



# Part C and Part D Compliance

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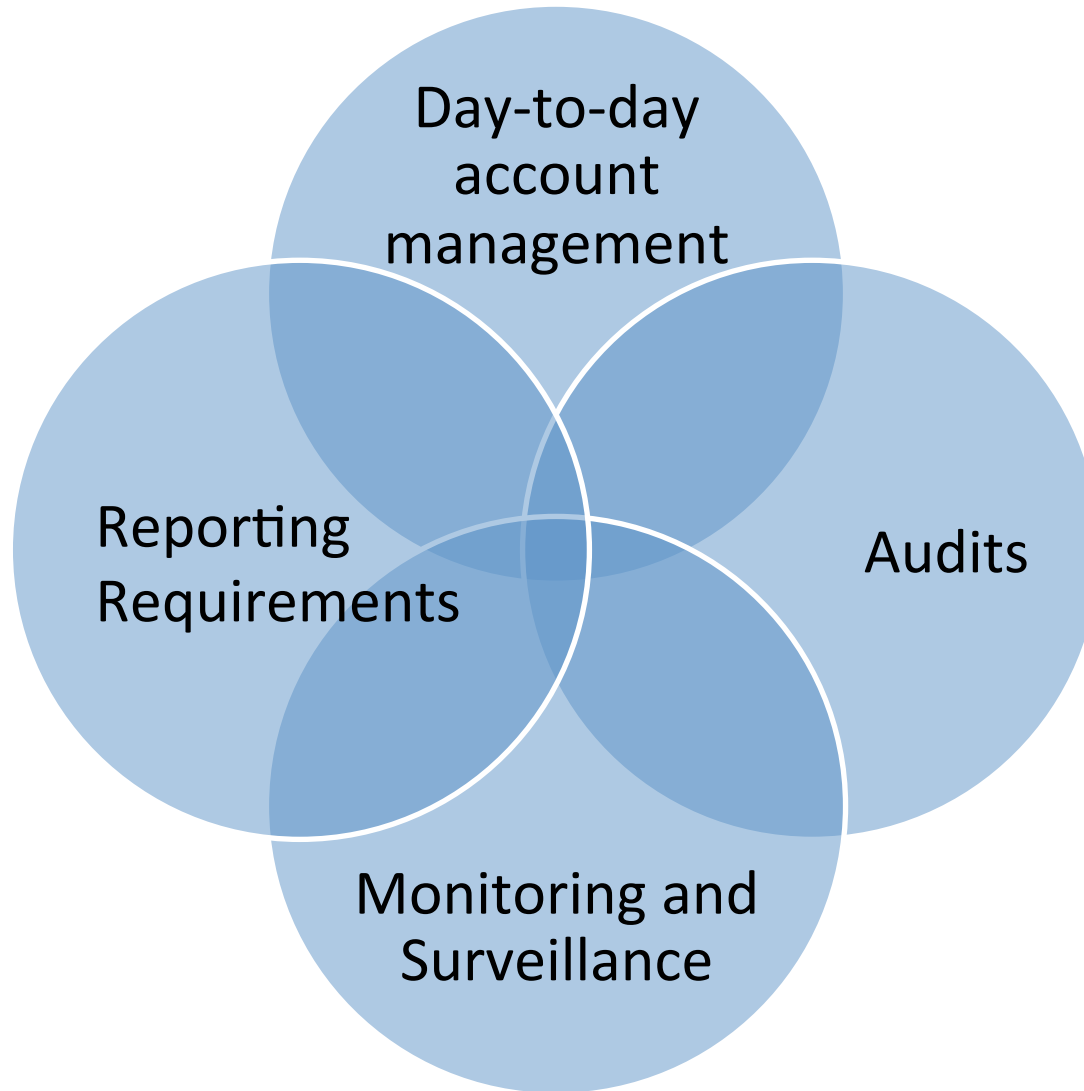
## Evaluating Performance: Oversight Strategy and Activities

# Evaluating Performance

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# Oversight Activities

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# Compliance Tools

Executive Conference Call/Meeting

Notice of Non-Compliance

- May include request for business plan

Warning Letter

- May include request for business plan

Various Suppressions and Exclusions:

- MPDPF suppression
- Medicare & You Handbook exclusion
- On-line enrollment center exclusion
- Fewer formulary update windows
- No reassignments/auto-enrollees

Request for Corrective Action Plan (CAP)

