DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

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To: All Medicare Advantage Organizations and Prescription Drug Plans

From: Gerard Mulcahy, Director
Medicare Parts C and D Oversight and Enforcement Group

Subject: Common Conditions, Improvement Strategies, and Best Practices based on 2013 Program Audit Reviews

In the course of conducting audits and best practice reviews, the Centers for Medicare & Medicaid Services (CMS), Medicare Parts C and D Oversight and Enforcement Group (MOEG), has observed program areas where multiple sponsors were non-compliant with Medicare regulations and guidance, in addition to areas in which Medicare Advantage (MA) organizations and Part D sponsors demonstrated excellence in operations and achieved strong results.

This memo seeks to share the top five common conditions (i.e., audit findings) for each audit area, the causes of these conditions, ideas for improving performance in these areas, and best practices identified through the course of the 29 program audits conducted during 2013. The audit or program areas include: Part D Formulary and Benefit Administration (FA); Part D Coverage Determinations, Appeals, and Grievances (CDAG); Part C Organization Determinations, Appeals, and Grievances (ODAG); Compliance Program Effectiveness (CPE); and Special Needs Plan Model of Care (SNP MOC). Note, not all 29 sponsors were audited in all of these program areas (see attachments A-E for details). In addition, although Parts C and D Outbound Enrollment Verification (OEV) was a 2013 program audit area, the OEV results are not included in this memo due to the issuance of CMS-4159-F on May 23, 2014 (79 FR 29844), which significantly simplified agent broker requirements.

We want to remind sponsors that 3 prior Best Practice/Common Findings memos[1] have been issued. These memos are intended to provide sponsors with actionable information to enhance their compliance with CMS regulations and policy and improve audit outcomes. The number of recurrent conditions highlighted in this memo and the frequency with which they have been cited in past memos suggests this information, as well as other internal monitoring recommendations and tools, are not being utilized as expected. Sponsors should be aware that conditions noted in one or more Best Practice/Common Findings memos will be considered an aggravating circumstance during the course of future program audits, which can adversely affect a sponsor's overall audit score. For example, an observation might be elevated to a corrective action required (CAR) or a CAR might be elevated to an immediate corrective action required (ICAR) if the condition cited had been addressed in a prior Best Practice memo.

CMS expects all sponsors to carefully and routinely assess risks to their organization, as well as

[1] January 20, 2012, "2011 Program Audit Findings and Best Practices"; September 10, 2012, "Best Practices and Common Findings from 2012 Program Audits"; July 30, 2013, "Best Practices and Common Findings Memo #2 from 2012 Program Audits".

monitor and audit their operations to ensure compliance with CMS requirements. Sponsors should review this memo with their compliance staff, compliance committee, senior leadership and other affected stakeholders and take appropriate action. CMS Account Managers (AM) will also be discussing this memo with their sponsors. We believe sponsors that implement the best practices described in this memo should expect to achieve even greater success. In addition, we hope that sharing the common conditions and their related causes will help all sponsors focus their internal monitoring efforts and ensure any problems are corrected.

If you have any questions regarding the audit findings or best practices, please submit your inquiry to part_c_part_d_audit@cms.hhs.gov.

Attachment A: Part D Formulary and Benefit Administration (FA)
Sponsors audited for FA: 28

Condition and Cause Summary (FA)	Sponsors Affected	Memo Recurrence
Condition: Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.	17 (61%)	4/4

Cause Summary:
• Inappropriately rejected claims based on the following:
  o Utilized maximum daily dose limits that were more restrictive than the CMS-approved quantity limits and/or Food and Drug Administration (FDA) maximum recommended daily doses.
  o Applied a CMS-approved quantity limit specific for brand drugs only to generic versions of the drugs.
  o Failed to appropriately test and/or implement coding of quantity limits in the adjudication system, resulting in inappropriate rejections.
  o Applied quantity limits to non-formulary medications.		

