009, 10, and 11, and we are hoping to maintain that in 2012.

As I mentioned in 2009, we entered the Medicare Advantage market. And in 2010, we were very pleased to learn that we had earned CMS's 5-Star designation. We weren't necessarily surprised, however, by that because again, we have been focused for our entire history on quality and on compliance, and it is what makes us who we are. We are a small organization, but we like to think of ourselves as the Little Engine That Could.

I put this slide up here not to talk to you about our organizational structure, but just to display our commitment to compliance. Compliance is spread throughout the organization. We don't just have it in one area or in one office, but there are several areas that support compliance. We also report to a Compliance Committee, obviously to the Board of Directors, but we also report to our Quality Management Committee.

In addition, on our Medicare side, we have several work groups around our Medicare line of business. These work groups are set up to address various components of Medicare, and it is in these forums that people also are encouraged to raise issues, to bring forward their concerns, and ask the questions that they need to operate effectively and efficiently.

Our commitment to our members – some of the best practices we have with respect to our members, we have a very transparent sales process. We try to make sure that all of our members, the beneficiaries that we are speaking to, have a clear understanding of our products and what they're going to buy prior to purchasing one of our plans. With that in mind, we make sure that our Provider Directories are available. We make sure that our Formulary is available at all of our sales sessions. And we encourage our beneficiaries to look through those to make sure that their providers are in our Plans or their drugs will be covered under our Formulary. We want to make sure that there are no surprises for our beneficiaries.

We use an employed sales staff, and we have very strict testing requirements. We believe that our employees are the best people to represent Health New England and our values and our commitment to the beneficiaries. So all of our sales staff are employed by Health New England. And we also encourage other employees who may not operate within the sales department to volunteer their time to do that as well. So for example, I myself have been certified in sales, so I have an opportunity to get out and meet our beneficiaries and speak to them firsthand.

We try to make sure our Plan designs are very easy to understand, so we do not have any deductibles on our Plans. We use per-stay copays instead of per-day copays. And we try and limit the number of co-insurance we have as well in our products.

In terms of grievances and appeals, -- as many of you do, I'm sure, we do trend analysis on grievance and appeals. But not only do we wait for a trend, in the area of grievance and appeals we are very active. And we look at each one that comes in – again, as I'm sure all of you do – but we use each one as an opportunity for improvement. So each one is shared with the operational owner, and the owner gets to look at it. And again, because of our commitment and our employees' commitment to quality and accountability, often those operational managers are taking action to change processes based on even one concern that has been raised. So although we do track and trend our grievances and appeals and take coordinated action, we also are looking at each and every one and often take action even on one complaint.

We also focus on clear communication and ease of use, so some of our best practices in this area are in our Part D area. We have a Part D Authorization Extension Process, so we will notify our members prior to their authorization expiring at the end of the year. And we will send out a new authorization form for them so that we can transition them and they will have no interruption in their drug coverage.

All of our complaints are responded to in writing -- Part D grievances as well, even if they are submitted to us orally. We want to make sure that our members understand clearly what our response is, so we respond in writing. And on the Part C side, we include clinical criteria. We'll include the LCDs. And when a provider or non-Plan provider is being requested, we will include lists of available providers in our denial letters. Again, we want to make sure that all of our Plans are very transparent and that our members understand our reasoning for making certain decisions.

In terms of our commitment to our employees, we strongly believe that our employees are our greatest asset. So we spend a lot of time up front on the hiring process. We use the Lominger model of hiring. All of our hiring managers are trained in this model of hiring. And we focus on

integrity and trust. Those are price of admission competencies. So in order to become employed at Health New England, you have to display these competencies even to get in the door.

So we very much believe that our employees, again, as our most important asset – we spend a lot of time up front on the hiring process. There are often several people involved in the hiring. But that's because many of our employees are with us for many, many years. We give them many opportunities for advancement and transfer. I myself have been with the organization for about 19 years in many different capacities – legal, operations, compliance. And that's because we feel that that keeps our employees engaged. It keeps them focused. It keeps them active in what we're doing and committed to our mission.