New Applications/SAE Denials

Audit Selection

Enforcement and Termination

# Strategy for Translating Performance Measurement into Compliance

- Take deadlines seriously
- Look for outliers and missed thresholds
- Take note of single instances of problems, but emphasize patterns of non-compliance



# **Strategy for Translating Performance Measurement into Compliance**

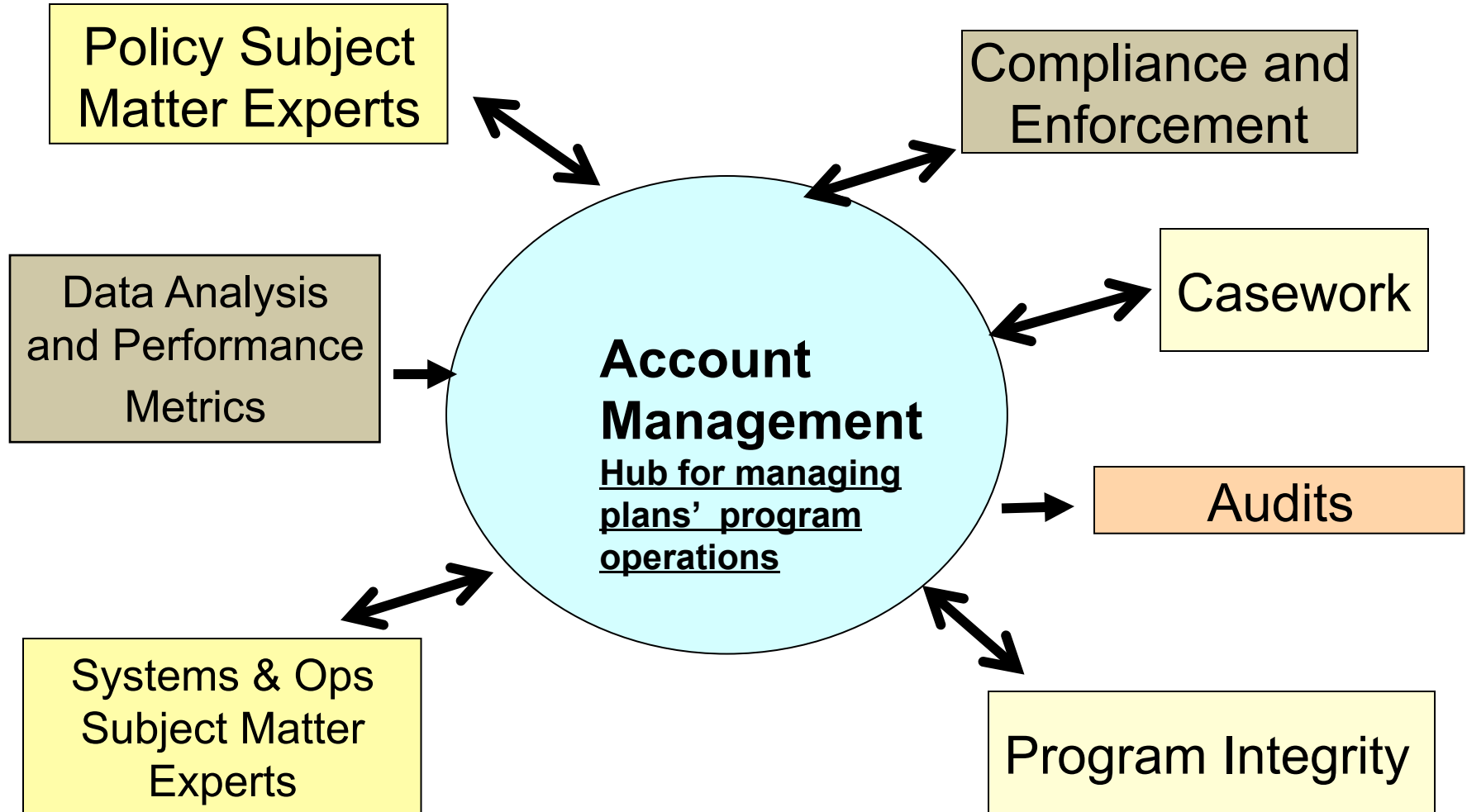
- Put aside the battering ram (CAP, enrollment sanctions) when a soft nudge (notice of non-compliance) is sufficient
- Don't hesitate to take significant action where warranted
- Consistent application of performance standard and choice of compliance action across all contracts

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## Dimensions of Oversight: Account Management



# Account Management



# Role of Account Managers

## Daily oversight and communication:

- Learns policy and operations of sponsor inside/out
- Ensures that sponsor complies with program rules, guidance, and program requirements
- Direct communication and point of contact to Compliance Office and other critical sponsor components (marketing, enrollment, etc.)