Condition: Sponsor failed to properly administer its CMS-approved formulary by applying unapproved utilization management practices.	14 (50%)	4/4

Cause Summary:
• Implemented system edits that were not supported by FDA labeling and not part of the CMS-approved formulary, such as:
  o High dose
  o Age
  o Gender
• Failed to allow claims for formulary drugs dispensed in the smallest commercially available package size when the day supply, based on the prescribed dose, exceeded the plan's day supply benefit.
• Failed to allow claims for extended day supplies on initial prescriptions.		

Condition and Cause Summary (FA)	Sponsors Affected	Memo Recurrence
Condition: Sponsor failed to properly administer the CMS transition policy.	12 (43%)	4/4

Cause Summary:
• Inappropriately rejected claims based on the following:
  ○ Applied prior authorization edits on claims for beneficiaries with a utilization history of protected class drugs.
  ○ Failed to document that a transition notice was mailed to a beneficiary (or his/her representative).
  ○ Failed to afford long term care beneficiaries multiple transition fills as necessary during the entire length of the transition period.
  ○ Failed to correctly identify drugs with a negative cross-year formulary change.
• Imposed utilization management edits that were not appropriate during transition (e.g., the inappropriate edits were <u>not</u> related to: Part B vs. Part D determination; FDA maximum daily dose; early refill, etc.).
• Failed to generate and/or mail transition notices in a timely manner due to a manual file transfer process.
• System was coded to reject transition-eligible claims for drugs in their smallest available package size when the calculated days' supply exceeded the transition day supply limits.
• Transition policy did not afford a transition fill for drugs with a negative cross-year formulary change.
• Transition policy classified emergency fills for long term care beneficiaries as transition fills which did not allow the system to recognize the medications as existing treatment/therapy.		

Condition: Sponsor improperly effectuated a prior authorization or exception request.	11 (39%)	4/4
Cause Summary: • Failed to appropriately process a manual claim for reimbursement. • Issued one-time authorizations instead of making coverage determination requests, which, if approved, would need to be effective for the remainder of the plan year. • System overrides were not properly coded as a result of favorable PA or exception requests (i.e., overrides of step therapy or refill too soon edits). • Improperly effectuated prior authorization and exception requests at too granular a level (i.e., dose-specific), which resulted in beneficiaries having to request additional coverage determinations with any change in dose. • Effectuated authorizations for less than the period of time required by CMS. Specifically, less than the end of the plan year for formulary exceptions, and/or less than the CMS-approved prior authorization coverage duration.		
Condition: Sponsor failed to provide a continuing beneficiary a transition supply of a non-formulary medication.	9 (32%)	4/4

Cause Summary:
• Continuing beneficiaries were not identified as eligible for a transition supply for various reasons such as:
  ○ Unsuccessful look-back logic.
  ○ Incorrect identification of drugs with a cross-year negative formulary change (e.g., deletion, PA/ST addition).
  ○ Incorrect enrollment date and/or plan information.
  ○ Sponsor lacked the ability to programmatically remove utilization management restrictions, previously in place, from drugs that changed to non-formulary status in the next contract year.		

Improvement Strategies (FA)
Test the logic of the programming for all drugs that changed formulary status from one year to the next to ensure they adjudicate properly.
Test claims for formulary drugs to ensure that inappropriate edits do not cause rejections.
Test transition logic prior to the start of the new plan year to ensure that claims for new beneficiaries will not reject for transition supplies.
Perform quality checks by routinely comparing the formulary file submitted to CMS and the adjudication system file to ensure that there are not inconsistencies that could create discrepancies and inappropriate rejections (e.g., unapproved UM, drug deletion, etc.).
Complete a review of 100% of rejected claims to identify and correct any formulary and transition errors and then periodically review rejected claims to ensure no new errors develop.

Best Practices (FA)
Concurrent drug utilization review (DUR) logic was used to alert pharmacists to potential therapeutic duplications and overutilization. Pharmacists were alerted when beneficiaries had claims from 4 or more prescribers or 4 or more pharmacies for drugs in the same therapeutic class.
When claims were adjudicated for oral corticosteroids that had Part B vs. Part D prior authorizations (PA Type 3), a claims look-back process for immunosuppressant therapy was used before rejecting claims. In the absence of immunosuppressant therapy, the corticosteroid claim automatically paid at point-of-sale under Part D to avoid unnecessary delays in accessing therapy.