We have a high performance coaching culture. We focus on employee engagement, but we don't just do an engagement survey. We take action on the responses. And we have a significant investment in training.

So, preparing for a CMS audit – I thought I would just talk a little bit about some practical matters. Space – we're a small Plan. Many of you I'm sure are also small Plans. Space can be an issue. Many of the CMS Reviews now are done via webinar, which is great. But you should have conference space available for your teams when you're doing these webinars because often they're happening consecutively, there's more than one going on at any time. And you often want several people from your end in the room at the same time. So if you're trying to do it in somebody's office, that could be difficult as people try and gather around a small monitor. So you want to be sure you have enough space available.

Computer and phone access and support – make sure you have somebody technical on hand to assist you should you need to set up a webinar or should you need to set up a conference call. Make sure that you have those people available to assist you in doing that.

Preparing your documentation – follow the universe specifications precisely. CMS – I was very thankful to see that they have released the universes. So everybody really should be spending time looking at those universes, pulling the data now so that you don't have to try and scramble to pull the data when they come knocking. Also remember that more is not always better. You want to be really thoughtful about what you are submitting to CMS. And again, submit to them only what they are asking for.

Prepare an entrance presentation. This is your opportunity to put your best foot forward with CMS. It can be a very brief presentation, but you want to give them a feeling and a flavor for who you are as an organization. So take time and prepare a brief entrance presentation for them.

All of your documents will need to be scanned because as you're going through these webinars, if you don't scan for example your complaints and appeals files, you're going to run into some difficulty during the review as they're asking for those files.

Prepare your team. Make sure that you have subject matter experts on hand. You want the people that are talking to the auditors to be the people who know the information inside and out and know how to manipulate through your systems. Your CEO, Executive Team, Board members -- all of those

may be interviewed. So you want to make sure that they are aware that CMS is coming. Your PBM, if you work with them – make sure that they are available. We had ours come to our business location. And let them know that you're going to have some late nights preparing your organization.

There's walk throughs. CMS will want access to your organization. They'll want to be able to walk through your organization. So you want your staff and your employees to know that this is going to be occurring. Nobody likes to be surprised by a CMS auditor showing up in their cubicle. So prepare them. Let them know that CMS is going to be on location.

If you have an issue – we all do compliance reminders and compliance training. Make sure that you're sending some extra ones out before CMS arrives. Make sure there's coverage for daily work. The people who are in these reviews, their time will be taken up for that entire week. You want to make sure that there's coverage for their work.

So some lessons learned – again, preparation is key. Use the protocols. You want to be always in an audit-ready state. You want to make sure that you understand where your areas of challenge are prior to CMS coming in to tell you where your areas of challenge are. So run the universes. Run the data. Review the data. Track and work items as they come up during the review. The auditors often are providing good information about what they would like to see or what they're not seeing in what they are reviewing. Make sure you're taking good notes during the review. Capture those notes. We were meeting every evening after the reviewers had completed their review, and we were comparing notes. We were gathering them. We were putting them together. We were documenting them, and we were starting to work the issues even when they were still in the review process.

Compliance Dashboards are important. Again, from a compliance perspective, you want to know what's going on within your organization and where those areas of potential non-compliance are.

And the last thing I just wanted to point out for those organizations who are NCQA accredited and may not have had a CMS Review, NCQA readiness is helpful. But it certainly is not a CMS audit. So Health New England again has had a long history with NCQA. We were new to CMS. They are not one and the same. Certainly a CMS audit is much more in-depth than an NCQA Review.

Thank you.

Hi. Again, I'm Peg Fry from Martin's Point. And I'm going to talk to you today about some best practices in our Compliance Program and ways that we've been able to measure success. Just to tell you a little bit about Martin's Point, we are a non-profit health plan and a health care provider. We have an MAPD Plan in Maine, a Tri-care Program in the Northeast; we have a Commercial Group Insurance Plan in nine health centers.

Something very dear to Martin's Point is our culture of people caring for people. We have many values attached to this and are very committed to living these values. And they're really reinforced throughout the company.