## Performance review, and follow-up to:

- Communicate and reinforce positive performance
- Ask for an explanation
- Request resolution (e.g. action steps, training/education, and/or business plan)
- Take compliance action, as appropriate

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## Dimensions of Oversight: Reporting Requirements

# Why Reporting Requirements?

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- CMS' use of plan-reported data
  - Program-descriptive
  - Evaluate differences between plan-types
  - Integrate with evaluation of other data sources
    - 1-800 Medicare complaints data
    - Prescription Drug Event data
    - IRE data
    - Monitoring studies (e.g., call center)
    - Audits
- Unavailable through other sources or collection efforts
- More timely than other means of collecting this information

# Examples of 2011 Part D

## Reporting Categories

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- Enrollment (e.g. denied and incomplete applications)
- Retail, Home Infusion, and LTC Pharmacy Access
- Access to Extended Day Supplies at Retail Pharmacies
- Medication Therapy Management Programs
- Pharmacy Support of Electronic Prescribing
- Coverage Determinations/Exceptions
- Appeals

# Examples of Part C Reporting Categories

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- Beneficiary Utilization
- Procedure Frequency
- Serious Reportable Adverse Events
- Provider Network Adequacy and Stability
- Grievances
- Plan Oversight of Agents

# Part C and D Data Validation

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- Effective in 2011 (for 2010 data), CMS has data validation standards and procedures for Part C and D reporting requirements
  - Standards ensure organizations' reported data are reliable, valid, complete, and comparable
- Organizations are responsible for submitting annual data validation audits of their reporting requirements data
- Contractors conduct these audits to ensure the independence and reliability of the data reported

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## Dimensions of Oversight: Monitoring and Surveillance



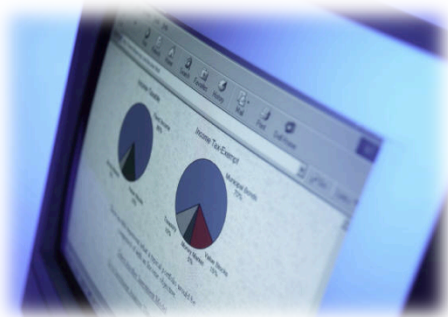
# Data-Driven Monitoring

- Essential tactic to systematically monitor these extraordinarily complex, large programs

753 contracts

495 legal entities

291 parent organizations



# Sources of Data

## CMS Systems and Administrative Data

- HPMS, MARx, other systems
- 4Rx, PDE, Formulary, Marketing, many others

## Contracted Monitoring and Surveillance Projects

- Monitoring – generally implies conducted systematically across *all* contracts with large enough sample sizes to draw inferences
- Surveillance – activities to address specific program concern; may be short term in nature or apply to only a cohort of contracts

# Examples of Compliance Action from Data Analysis and Monitoring

## Enrollment Timeliness

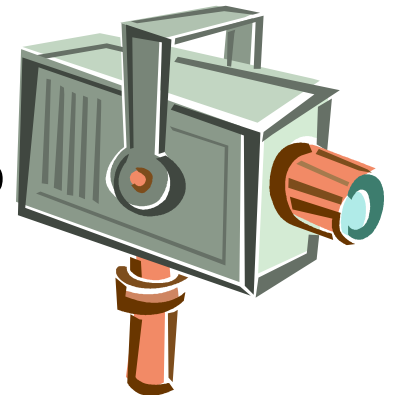
- Failure to successfully submit enrollments to CMS within the required 7 days
- Compliance threshold of 90%
- Number and type of prior compliance actions on this topic drive the next action

## Call Center Monitoring

- Inadequate call center hours
- Failure to meet call center standards
  - Hold time and disconnect rates
  - Interpreters for limited English-proficient (LEP) beneficiaries
  - TTY/TDD functionality
  - Information accuracy and understandability

# Example of Surveillance Activity

- Marketing Event Secret Shopping
  - Why? Ensure agents/brokers in the marketplace do not mislead, use scare tactics, or provide inaccurate information to beneficiaries
  - What? 1938 secret shops conducted for the CY2011 AEP
  - Results:
    - Less egregious agent actions compared to previous years
    - Compliance notices sent to plan sponsors
    - Sentinel effect