Attachment B: Part D Coverage Determinations, Appeals, and Grievances (CDAG)
Sponsors audited for CDAG: 27

Condition and Cause Summary (CDAG)	Sponsors Affected	Memo Recurrence
Condition: Beneficiaries and prescribers did not receive an adequate and/or accurate rationale for the denial.	24 (89%)	4/4
Cause Summary: • Denial language was not clearly understandable to the beneficiary and prescriber and did not contain the specific reasons for the denial and any requirements that needed to be met to allow coverage. • Sponsor's software did not permit the user to modify or customize the denial reasons to comply with the requirement that the denial rationale is specific to each case. • Denial rationale did not comport with the CMS-approved formulary and/or coverage criteria for the requested medication.		
Condition: Sponsor did not demonstrate sufficient outreach to the prescriber or beneficiary to obtain information necessary to make an appropriate clinical decision.	21 (78%)	4/4

Cause Summary:
• Sufficient outreach was not performed for the following reasons:
  o No formal outreach policy in place.
  o Existing outreach policy was not followed nor were there proper internal controls to detect the sponsor's non-compliance.
  o No additional outreach attempts were made by the sponsor after the initial attempt.
• Sponsor lacked effective internal controls to ensure sufficient supporting documentation was obtained from the prescriber.		

Condition: Sponsor misclassified a coverage determination or redetermination request as a grievance and/or customer service inquiry.	16 (59%)	3/4
Cause Summary: • Sponsor lacked effective controls to monitor the processing, classifying and resolution of beneficiary inquiries to ensure Part D requirements were followed (e.g., grievance coordinators, Customer Service Representatives, etc.).		

Condition and Cause Summary (CDAG)	Sponsors Affected	Memo Recurrence
Condition: Sponsor did not notify the beneficiary or their prescriber, as appropriate, of its decision within 72 hours of receipt of a standard coverage determination request or, for an exceptions request, the physician's or other prescriber's supporting statement.	15 (56%)	3/4
Cause Summary: • Sponsor lacked adequate processes and internal controls to ensure beneficiaries were notified of standard coverage determination decisions within the CMS required timelines. • Sponsor inappropriately tolled all coverage determination and appeal requests instead of adhering to required regulatory timeframes. • Coverage on weekends/holidays was not sufficient to ensure cases were worked within the required timeframes if they were received close to or over the weekend/holiday. • Notifications were not sent to beneficiaries after decisions were made.		
Condition: The Sponsor made inappropriate denials when processing coverage determinations.	15 (56%)	4/4
Cause Summary: • Sponsor failed to comply with CMS and plan coverage rules, including CMS-approved utilization management criteria. • Sponsor failed to ensure the clinical accuracy of medical necessity denials. • Clinical staff was not adequately trained or monitored to ensure proper clinical review of prescriber documentation. Clinical reviewers did not consider all available clinical information prior to making a coverage determination (e.g., failure to utilize physician supplied information and previous prescription claims history).		

Improvement Strategies (CDAG)
Clearly provide and explain the reason for denial in the free-text field of the standardized denial notice (e.g. non-formulary, Part B vs. D determination, prior authorization, step therapy, safety edits, etc.). If there is a formulary requirement that must be met, it must be specifically stated and must comport with the CMS-approved formulary. Any applicable Medicare coverage rule or plan policy must be described in the denial rationale (e.g., a B v. D denial for an immunosuppressant drug must describe Medicare coverage rules for these drugs).
Ensure that systems clearly indicate time of receipt of a coverage determination or redetermination request (via a time stamp) and identify whether it is a standard or expedited request. The system should provide reminders of impending deadlines that are accessible to multiple staff members, and allow for tracking of elapsed time and daily management reports of pending workload. Additionally, the system should indicate when the beneficiary/provider notice was mailed, not just when the notice was created.
Ensure that the staff processing coverage determination requests understand and follow CMS' policy for tolling adjudication timeframes for exception requests (i.e., tolling only at the coverage determination level and only when a prescriber's supporting statement is needed for adjudication).
Improvement Strategies (CDAG)

Sponsor and their medical directors must ensure the clinical accuracy of plan decision-making, including adherence to Medicare and plan coverage criteria (e.g., clinical reviewers are trained and can access all applicable rules, formularies and compendia). This includes ensuring all adverse coverage determinations involving medical necessity are reviewed by an appropriate clinician, all redeterminations involving medical necessity are made by an appropriate physician, and all prescriber supporting statements for exception requests are given appropriate consideration.