One of our most important best practices is our Compliance Business Partner Model. We use the Compliance Business Partner to work collaboratively with the operations departments. They're advisors, not police. So we establish relationships. We become a resource and a point of contact. We're problem solvers and we identify process improvement. We educate. We talk about new regulation. We talk about HPMS Memo's. We assist in interpretation of those regulations, and of course we answer any privacy questions that come up.

And we really do live the values of the organization. We help each other. We act as owners of the business, and we're always learning better ways to do things. And of course everything is built on trust and respect. This is in our Compliance Program and supports how we do business.

Our Medicare Compliance Committee is chaired by me, and we have representation from all business areas that administer our Medicare Program. We have various levels of management, from VP to managers, so there's a lot of dimension in our interactions. We work with our Med Ops Team to come up with different topics each quarter that we discuss. We could talk about our bid process, the latest MARx software update, or of course Part D issues. But they're generally related to a current activity or a very recent activity. We discuss HPMS Memo's. We review any significant Memo's from the previous quarter. And the group discussion actually gives us a nice ability to collaborate across all operational departments so we know the full impact of what this Memo means and what it's going to do to our program.

And we have a "hot topic." This is decided by our compliance managers. It's generally educational and related to our Compliance Program. So we would talk about maybe the compliance training; different ways to identify fraud, waste, and abuse; or most recently, we talked about vendor oversight. So we use this as a way to continually educate on compliance, and we expect that the participants in our meeting will take this back to their departments. So we're really sharing the love.

Some additional things we do is we secret shop. So we attend our own marketing seminars. And we call our Customer Call Center after hours or early in the morning, and we ask questions about enrollment, benefit questions. And the reason we do this is we want to verify the accuracy of information that our members are getting. And we also take this opportunity to look for training needs or, again, process improvement.

Something else that we do is we audit our EOC against our configured benefits. We do this again to make sure that what we're telling our members is really what we're giving them. We do this annually, just prior to the start of the new contract year.

We also perform a final review of our marketing materials. And we review all appeals, grievances, and CTMs with our Appeals and Grievance Department – again, another opportunity to get the pulse of what's happening with our members and any opportunities that we can have process improvement or education.

We're very involved in our new employee orientation, so we have a physical presence there. People get to know us. They can ask us questions. And we talk about current trends. So we use

Compliance Newsletters, and we talk about the latest violations – the latest Plan that's been fined or doctors that have received imprisonment or serious fines.

We have a dedicated phone line. So not only do we have a compliance business partner that reaches out to every operational area, but we have a dedicated line. So if you can't find your business partner and you have a question that you need answered right away, you can always get somebody in Compliance.

And we're very involved in the operational departments. We attend team meetings. We attend project implementations, and we even get invited to parties sometimes.

Something very important to us is we do one-on-ones. So this is a relationship with a compliance business partner and a designated individual in the operations area. And it's really a very casual meeting. It's just a chance to talk about what's going on, what's on your mind. We don't come in with any agenda. There's no pressure to respond to an incident or meet a deadline. It's really just a way to establish that relationship to really form the partnership.

So how do we know this is working? Well, we passed all elements of our compliance review with no findings. And our Compliance Business Partner Model has been called revolutionary. But beyond that, our employees and our vendors know us and they trust us. They know who to call when they have questions, and they're not afraid to speak up.

We also make compliance interesting. So last year, we visited every department and every health center. And we introduced ourselves to every single employee. We asked them little questions about compliance, and we gave out gifts – simple things like a magnet, a notepad, or the never fail chocolate. And we know that they feel safe in reporting incidents to us. We know that there's always problems in a health plan, but those can go underground or people can talk about them. We talk about them. And we've seen an uptick in our self-reporting this year. So last year, we had six self-reported non-compliance issues. So far this year, we've had 17. And most of those were discovered during routine monitoring. Now very few are serious, but they do show a trend of openness and communication.