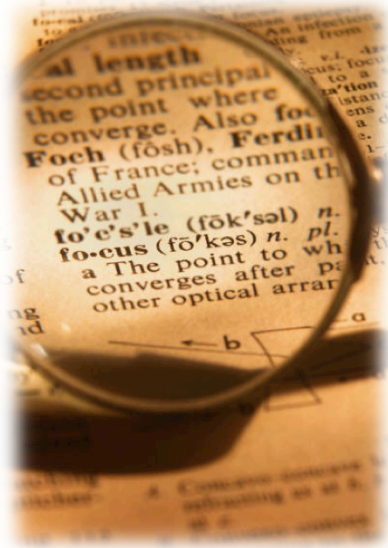
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## Dimensions of Oversight: Auditing

# Audit Approach

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- **Audit/Review Activities**



- Selection based on risk assessment
- Primary focus on outcomes (i.e. drug access, etc.), not policies and procedures
- Quality assurance and quality improvement goals

## On-site Audits

- Formulary Administration
- Prescription Drug Coverage Determinations, Appeals, and Grievances
- Compliance Program
- Marketing & Agent Broker

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## Putting it All Together: Performance Metrics and Analyses



# Medicare Plan Ratings

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Allow Medicare beneficiaries to compare plans' cost, quality, and performance

Overall Parts C and D composite scores for quick evaluations of plans across broad areas

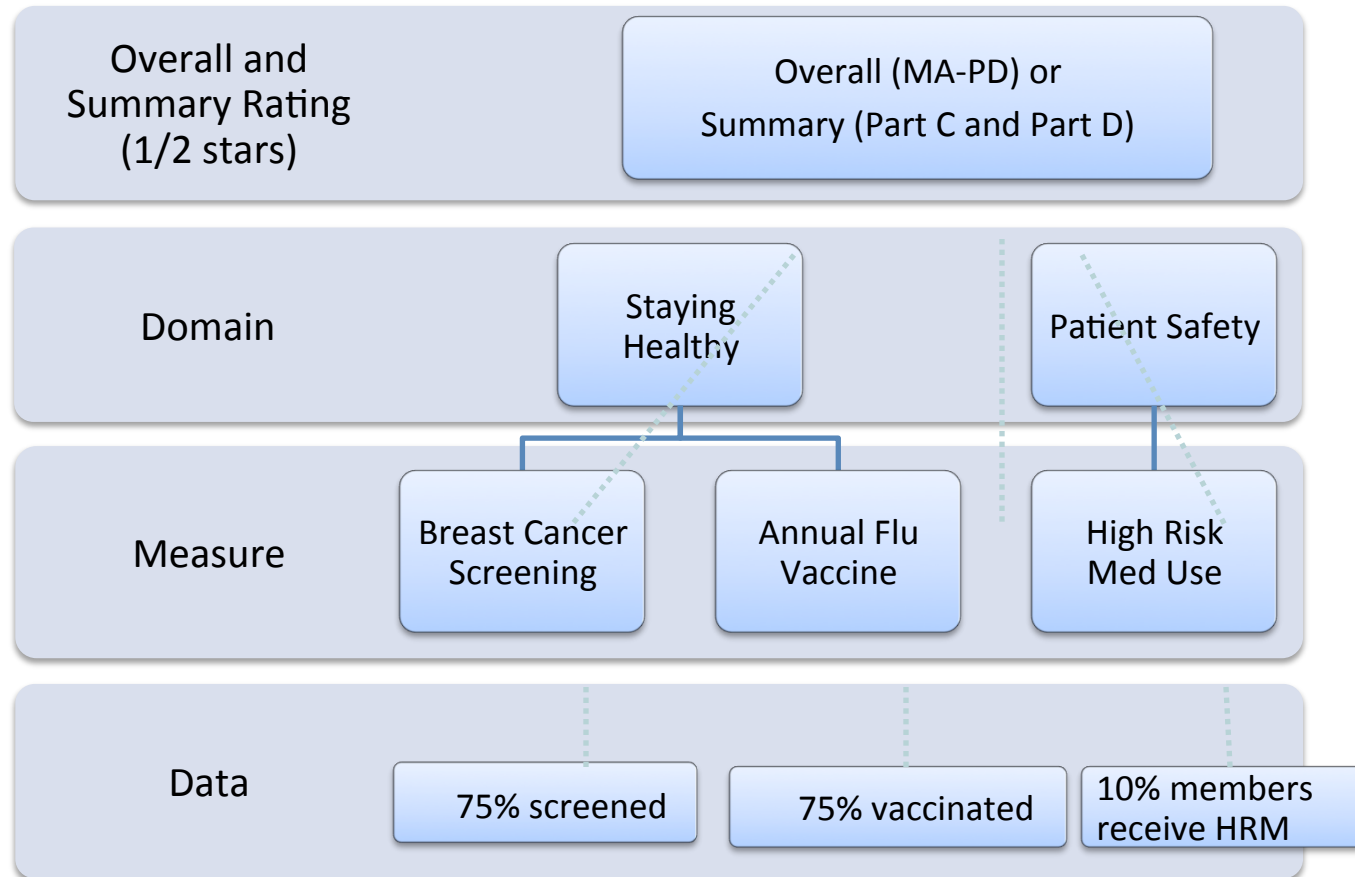
Domain groupings and display of individual measures provide wealth of information

