



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Real Time Caption Transcript

The following is a transcript of the real time captioning provided live, during the webcast. It is not a 'text perfect' translation of the spoken word. Rather it is imperfect translation of what the captioner heard. Please refer to the webcast recording for the actual record of the event.

Overview of Retroactive Enrollment/Disenrollment Process

Andrea Hamilton, CM/MPPG/DPP

Denyse Wise, Reed & Associates

Andrea Hamilton

It's my pleasure to introduce the person presenting this information. Andrea Hamilton, the retroactive processing contractor project officer in the division of prospective payment, Medicare payment group. She's worked on various groups and team lead for the 1-800 Medicare project. Prior to joining CMS Ms. Hamilton spent four years as quality assurance manager and training for call centers in both banking and healthcare industries. Joining Ms. Hamilton is Denyse Wise, served on the retroactive processing center since 2007. Served as capital director and oversees tasks assigned to the RPC, over 13 years of program management experience within health compare and the banking community.

As third presenter this afternoon, from the floor, Mr. John Campbell from the division of perspective payment at CMS, Mr. Campbell has been with CMS over five years in the Medicare plan payment group. Prior to CMS Mr. Campbell worked for Human A military healthcare services, supporting active duty and retired military family members. Welcome to all of our presenters. [Applause]

Good afternoon. A promise this will be an interesting presentation, you can close the door. I guarantee you no one will want to leave until the end. This is a much better turn-out than I anticipated, I knew everybody would be down stair and we would have 10 people. This is really good.

Before we start talking about the retroactive enrollment process, I wanted to talk about the general enrollment process. The goal is to reduce the number of retroactive submission that's go to RPC. I will talk about The overall enrollment process and I will turn it over to Denise to talk about the retroactive piece of it.

We will talk about the enrollment process, give a general overview, definition of retroactive request, how to submit to the R PCs, the processing changes, improvement opportunity and the RPC's role after MARx and [indiscernible].

Technology is not always my friend. It was working during the test. I will just talk and eventually the slides will catch up. To start we wanted to talk about how to prepare your CMS transactions for submission. Randy went over a lot of this during the general session talking about the enrollment process. Prior to submitting something to CMS you had to prepare, ensure the information is accurate, correct format, to reduce the number of errors you receive.

Once you get an application request you know there are three things you as a plan can do. Accept it, reject it or request additional information. You are the plan, once you get the information request, those are the three things you can do. For CT MCOM plant, the effective date, CTM is about an enrollment, the rate the enrollee is requesting, beneficiary is requesting,



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

August 1 -- [indiscernible] classified as category two.

Category three cases are effective dates that are more than three months. If you are a plan and are still reconciling your enrollments, still a few are, for January 1 effective date that, is clearly a category three and you need to request approval from your account manager observe before you can submit RPC. If you don't have approval from account manager up get a rejection on the final report. The final report from the RPC is similar to the transaction report or batch, BCSS you received when you submit transactions directly to CMS, a status of the request you sent to the RPC.

I do want to mention the approval for category three, approval letter is required and should be part of the documentation you sent to the RPC. I want to mention the approval only weighs the timeliness requirement, approval from account manager does not mean your request will be successfully processed. You are still required to submit all the necessary documentation. Your account manager approved you to submit a thousand cases for a January 1 effective date, but you failed to commit an enrollment request or PVP, short enrollment form, account manager does not clearly document, it will be rejected. It's income inn KUPL bent on you as a plan Denyse Wise: Andrea's goal is to reduce the retros. My goal is to improve quality and timeliness of processing RET RO active requests. I will go over in general what we consider retroactive submissions, enrollment and disenrollments, PPG change, reinstatement and within payment validation adjustments we have SCC and ESRD, Medicaid and LIS updates.

We have retroactive enrollment, standard, take place during valid election period, employer group health plan enrollment, enrollment corrections, those would include corrections to your PVP numbers, and enrollment with the wrong PBP number, you send it to us as a correction. I have seen cases where plans need to submit effective date changes, those are what we consider enrollment corrections.

We have case enrollment. For the most part case enrollments are the same timeliness guidelines as stated in the December 242009 HPMS memo in terms of documentation requirement and other things you can find that information within the memo.