Best Practices (CDAG)
Payments for Direct Member Reimbursement (DMR) requests were issued on a daily basis. By making prompt and timely payments for reimbursement requests beneficiaries did not experience financial hardships or delays in access to care.
Sponsor initiated an internal review process to aggressively resolve Part B vs. Part D rejections from the previous day by reviewing all rejections and proactively beginning a coverage determination if one had not already begun. The process included researching information, such as call logs and claims history, and performing outreach to pharmacies and prescribers to determine the appropriate coverage in each case. This proactive approach ensured that beneficiaries did not experience more than a one day delay in access to medication as a result of Part B vs. Part D system rejections.
Sponsor had systems that were able to provide an automated claim look-back for medications requiring prior authorization for new starts only (PA Type 2), for a period of 180 days, to allow effectuation without requiring another coverage determination.

Attachment C: Part C Organization Determinations, Appeals, and Grievances (ODAG)
Sponsors audited for ODAG: 24

Condition and Cause Summary (ODAG)	Sponsors Affected	Memo Recurrence
Condition: Sponsor did not make payment decisions within the required 30 or 60 day claims processing timeframes.	18 (75%)	2/4
Cause Summary: • Paper claims were converted into electronic data interchange (EDI) files prior to uploading them into the claim processing system, which caused a delay. • Sponsor lacked effective processes and internal controls to ensure that needed documentation was gathered and reviewed on backlogged cases, so that a decision could be made within the required timeframes. • Sponsor held claims and requested information before sending it to their delegated entity to issue a decision, which resulted in late determinations being issued by the delegated entity. • Sponsor lacked adequate processes and/or internal controls to detect the absence of an internal or external (if completed by a delegated entity) comprehensive and timely review process. • The claims department lacked sufficient staffing to ensure payment requests were adjudicated timely. • Claims were incorrectly determined to be unclean when received and thus were not processed within required timeframes. • The claims system payment code was not properly programmed for immediate payment release.		
Condition: Sponsor did not notify the beneficiary or the provider of its decision within 14 calendar days of receipt of a standard, pre-service organization determination request.	14 (58%)	3/4
Cause Summary: • Inappropriate use of timeframe extensions when a provider was not prompt in returning information. • Inadequate processes and internal controls to ensure pre-service organization determination requests were adjudicated timely. • Systems or processes lacked the ability to alert a sponsor that the timeframe to issue a decision was about to expire. • Inappropriate staffing levels (i.e., being understaffed).		
Condition: Beneficiaries and providers did not receive an adequate and/or accurate rationale for the denial.	13 (54%)	3/4
Cause Summary: • The system which generated the Explanation of Benefits (EOBs) did not have the capability to incorporate a clear and detailed rationale for the denial. • Sponsor lacked effective internal controls to ensure the Integrated Denial Notice (IDN) was written in a manner the beneficiary could understand, or that the IDNs contained accurate information about the denied services and a clear and detailed rationale for the denial.		
Condition: When the sponsor denied a request for payment from a non-contracted provider, the remittance advice/denial notice did not state the specific reason for the denial nor did it provide a description of the appeals process.	12 (50%)	3/4

Condition and Cause Summary (ODAG)	Sponsors Affected	Memo Recurrence
Cause Summary: • Sponsor did not have policies and procedures to provide appeal rights to non-contracted providers with the denial notice. • Sponsor lacked adequate internal controls to ensure the Explanation of Payment (EOP) notices or remittance advice sent to non-contracted providers contained the standard appeal language.		
Condition: Sponsor did not demonstrate sufficient outreach to the provider or beneficiary to obtain the information necessary to make an appropriate clinical decision.	12 (50%)	3/4
Cause Summary: • Sponsor lacked adequate processes and internal controls to ensure clinical information was obtained prior to making a decision.		