In the month that we visited all those departments, our HIPPA privacy incident reports doubled the norm. Again, no serious issues – but it shows people are more aware. And that's exactly what we wanted to happen. When it comes to monitoring reports, our departments aren't afraid to give us the bad news along with the good news. That's how we know they're accurate and truthful. In fact many times, we're the first person they call when they think they have a problem.

So in summary, we measure our success by the partnerships that we develop with operations, our health center staff, and our vendors. These partnerships are built on trust and respect, and the reward is collaboration and communication.

Thank you.

Good morning. I'm Dawn Thompson. I'm the Director of Medicare Programs and Compliance in Seattle. We are a non-profit, consumer-governed HMO in the state of Washington. We have

approximately something over 600,000 total enrollees. We currently serve a little over 79,000 Medicare beneficiaries.

I came today to talk about how we assembled a Leadership Team to organize the review for the Best Practice Review. And I'm hoping that this information will be helpful for Plans that have not yet been reviewed. I think you're going to hear some common themes to what you've heard already today.

Although we had best practices identified in all of our operational areas, CMS asked me to share with you one particular area in which they had identified several best practices – our Part D Formulary and Benefit Administration area. So how did we prepare for the Best Practice Review? Our Best Practice Review is comprised of two reviews in one – an Operational Compliance Review and a Compliance Program Review. We assembled a Group Health Audit Team, a leadership team that was capable of deciphering the documentation and data requests. Our team consisted of my department, Medicare Programs and Compliance; our Chief Compliance Officer and several of his staff; as well as our Government Programs Executive Director.

The directions for submission are detailed and wide ranging. So we took a divide and conquer approach. We split the directions and the attachments up amongst our team. We identified the internal operational staff that would be responsible for the submission of the data and documentation. And we worked directly with them to ensure a quality submission.

Many attachments you'll find contain crossover information. So we attempted to consolidate similar information into a single request of an operational area. For example, employee-specific information is contained within several documentation requests. Knowing that our Human Resources Department needed to compile the information, we pulled the data and documentation requirements into a single request where we could when we submitted it to our Human Resources Department. And then when the Human Resources Department returned that information back to us, we divided it up into the format that CMS required for the submission.

Our single point of contact communicated all clarifying questions and concerns to CMS. And I want to share that we met early on with our Executive Leadership Team, and they engaged all of our teams from the top down. They clearly knew that responding to this Compliance Program Review and operational review was a priority for them.

So how did we organize our time? Our Leadership Team met in my office twice daily – once in the morning and once in the afternoon. We planned to have 30-minute huddles. We are a lean organization as well. But we only used the time that we needed to stay current on our work. Sometimes this meant we met for ten minutes, and other times we extended it to as much as an hour. We really took time to understand the documentation and data universe requests. I cannot place enough emphasis on the importance of this piece. This is how you will achieve success in your review as well.

And we divided the work up each day. We created a wall of work. Again, we're a lean organization. We literally covered my office walls with white paper and post-its, and we created a color-coded system that we could prioritize our work, check it off as it was completed, and identify any gaps.

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Meeting twice each day prevented duplication of effort and identified team members with capacity to take on more work. If you've heard me say "work" a lot, it is a lot of work. You should prepare for extra hours. And your teams really should be prepared in advance to understand the requirements and to gather and submit the information.

Plan for open communication with CMS. From the time we were notified of the review, we stayed in very close contact with CMS. CMS encouraged us to ask questions, and we did. But we did try to avoid batching or unrelated questions to CMS. This ensured that the CMS Leadership Team could send the question to the dedicated operational review team, and that ensured swift responses back to the Plan, to us. Our continuous contact with CMS staff ensured we understood the requirements outlined in the attachments. And communicating frequently with CMS was made easier by having this single point of contact at our Plan for CMS staff. CMS liked this approach, and it worked very well for us.

Calendar management was essential. CMS uses separate teams to perform the overall review. For example, Part C and Part D grievances and appeals are reviewed by different teams, oftentimes in different time zones. Prepare an agreed-upon calendar in advance of your reviews. To our benefit, we were able to have our entire Group Health team in one location, which made calendar coordination easier. To the extent that your Plan is able, we highly recommend a single site for the reviews – especially when your subject matter experts may be needed by multiple audit teams. I walked from room to room to be able to be with different review teams, so this worked really well for us.