The type of retroactive PBP change we have, resident change, Benny elected PBP changes, fall within an election period and the last one, PBP correction for original enrollment, I want to clarify that. If this is a correction, PBP number correction, we prefer you don't submit this as a PBP change but enrollment, retroactive enrollment in exchange to the PBP number. Would require you to have a different enrollment form, a short enrollment form to substantiate that PBP change. So be very careful about how you define, categorize your requests so our processors don't box it into a certain type, then deny it when it could have been processed.

Another thing, when dealing with corrections, it's very helpful for processors, specialists, to know exactly what we're correcting. Be very clear on your cover sheet what the data element is in CMS's system and what you're changing it to. Provide whatever substantiation and support. The more information we have on the cover sheet the better we will be able to understand the case, process more timely.

The types of retroactive enrollment, for true dis-enrollments, volunteer disenrollment, Benny driven or involuntary. The other types of disenrollments corrections, plan errors, be very clear on your documentation worksheet the situation behind the plan error, what led up to it and what you need us to do to correct whatever correction took place. Whatever error took place.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

The N type of retroactive enrollment is reinstatements. To understand reinstatements, defined as essentially to occur when we want to erase -- [indiscernible] a retroactive enrollment and documentation supporting that, follow the guidance accordingly.

For a reinstate to correct invalid disenrollment, we have various scene scenarios, mistake made by the member, erroneous death indicator or loss of eligibility. Due to member's involuntary disenrollment by an organization, plan error again.

As we know, plan error is not clearly defined within the guidance at the moment, however I believe within the other situations we -- cases we handle, with more information, documentation worksheet we can usually work through your retroactive reinstatement with the proper information, assuming it's timely and if not timely, assuming you have a valid RO approval. Another thing to make clear, especially with plan error reinstatements, if there's any indication your member was notified of the disenrollment, letter of instruction will be required, if you are not using -- the request will be denied, returned.

In terms of the other type of reinstatement clearly defined in the guidance, I think it's pretty clear a CTU is required for supporting documentation and that's spelled out in the SOP.

Outside of [indiscernible] and requests, a validation adjustment. In general validation adjustments work similar to E and D. Pretty much come about based on reconciliation to MMR, TRR, when you identify any discrepancies based in your system to CMS's system. You should submit information within 45 days of receiving your report; however, we allow each plan to submit payment validation requests within six months. So you have within six months of the request of the effective date, and our receive date to submit the parent validation transaction without supporting documentation.

even though for payment validation request, timely requests, though those do not require supporting documentation you are required to retain that documentation in-house.

Payment validation requests again include Medicaid's [indiscernible], LIS requests require 100% documentation for review similar to enrollment on [indiscernible]

Going further into the payment validation support and area -- is somebody moving the slides? The quality review process, we have the oversix quality review process. The over 6 requests, payment validation request with effective date greater than six months from our receive date. Cases where the effective date, these requests are not timely, not called category three. At this point they don't require an RL approval, but you have to submit documentation to ensure the change you requested is in line with whatever the beneficiary's demographic information is to date. More than 45 days has gone by, CMS strongly recommends, feels it's necessary a recent contact is established with the member to ensure nothing changed and that whatever adjustment you are making is valid.

Foe, validation requests over six months we require up-front documentation. In addition to that, for the request that we process in good faith without documentation that is timely, we are now calling those quality review cases. Used to be called the [indiscernible] process, no one like that's word, got rid of that. The quality review process is to help CMS ensure appropriate documentation is used and saved for all [indiscernible] submitted and processed by us. Overall this helps improve the compliance, and allows for opportunity of planned outreach should we notice a pattern or trend in processing, operations that we report to CMS and your



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

account manager may contact you for further training and updates.

The quality review process, each month we have a cut-off for requests processed favorably we perform a 5% sample. That 5% sample is sent back to your organization to then turn around and submit the supporting documentation to substantiate the requests. The time frame is usually seven days, playing catch-up at the moment, but will soon get to an automated process where it will be pretty systemic and you will receive them on a monthly basis right around the same time pretty much.