# 2012 Plan Ratings Strategy

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- Consistent with the Triple Aim
  - Better care,
  - Healthier people/healthier communities, and
  - Affordable care
- Measures span five broad categories
  - Outcomes
  - Intermediate outcomes
  - Patient experience
  - Access
  - Process

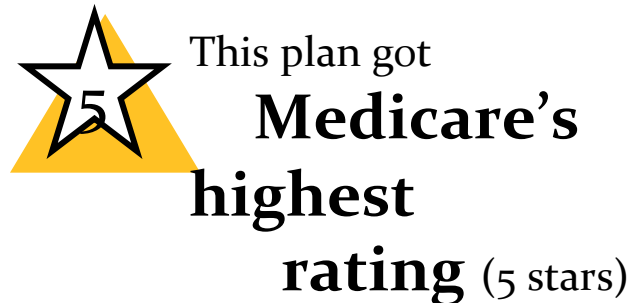
# Plan Ratings – 3 Levels of Stars



# New for 2012:

## High Performing Icon



- CMS will highlight contracts receiving an overall or summary rating of 5 stars with this icon:



- Information on [medicare.gov](http://medicare.gov) will note that beneficiaries can enroll in 5-star plans at any time during the year

# CY2012 Plan Ratings

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- Low performing icon  displayed for contracts with less than 3 stars for the summary rating
  - New for 2012: An additional cautionary message will appear on the MPF for beneficiaries selecting to enroll in these plans
- Used minimum thresholds for CMS' assignment of 4 stars 
  - Other star assignments are based on data distribution
- When a CMS standard is reached, a contract receives 3 or more stars
- 11 measures added; 10 measures retired

# 2012 Plan Ratings Weights

- Previously all measures weighted equally, suggesting equal importance. 2012 Plan Ratings will:
  - Weight outcomes and intermediate outcomes 3x as much as process measures
  - Weight patient experience and access measures 1.5x as much as process measures
- Sanctions will also affect ratings:
  - Contracts under sanction with 3 or more stars will be automatically assigned 2.5 stars
  - Contracts under sanction with less than 3 stars will receive a 1-star reduction



# 2012 Part D Domains

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Drug Plan Customer Service

Member Complaints, Problems Getting Services,  
and Choosing to Leave the Plan

Member Experience with Drug Plan

Drug Pricing and Patient Safety

17 individual measures total

# 2012 Part C Domains

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Staying Healthy: Screenings, Tests and Vaccines