Know what to expect of the review process. In our case, CMS was onsite one full week for both the Compliance Program Review and the Formulary and Part D Benefit Administration Review. The other operational areas were reviewed by webinar, and that was completed over three separate weeks. But most were during the same week as the onsite review.

Engage your technical support early on in the process. We reserved rooms close together for the individual operational reviews. We pre-tested our webinar capabilities, and we had technical support onsite during the review. This preparation and readiness during these reviews ensured seamless webinar communications with offsite CMS teams.

And be prepared for CMS review teams to request additional uploads. These uploads ran from new data requests to previously unrequested or newly updated policies and procedures. Generally, these uploads must occur the same day. Again, we dedicated a staff person to be the single point of contact, and this person completed all uploads and downloads as requested by the CMS audit teams. I can't emphasize enough that CMS was very respectful of our team and our organization.

It was clear to us at the end of the review what areas we passed, where improvements were recommended, and where corrective actions would be required. This allowed us to start closing any identified gaps before the final report came.

So now I'm going to transition to our review area where CMS identified several best practices – Part D Formulary and Benefit Administration. CMS identified four best practices in this area. First, we have an open Part D Formulary. And we really believe that having an open formulary gave us an

advantage in this review because it simplifies our benefit adjudication, it provides for minimal disruption for the member at the pharmacy window, and it increases customer satisfaction greatly.

CMS also identified Group Health's Closed System as a best practice. Clinical pharmacists are employed by Group Health and work with providers to ensure appropriate preferred medication utilization. We don't delegate our Pharmacy and Therapeutics Committee to our PBM. CMS also culled out our use of electronic health records. The electronic health record at the time of prescribing drives providers to choosing the preferred medication. We call this the "Think Preferred Program." Our coverage determination process is efficient because we use the electronic health record to quickly access needed clinical information for coverage determinations. CMS found this to be advantageous to the member as well.

And customer service and pharmacy Help Desk functions are not delegated to our PBM. Coverage questions, Part D technical questions, and Part D coverage determinations are all managed in-house.

We also attribute success in this area to a couple of other factors. While we do have a mixed model of employed and contracted physicians, more than 80% of our Medicare Advantage enrollees are patients in Group Health medical centers. We have 25 Group Health owned and operated medical centers. Again, this allows us to maximize the benefits of the electronic health record.

And one more thing – we do not delegate our mail order pharmacy. All medications ordered through our mail order pharmacy link directly to our electronic health record and are accessible to clinical pharmacists – even those prescribed by contracted network providers. And more than 30% of our Part D enrollees use our mail order pharmacy. This is significantly higher than the industry average.

So in conclusion, we believe that the best practices that CMS identified in this area reflect services that we have in-house rather than delegate to our PBM or to other entities.

So hopefully this overview of how we prepared for the Best Practice Review will be helpful to you. These reviews are different from prior audits. So again, understanding the submission requirements is absolutely critical.

And lastly, I really want to say that at Group Health we have top notch operational leaders and staff. They were actively engaged in meeting the requirements. They worked really well with our Leadership Team. And they understand their daily commitment to meeting CMS requirements contributes greatly to our 5-Star status.

Thank you.

Good morning. So like the other panelists, I thought it might be useful to share some information related to Kaiser's experience going through the CMS Best Practice Review. So what I'd like to do is just go through just a little bit of background about Kaiser for those of you who might not be familiar, talk a little bit about the process and protocols associated with the Best Practice Review, and then talk a little bit about our Compliance Program best practices that were cited by CMS.

Again, for those of you who might not be familiar with Kaiser, we operate in seven regions and have over eight million members. We have members in California, Hawaii, Northwest, Colorado, Ohio, our Mid-Atlantic Region which includes D.C., Virginia, and Maryland and Georgia. And in 2012, four of Kaiser's Medicare Health Plans were awarded an overall rating of five stars. And they were in California, Colorado, Hawaii, and Northwest, with a combined membership of over 900,000 members.