Now we are going into how to submit requests or transactions and work to us. I want you to know that in general you can find within our toolkit on our website, information on how to submit to us, whether reTRO active request or quality review transaction. Specifically, for active requests you want to use the submission spreadsheet, separate category two from category three cases. You want to do that because category three cases require an approval letter, we must reconcile your category three cases to your approval. If they do not reconcile then we usually run into processing problems, that requires us to do further analysis and evaluation which greatly delays the processing of your request.

It's preferred to separate categories. The spreadsheet has a macro function to ensure you use correct formatting for state and county code, election period, things of that nature. We find often plans tend not to -- just quality check their spreadsheet and some honest typos can be avoided using that function. I know it's not the easiest function, but if you are able to use it I highly recommend it.

For documentation worksheet, it's required for all enrollment and disenrollment requests. I also highly recommend using dock AOUPLTation worksheet for -- not required, but a good practice to get into just so we have all the necessary information to understand again why was the request not reconciled timely or not submitted timely. What did you need to do to obtain the information to validate it, et cetera. I recommend you use that. It really helps processors understand the situation rather than trying to draw conclusions.

Be sure to provide detailed explanations, especially for plan errors, it's very important. Select the appropriate request type, as well as the election period. This is always important. Sometimes plans use PBP change and enrollment interchangeably, things of that nature, sometimes disenrollment instead of enrollment. Not sure why.

Trying to streamline, get anywhere from 400 to 500,000 cases a year, so we need a system to add admin STER this and it would be nice to rely on accuracy of the documentation you submit to streamline the process.

Including appropriate documentation, the enrollment form, continue to use letter, et cetera, unfortunately we cannot make exceptions, I have seen cases where the cover letter doesn't have enrollment form but have a letter. That's not something we can waive or even consider. If you don't have appropriate documentation outlined in the guidance, or SOP, contact account manager for further guidance, not a decision we can make regardless of the circumstances on your end.

What happens once you submitted the submission? Well, we receive a submission package from the courier, the package is logged by our front desk, then saved on to a third directory. Then we consolidate your data, try to clean it up so it's compatible with our system for uploading



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

purposes. Once we have determined all the necessary data elements are on the spreadsheet, your file, naming convention is accurate, things of that nature, we know what type of request it is, category two, three, then we can move on and put it into our support services queue. We go through requests on the system, match documentation to each request and send an acknowledgment e-mail.

If there are any errors within the submission spreadsheet you receive a separate e-mail or correspondence, error report. That lists the requests we could not upload due to the -- either bennie name or [indiscernible] name mismatch or incorrect invalid start or end date, things of that nature. It works similar to the BCSS file. I highly recommend you look at them, cure whatever problem is identified and resubmit immediately. That way there's no delay, concern with the case aging into possibly category three status if it was submitted as category two. Once the request is submitted, uploaded successfully, it's routed to the functional area, [indiscernible] two separate trained divisions, requesting review by trained specialist in the order received. If the request is valid, upon the review, meaning they review the request, includes the data on the spreadsheet, data you entered on the documentation worksheet, the actual documentation and information in MARx, it's very important for all of you to be sure you quality check all your information, because we do. If there's any inconsistencies between the documentation spreadsheet and MARx, we have a problem and don't know what to do. I am finding more and more those are the reasons we are unable to process requests, due to inconsistent information. If the request is valid we are able to process in MARx, disposition code, indicates whether or not we can process it, and if not why we could not process as requested.

Dom completed, reported, e-mailed to your organization point of contact through our secure encrypted program.

I want to take a brief moment to highlight changes we will make. I know that we came out with a toolkit, including SOP, I hope everyone found to be more helpful, informative, however everything is always a work in progress. There will be another release to add items or clarify points that seem to have been a little misleading or confusing for some.

The first thing we will change the documentation worksheet to include components for the telephonic enrollment. We will add an option, type of enrollment mechanism when it's other than a paper app. We will ask you note the date of the call, since the date of the call equals the application receipt date, it's important to note the date of the call. This does not waive needing telephonic enrollment, your call log or whatever you use to provide us as your telephonic enrollment, however that information is not always clear what date the call took place. There's conflicting information. We need you to attest to the date the call took place so we can validate the effective date of that enrollment.