Improvement Strategies (ODAG)
Ensure that beneficiaries and providers receive accurate, clear and detailed information related to the specific reason(s) for denial (e.g. not a covered benefit, not medically necessary, did not meet clinical/medical criteria, etc.) The applicable Medicare coverage rule or plan policy (e.g., EOC provision) must be described in the denial rationale. If a requirement must be met to obtain the service, the sponsor should include that information in the denial notice.
Ensure that beneficiaries and providers receive detailed, accurate and complete information about the appeals process, including information about how to file an appeal with the Independent Review Entity (IRE).
Perform quality assurance tests on systems to ensure that processing and notification of standard and expedited organization determination requests occurs within required timeframes. Sponsor should ensure its systems clearly indicate the date and time (for expedited requests) of receipt of an organization determination or reconsideration request and identify whether it is a standard or expedited request. The system should provide reminders or alerts of impending deadlines not only to the staff assigned to process these requests but provide management reports of pending workload.
Provide training and adequate support to staff responsible for processing organization determinations and reconsiderations to ensure its staff understands CMS' policy for using the 14 day extension to requests additional information.

Best Practices (ODAG)
A health care manager was assigned to beneficiaries to guide them through the organization determination and reconsideration processes, namely, requesting prior authorization for items and services.
The Explanation of Benefits (EOBs) denoted a zero dollar balance, which helped ensure the beneficiary understood that they did not have any financial liability.

All calls received by customer service representatives were recorded. This allowed for a comprehensive review of all beneficiary grievances or coverage requests, and for the opportunity to improve performance associated with call classification issues.

Attachment D: Compliance Program Effectiveness (CPE)
Sponsors audited for CPE: 28

Condition and Cause Summary (CPE)	Sponsors Affected	Memo Recurrence
Condition: Sponsor did not review OIG and GSA exclusion lists for any new employee, temporary employee, volunteer, consultant, governing body member and/or FDR prior to hiring or contracting; nor monthly thereafter.	18 (64%)	2/4
Cause Summary: • Sufficient resources were not deployed to review the OIG and GSA exclusion lists in accordance with CMS requirements. • Sponsor failed to review employees of delegated entities against the exclusion lists. • Sponsor was unaware of the CMS requirements for FDR oversight.		
Condition: Sponsor did not provide evidence that it audits the effectiveness of the compliance program at least annually and that the results are shared with the governing body of their organization.	10 (36%)	2/4
Cause Summary: • Sponsor did not provide sufficient resources to conduct an independent audit of the compliance program. • During periods of management transitions the need for an annual audit of the effectiveness of the compliance program was not communicated internally. • The FWA regulatory requirements were excluded from the scope of the compliance program audit. • When an external audit firm was hired to perform a compliance program audit, the audit did not address many of the elements of an effective compliance program as required by Chapters 9 and 21.		
Condition: Sponsor did not provide fraud, waste and abuse (FWA) training or training materials to its FDRs.	8 (29%)	3/4
Cause Summary: • Sponsor lacked adequate processes to ensure that FDRs were identified to receive FWA training both upon contracting and annually thereafter. • Sponsor lacked sufficient resources to implement a compliance program in accordance with CMS requirements, particularly related to FDR oversight. • Sponsor lacked awareness that FWA training materials needed to be provided to FDRs or that FWA training be provided directly to its FDRs.		
Condition: Sponsor did not provide evidence that general compliance information was communicated to its FDRs.	7 (25%)	1/4
Cause Summary: • Sponsor lacked awareness that the distribution of general compliance information to first tier entities was a CMS requirement. • Sponsor lacked adequate processes to ensure compliance program requirements were met and well documented. • Signed attestations from FDRs during the audit period were not received and no follow-up was conducted to obtain the attestations.		

Condition and Cause Summary (CPE)	Sponsors Affected	Memo Recurrence
Condition: The Sponsor did not distribute its standards of conduct (SOC) and policies and procedures to employees who supported the Medicare line of business: (1) Within 90 days of hire; (2) when there were updates to the policies and procedures, and, (3) annually thereafter.	7 (25%)	3/4
Cause Summary: • Sponsor lacked adequate internal controls or formalized processes to ensure that all FDRs either received its SOC and compliance policies and procedures. • Adequate documentation was not maintained to verify that all employees received SOCs upon hire.		