Managing Chronic (Long-Term) Conditions

Ratings of Plan Responsiveness and Care

Member Complaints, Problems Getting Services, and Choosing to Leave the Plan

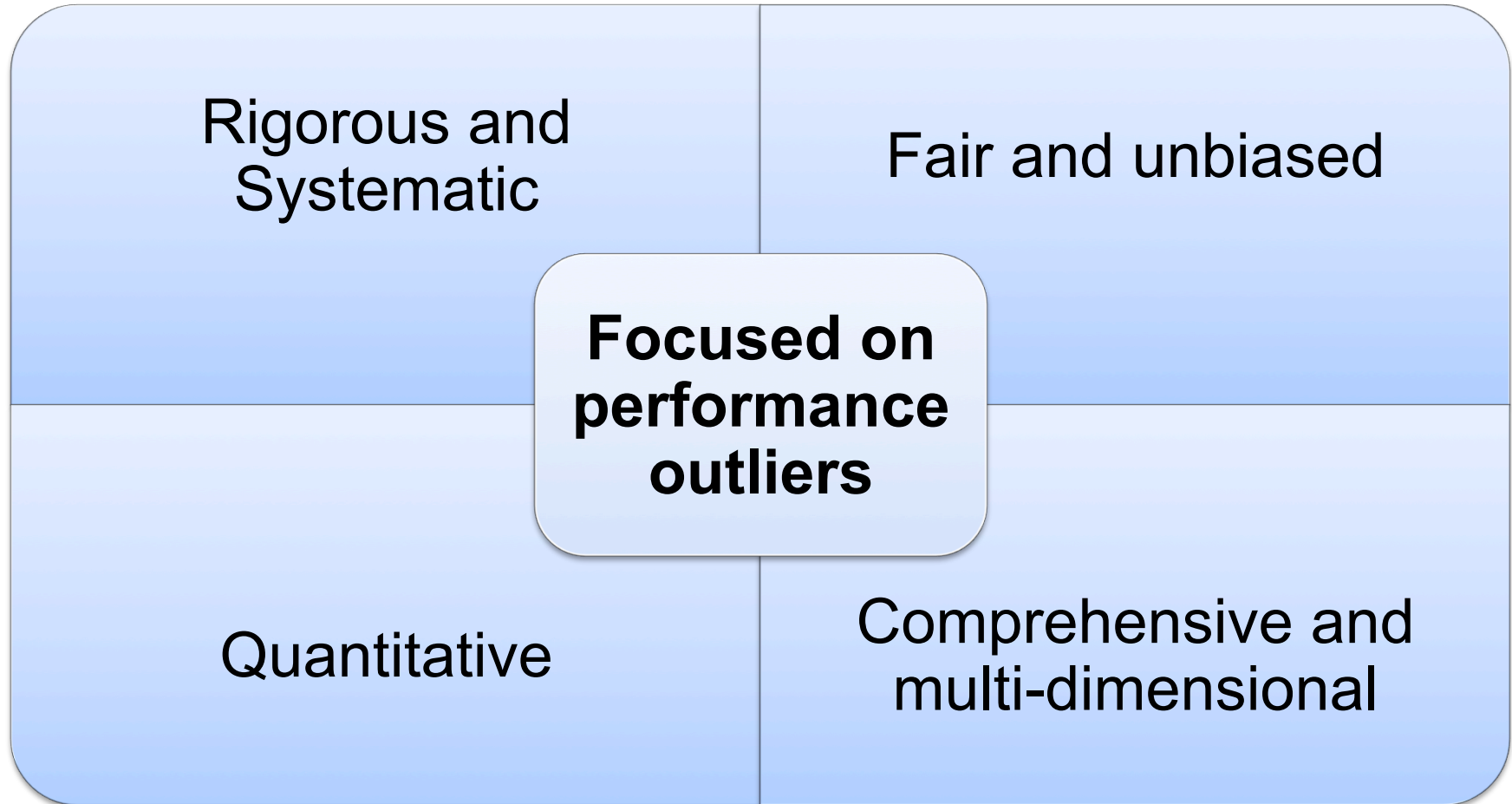
Health Plan Customer Service

36 individual measures total



# Annual Performance Review

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# Eleven Performance Dimensions for 2012 Application Cycle

*Outliers or extreme poor performers identified in each category,  
based on the prior 14 months experience*

Compliance  
Letters

Performance  
Metrics

Multiple Ad  
Hoc CAPs

Beneficiary  
Impact of  
Problems

Financial  
Instability

Performance  
Audits

One-Third  
Financial  
Audits

Exclusions

Enforcement  
Actions

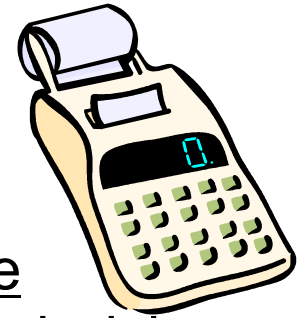
Terminations

Open,  
Significant  
Problems

# Compiling Results

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- Point values assigned for each dimension
  - Point values vary depending on nature of problem and risk to program
- Analysis identifies overall performance outliers
  - Hones in on sponsors with problems in multiple categories and/or in one or more particularly high risk area
  - Overall negative scores calculated at the contracting entity level