Again, for those who don't know Kaiser, we are an integrated health care system with a health plan. And we own and operate hospitals. We own and operate our own pharmacies and have affiliated medical groups. Our operations, however, are largely decentralized although we do have a National Compliance Program in place.

So in terms of CMS's approach, Kaiser received formal notification on February 6<sup>th</sup> of 2012 that it would be the subject of a 5-Star Review. And I think that we were actually the first Plan to undergo the 5-Star Review. CMS conducted the review in two phases. The first phase consisted of a Formulary and Benefit Administration Review, Part C and D Coverage Determinations and Appeals, Part C and D Grievances, Part C Access, and Compliance Program Effectiveness. And the Compliance Program Effectiveness was the only part of the review that was onsite. Like the other panelists, most of this was all done via webinar. Phase II of the review consisted of Agent/Broker Oversight and a review of our Late Enrollment Penalty.

This slide shows the timeline from the official notification of the review to the submission of our final CAP. So if you're looking at the slide from left to right, again, you can see that we received our formal notification on February 6<sup>th</sup>, and our universe and preliminary documentation was due about nine days later. So as you can see, it was a really short turnaround time. And then about two weeks later, CMS was onsite for the Compliance Program Effectiveness. And during that same week, the Phase I of all the operational areas were reviewed.

Phase II followed a very similar kind of schedule where our universes were due. The actual review took place about two weeks later. We received our final draft report about six weeks later, and we had two weeks to comment on that. And as you can see, we received our final report on July 6<sup>th</sup>. And we're currently preparing our final CAP submission, which is due October 4<sup>th</sup>.

So since Kaiser was the first Plan to be reviewed, there were some surprises for us that we had not previously encountered in other audits. And I just thought I would share some of those so that Plans can prepare and perhaps benefit from our experience. The first of those had to do with the universe submission. And I think a lot of the other panelists talked about this. The data elements in the universe submissions were different than other universes we had previously submitted in any other audit. And while we had the data available to us, we weren't collecting it in a systemic way.

And I know CMS has since released the audit protocols, and I really can't emphasize enough how important it is to do a deep dive, look at those universe data elements, and make sure that you are ready to provide that data when CMS comes and asks for it because it's quite a short time to pull them and turn them around. And I will say that CMS did allow some extensions related to those data requests, knowing that this was the first time we had seen universe requests in those kinds of formats.

Another change that we saw with this review, unlike other audits, was the sample review. Our samples were provided to us just a few days in advance and/or on the same day. Again, this is very different than what we had experienced in previous audits where you had time to pull together your case file, review it. If you had paper files, you could scan or put them together in a clean way. To the extent that you have any paper related to your case files, make sure that they are scanned and available in electronic version so when you do your webinar reviews, you can pull up the supporting documentation easily and quickly.

And that gets to the last point. All these reviews were conducted via webinar. And for Kaiser, which is a really large plan, when you operate in several time zones and in several regions and on different platforms, this just requires an enormous amount of coordination.

So I think the previous slide talked about what the new protocols are. And not surprising, those new protocols also proved to be our challenges in the review. And again, I think I touched on some of them. And that has to do with the short turnaround times to produce those universes. We basically had about a week. So it's hard enough when you have the universe fields automated, but it's even harder if you don't. So again, a lot, a lot of late nights – so again, look at those audit guides that CMS has released and make sure you know what they're going to ask for.

Again, the coordination aspect that I just touched on with folks across multiple time zones, this was really an all-hands-on-deck exercise whereby it wasn't just Compliance pulling together these case samples or the universes. It required full partnership and cooperation with our operational partners and then having people -- making sure that they were available at the right time -- also making sure that your vendors are aware of your audit and are ready to produce files when necessary or even sit in on the audits.

Another issue that we had had to do with some of our technical difficulties related to WebEx. You know, viewing and opening large files via webinar can be challenging. Some of our systems are slow. Again, we were organizing across multiple time zones and multiple platforms. So sometimes we even stalled. It's real important to have technical folks, and I think again other panelists spoke to this as well. And then navigating complex data systems in real time could be challenging.