Improvement Strategies (CPE)
Ensure that internal processes for communicating compliance information to FDRs are implemented timely and followed appropriately. Annual FWA training can be met through use of the web-based training module available through the Medicare Learning Network (MLN).
Develop a process that monitors and tracks the distribution of standards of conduct (SOC) and policies and procedures to ensure sponsors are distributing: (1) within 90 days of hire, (2) when there are updates, and, (3) annually thereafter.
Develop automated monitoring and auditing systems to detect excluded providers and retain source documentation or screen prints from OIG and GSA exclusion databases. A robust monitoring system is needed to detect excluded providers, employees, temporary employees, volunteers, consultants, governing body members and/or FDRs prior to hiring or contracting, and monthly thereafter.
Develop effective working relationships and frequent communication between the compliance department and business function areas and FDRs (e.g. PBM, providers, pharmacies, hospitals, suppliers, contractors, etc.)
Streamline compliance and FWA training and education efforts with the use of CMS' web-based Compliance and FWA Training module on the Medicare Learning Network (MLN).

Best Practices (CPE)
Sponsor placed their compliance/fraud, waste and abuse (FWA) reporting hotline contact information on the back of all employees' security access badges.
Sponsor developed a process for distributing CMS guidance memos received via HPMS to appropriate personnel and confirming the new programmatic requirements were implemented by the appropriate functional areas. The Compliance Officer notified appropriate parties on the distribution list within hours of receiving HPMS memos. In addition, a Vice President with executive responsibility for the Medicare program ensured that other appropriate personnel (including first-tier, downstream and related entities (FDRs)) received information about the memos within 24 hours. When HPMS memos were received by operational owners responsible for implementing the new guidance, the operational owners were required to confirm review of the memo and provide an action plan if steps were needed to update procedures and processes.

Best Practices (CPE)
Sponsor checked the Office of Inspector General (OIG) and General Services Administration (GSA) Excluded Parties List System (EPLS) exclusion lists on a monthly basis which was automated for all employees, providers and first-tier, downstream and related entities (FDRs) involved in providing healthcare services to Medicare beneficiaries. In return, the workload for the compliance and human resources departments was reduced and documentation could easily be tracked and obtained for auditing purposes.
Sponsor provided detailed training to the governing body regarding roles and responsibilities, as well as the complexity of the Medicare Parts C and D requirements. These included specific questions the members of the governing body should be asking the compliance officer, in relation to the risks and compliance activity specific to the Medicare line of business, and to the effectiveness of the compliance program with detecting, responding to, and preventing noncompliance and fraudulent activities. The training encouraged the governing body members to become active and engaged in the discussions regarding oversight of the compliance program.
Sponsor developed an online monitoring tool to track and manage corrective action plans (CAP) developed from external and internal audits. The tool was used to track Medicare key performance indicators across operational areas, manage annual reviews of all Medicare policies and procedures, and served as an audit module for operational audits conducted by the Compliance Department. The tool included links to all Medicare guidance and audit protocols.
Sponsor developed an internal Medicare FWA prevention program. Various materials were developed including creative posters and puzzle cubes to get employees as well as delegated entities engaged in FWA detection and prevention. Following the official launch of the campaign, an increase in employees reporting potential/suspected FWA issues for its Medicare plans was observed.
Personnel within the Compliance Department had background and technical experience specific to the Medicare Parts C and/or Part D areas they oversaw. For example, a compliance officer with experience in a clinical/pharmacy setting worked closely with the formulary, PBM and CDAG departments to develop training, provide technical guidance on regulatory requirements, and perform auditing and monitoring activities.
Sponsor added common conditions from the CMS program audit Best Practice/Common Finding memos to an internal risk assessment to drive internal audit processes to identify and correct areas of non-compliance.