We are now going to make changes to documentation requirement to individuals with RDS status. The training code, 127 works similarly on our end as your end batch. When we receive a request from a member with the employer group, employer [indiscernible] coverage, we also receive an error message in MARx, required to override that. Since 2009 was a new memo we based a processing of this, assumption that you were contacting the member, obtaining intent to enroll, however we cannot go on that, need you to submit documentation, contacted member, wish to be enrolled, aware of consequences of that enrollment.

In addition, another point I would like to make, the change to our SOP. These changes will be



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

clearly defined within the SOP, so you will be able to follow them more easily. The other thing we will change in the SOP is clarifying the RBPC guidance on transactions, it was construed within the CTM section in the SOP where it states a proved or current CTM requests are category two requests. We were in no way referring if you had a current complaint that drove the time frame requirement. That is not true. The CTM requirement has to follow the requirements of other requests. The complaint does not start the clock. The transaction starts the clock. We will be sure to make that clear in the update. If you have retroactive enrollment, with current, within the current three months effective date and appropriate documentation, you do not need an R approval, there are those out there driven by complaint, don't necessarily need case work or RO approval. Sometimes the account manager will never look at it, but it is driven by a complaint. Those cases you can send to us simply as category two request; however, we still need appropriate documentation as if it stood alone, as if it wasn't a CTM. On the other hand, if you have approved CTM, meaning your case worker did approve it, have reviewed it, then you don't need to go through the category three process. The CT MCOM plant process is different from category three. Category three was meant to be, to resolve the issue of operational problems within an organization and address timeliness of submitting retroactive requests. CT MCOM plants are a different story. If you have a case reviewed and approved by your case worker, no need to go through another entity at your regional office for a second approval.

I think that's pretty much it. We can move on to -- validating data for submit suggest key. Our number one errors come from inconsistent data on spreadsheet and documentation work sheet. Review the upload error reports timely. Make sure your designated point of contact is checking their e-mail, reviewing e-mail and taking action immediately.

Review final disposition reports timely, same thing. Whoever your organization designated as point of contact; they are the one we assume are reviewing e-mail daily and are taking action on anything they see that is not processed.

Submit all RO approvals together, increases your chances of requests not being processed. Provide detailed explanation on the documentation worksheet, especially for plan errors. A signed cover letter with a statement with every submission, doesn't mean every beneficiary submission, means your entire package. We need a cover letter from an authorized individual from your agency attesting the information is accurate, valid and somebody submitted for processing.

Submit all requests for KPRARBGT and record types, contracts, we have a system that breaks it out. You don't need to worry about sending many, many excel spreadsheets, just segment out, especially the large parent organizations that have up to 100 contract numbers. It's okay to do them all on one spreadsheet if that works for your organization. Either way, we can support it. Please submit all on one spreadsheet. Provide [indiscernible] documentation worksheet to have a field for election period so each period attests to the transaction they are submitting. In addition, it would be helpful if your organization could be consistent with the formatting for election period, sometimes I see they change when they are resubmitted.

Use the same pass word for the submission, as well as FDRs. Sometimes we receive a CD submission package and has an unknown or new password which I assume is probably from somebody from your enrollment gathering department that put that together, but if we could coordinate with the enrollment, be consistent, that would be helpful.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Last, cure your rejected requests before resubmitting. I can't tell you how many times I have seen a resubmission come in the door multiple times, three to five times with no action taken, documentation is completely the same, no new notation on the cover letter. If we denied it there's a reason. If you don't understand, contact client services so they can help you. Otherwise, it will continue to be denied and denied. That's not helpful for anyone, you, your member, or us.

I am going to turn it back over to Andrea, she will talk about the RPC's responsibility post the RNM. [Applause]

I will take a few minutes to talk about how the responsibilities will shift. The RPC will not go away, but slightly shift. I want to talk about that. But before I get to that, I mentioned -- approval, unless account manager waiving documentation -- I want to clarify. RO account manager has the authority to waive documentation, but we do allow that in rare instances where the documentation cannot be produced. Say there was a fire in the facility, you can't produce the documentation, that would be an exception the account manager would say in their approval letter we are waiving because the plan can't produce it. Not something the RO account managers will arbitrarily do.