And then one issue that proved difficult for us and could be a problem for you all was our OEV calls over the webinar. We actually had to install special software upgrades to allow those audio files to play over webinar.

So in terms of lessons learned, again, these are going to look familiar. Secure your leadership support to ensure that you have adequate resources when this review does occur because, again, it takes a village. This cannot be a Compliance Department exercise. You need WebEx savvy people available to facilitate those meetings so when your system stalls, your WebEx stalls, or something doesn't work, you can utilize folks' time appropriately. Because again keep in mind all the time your operational folks are spending on this audit, they're not spending the time doing the work that they're supposed to be doing.

And again, I've touched on this – ensure your electronic versions of documents are available. Anything that you have on paper, try to get that scanned so it can be quickly retrieved and effective

archiving. And again, this is all hands on deck. So I think a lot of folks talked about the partnerships with their operational departments, and I can't say enough how important that was and how cooperative our operational departments were. And I do want to mention that CMS, because I think we were the first Plan, was extremely accommodating to some of the challenges that I mentioned before. And again, hopefully you all can benefit from our experience.

So I just wanted to switch gears a little bit and talk about Kaiser's Compliance Program audit and some of the best practices that CMS cited as a result of our review. We did end up passing all eight elements of our Compliance Program Review. I do want to say that Kaiser's program was reviewed in the fall of 2010, and I do feel like we did have the benefit of that review to fix any past deficiencies that might have been cited. And I think that played into why we might have done so well.

First, I wanted to mention our Data Mining Team. We have an analytic team that's dedicated to data mining. They look at encounter data claims, pharmacy claims for outliers; and they identify patterns that may suggest fraud, waste, and abuse. And then they refer those cases to our Special Investigations Unit. We do not have a dollar threshold associated with any of their findings, so they will pursue any case that we recommend. And they also conduct ad hoc study based on tips. These tips could be a CMS fraud alert, a Google alert, a Hot Line call. And then we also monitor claims paid and CMS-designated high risk counties. This was a finding for us back in the fall of 2010, and we've since corrected that. And we've actually expanded from those five counties – I believe it's ten now.

Another best practice that was cited by CMS was our tracking of our FDR training. And this may be unique to Kaiser because of the special and unique relationship we have with our medical groups. But we actually offer and require that our medical groups take annual compliance training in a standard format. So we create the format. It is web-based. And it sits on our learning management platform. They also attest to our principles of responsibility, which is our Code of Conduct, and we are actually able to track completions at the individual level.

Our Compliance Hot Line is another best practice that was cited by CMS. We receive 7,000 calls a year. It is integrated with a case tracking system, so all of those calls are tracked and investigated and determined whether they are substantiated or not. We track all CAPS where we do have a substantiated case and disciplinary actions that are associated with them. Our system also allows for triaging and then also active monitoring of open cases that we're sure that cases aren't open for too long.

Another best practice that was cited, and this one is near and dear to my heart because I'm intimately involved almost on a daily basis, is our new CMS Issuance Process. This is process whereby our Regulatory Team, our Legal Team, and our business partners meet on a weekly basis where we look at CMS Sub-regulatory Guidance. We determine business impact. We create a communication, and we push it out to the Medicare Business Line. We determine what next steps -- if it's actionable, what the timeline for implementation is. And then we track implementation to completion.

And finally, and not least of all, our Code of Conduct was also cited as a best practice. And it wasn't just the content of the Code of Conduct. It was our website that allows employees to add comments or ask questions. And it also showcases our policies, procedures, and compliance tool kits.

CMS also cited numerous other best practices related to our Compliance Program. And again, very similar to what you heard today – robust monitoring program, a specialized unit that does internal audits that is focused on our Medicare line of business, our Part D open formulary. So whether it was a functional area or compliance program, you'll hear a lot of the same themes. And again, I think it's really about your partnership with your operational areas in your line of business. It's about open communication, and it's about leadership support.

Thank you.