Attachment E: Special Needs Plans Model of Care (SNP MOC)
Sponsors audited for SNP MOC: 12

Condition and Cause Summary (SNP MOC)	Sponsors Affected	Memo Recurrence
Condition: Sponsor administered the initial health risk assessment (HRA) to a beneficiary more than 90 days after their enrollment.	9 (75%)	1/4
Cause Summary: • Inadequate processes and controls to ensure initial assessments were consistently performed within 90 days of enrollment. • Documentation from the sponsor's vendor was not available to prove the HRA was conducted. • Initial HRAs were missed due to incomplete data. • Resources were not sufficient to manage all elements of the model of care.		
Condition: Sponsor did not administer the comprehensive annual reassessment within 12 months of the last risk assessment.	9 (75%)	1/4
Cause Summary: • Inadequate internal controls to ensure annual reassessments were consistently performed within 12 months of the last risk assessment. • Sponsor did not make multiple attempts to contact beneficiaries.		
Condition: Sponsor did not provide evidence that it had an individualized care plan (ICP) for the beneficiary.	7 (58%)	1/4
Cause Summary: • Sponsor lacked sufficient internal controls to ensure that beneficiaries were consistently assessed, especially those that required care coordination or other related case management services, or to ensure that beneficiaries' ICPs were implemented. • Inappropriately relied on a nursing home facility to develop a beneficiary's ICP. • Evidence was not provided that an ICP was initiated or completed. • Care coordinators did not follow the model of care (MOC) for clinical services. • The HRA process relied only on phone call attempts with little or no follow-up efforts.		
Condition: The ICP did not address issues identified in the HRA.	7 (58%)	1/4
Cause Summary: • Sponsor lacked sufficient internal controls to ensure chronic conditions, especially those that have become exacerbated and/or problematic, were addressed in the ICP. Delegated entities did not receive the HRA; therefore, the delegated entity was not able to develop the ICP based on the needs disclosed in the HRA. • Case management staff did not have the requisite knowledge or experience to identify and prioritize health risks and include these needs in the development and implementation of the ICP. • There were no checks to ensure the ICP addressed issues identified in the HRA. • Care coordinators did not follow the MOC for clinical services.		
Condition: Sponsor did not provide evidence of individualized care plan (ICP) implementation through care or case management notes.	5 (42%)	1/4

Condition and Cause Summary (SNP MOC)	Sponsors Affected	Memo Recurrence
Cause Summary: • Inadequate staffing to manage required functions (e.g., documentation); existing staff required to carry a heavy caseload. • Sponsor lacked effective internal controls, or evidence of such, to ensure the implementation of the ICPs is properly documented.		

Improvement Strategies (SNP MOC)
Implement processes to fully complete the initial and annual HRA in a timely manner.
Ensure staff has appropriate training and tools to implement and document the ICP, and include how the ICP was developed using the HRA.
Implement processes within the ICT to establish roles and responsibilities to ensure appropriate ICP implementation and documentation.
Implement processes to ensure staff is fully trained and understands all components of the SNP MOC. Document evidence that the SNP makes available and offers training to network providers and explain the challenges associated with the completion of the MOC training for network providers.
Periodically review organization policies/procedures as well as desktop procedures for staff and ensure they are in accordance with the SNP's most recent MOC.
Perform regular internal monitoring of procedures that support the MOC implementation (i.e., HRA contact attempts, documentation of member issues and/or updates, completion of HRAs and ICPs in accordance with CMS timeframes, outreach completed regarding training of providers in the network, and documentation of completed staff training in the MOC). Track and include these activities as part of the MA organization's compliance plan.
Ensure that electronic record systems are documenting notes/updates for members and outreach attempts. MA organizations could develop or configure a tracking mechanism/process to alert staff when an HRA is due to be completed for a member.
Develop outreach processes with primary care, specialists, hospitals, and/or long term care facilities to build relationships and further develop methods in care coordination, especially in contacting "hard-to-reach" members.

Best Practices (SNP MOC)
Sponsor's Model of Care established a standard of performing the initial health risk assessment within 30 days of enrollment.
Sponsor established an "Embedded Nurse" program, which included a nurse as part of the interdisciplinary care team to aid in individualized care plan implementation, member assessment and care coordination.