Two other enhancements we are in the process of making, the [indiscernible] on the final disposition report you receive, we will clarify the definition so you as plans know what actions you are supposed to take after you receive that disposition should you receive an unfavorable decision we want to be sure it's clear on what actions you are required to take to resubmit to the RPC. Lastly, we are working right now with O ISR information systems to try to think of ways to enhance the submission process. We anyhow you submit things to the RPC on a CD and some people still submit paper documentation. We are trying to technologically savvy so that information comes to us. Once we have a strategy we will share that information with you. Now I want to talk about the RPC, quality review, state and county code changes directly to CMS, as well as a lot of the category two information you submit to the RPC today you will have the ability to submit online via the plan user interface. With that, responsibility comes again some risk, and we want to make sure the RPC's role will in turn be quality checking the work you submit. On a monthly basis they will sample the transactions you submit and will require documentation, much like the old pro-- where you submit without documentation and receive a request to submit documentation responding to the requests. With the quality review it will be in response to submissions directly as opposed to the transaction and then them processing for you.

I want to mention the R PCs are not monitored, not auditors. They are going to analyze data, look for trends in enrollment, provide information to your account managers, which in turn will allow them to help you be compliant with CMS standards. How many rejections you receive based on a number, not just user interface transactions, all transactions, what you submit directly to CMS, to them directly, as well as what you submit via the user interface, take the holistic view of transactions to say what are the common errors we see from this organization? How timely are they as far as when they get notified of a data discrepancy, how time lie are they at reinstating beneficiaries. They are not monitors, auditors, just analyzing data and providing to people responsible for, you, to [indiscernible] the standard.

I want to mention, you know your account managers are supplied with information, RPC submits a monthly report allowing them to see the performance at a [indiscernible] level, information we share right now at a patient and you the sponsor, [indiscernible] RPC timely. I am sure some of



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

you who have not been submitting have received a call from your manager and that type of information we share from them to help you.

With that, we will take questions.

Okay, again, there are mics front left and front right. Make your way down, state your name, what organization you represent and whom your question is to be addressed by.

Question: Hi, Jonathan Ayers, compliance consulting for a couple of plans. One question is on the reinstatement process, in particular where there is an erroneous data -- processed by Social Security, you send reinstatement letter. What we're doing that, is a negative impact to the family, makes the plan look incompetent, we are going to regional office, asking for exception approval and wanted to get that out for consideration, something to potentially change in your SOPs. So --

That is definitely something we're taking into consideration. Lynn Orlosky --

It looks like a [indiscernible] on the plan side, it isn't. We had one over a year retro, lots of issues, so thank you.

Thank you very much, sir.

Question: Jennifer [indiscernible], with Health Partners. Can you say a little more about what documentation you are looking for on a quality review, so when you proceed with these -- The quality reviews are any documentation you currently submit to the RPC today. You look at the SOP on the website, state, county code changes submitted to the RPC today, enrollments, disenrollments you submit, the documentation requirements are not going to change. Whatever you submit today will be what will be required for the quality reviews.

Question: Sandra Kane, Etna. For plan errors, statements, it talks about [indiscernible] account manager, does that apply to category two, even within the 90 days?

Say that again.

The final -- talks about sending to account manager. Is that for category two as well? Didn't specify.

[indiscernible]

We will clarify that. Get back.

Hello. I am Michele Jones, from Superior. I wanted to ask on the category two where it says CTM, what if you have a complain that the came from the State Department of insurance, would it still qualify or need to come directly from the CPM?

It did not come as a CTM complaint? What if --

Sometimes because of some of the partnering CMS is doing with the State Departments of insurance, sometimes you get the complaint directly from the Department of Insurance rather than CMS. Would it still qualify or need to come from the CTM?

It would still be a complaint. You can log it into CTM, logged as CTM complaint.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

So you can put it in there?

Yes.

Thank you.

Question: Right now we can't submit [indiscernible] updates until four months, there's the six-month window. I understand those are not considered category two or three, don't specifically have to go to the RO for prior approval. Are there any extenuating circumstances where we would need to go so we can make sure we are prepared, have all the information you need ahead of time?

Is there anything specifically you are looking for, situations where even though it's a -- instead of -- we need to go to the RO, based on time frame or -- no, only for if your documentation could not support the request or the documentation ought lined in [indiscernible], that was it.

Thank you.

You're welcome.

Are there other questions?

Well, if there are no other questions, let's give our panelists another round of applause.
[Applause]