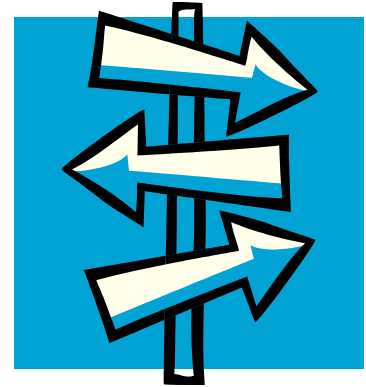
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## Using Performance Results

# Making Meaningful Decisions

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- Oversight activities provide a wealth of information
- Key objective is to summarize data on plan performance for:
  - MA organization and Part D sponsor self-initiated quality improvements
  - Beneficiary and stakeholder decision making
  - Informing policy changes
  - Ensuring the best and most qualified organizations participate in CMS programs



# Taking Action

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Public reporting

Technical  
assistance

Policy review

Basis for  
compliance and  
enforcement  
actions

Identifying audit  
candidates

Decisions for  
application  
approval and  
denials

# **Example: Past Performance as an Element of Application Decisions**

**Organizations with a recent history of performance problems must focus on their current books of business, and not expand until they are operating in full compliance**

- 42 C.F.R. §422.502(b) and §423.503 (b) – long standing authority to deny applications based on past performance
  - Even if applicant otherwise meets all application requirements
- April 2010 regulation clarified period of review as 14 months leading up to application deadline

# Applications Denied for Past Performance

## 2009 - 2012

### 2009

- 2 organizations notified their applications would be denied; both withdrew

### 2010

- 9 organizations identified as performance outliers, 7 of which had submitted applications; all 7 organizations withdrew

### 2011

- 21 organizations identified as performance outliers (increase due to inclusion of terminated or non-renewed contracts), 10 of which had submitted applications
- 8 organizations withdrew all pending applications; 2 withdrew most of their applications

### 2012

- 14 organizations identified as performance outliers; 7 of which had submitted applications
- 6 organizations withdrew their applications; 1 appealed
- **CMS' past performance methodology was upheld through two levels of appeal**



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## Key Compliance Concerns and New Areas of Focus

# Premium Billing

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- Federal regulations at 42 C.F.R. §423.104(b)(2)
  - A Part D sponsor offering a Part D plan must offer the plan “at a uniform premium, with uniform benefits and level of cost-sharing throughout the plan’s service area”



# Recent Billing Non-Compliance

- Suppressing Beneficiary Bills
- Wrong Low Income Subsidy (LIS) Levels Assigned
  - Resulting in bills and/or refunds to beneficiaries
- SSA Premium Withhold Status Discrepancies
  - Resulting in billing beneficiaries for premium they thought they were already paying
- Premium Waiver or Voucher Programs Offered
  - Violation of the Uniformed Benefit regulation
- Late Enrollment Penalty (LEP) Not Billed
- Marketing Plan As Zero Premium
  - Resulting in billing beneficiaries for large amounts



# Translations

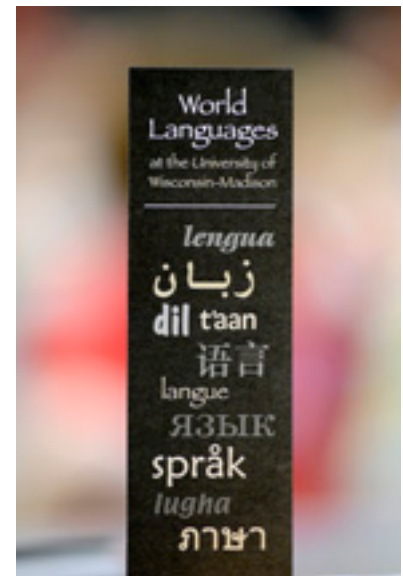
## 5% rule for key written materials

- 42 C.F.R. 422.2264(e), 423.2264(e), and Medicare Marketing Guidelines

## Documents that must be translated

- Enrollment instructions and forms
- Annual Notice Of Change /Evidence Of Coverage (ANOC/EOC)
- Comprehensive formulary or abridged formulary
- Pharmacy directory (For all plan sponsors offering a Part D benefit)
- Explanation of benefits
- Part D Transition Letter

CMS began translating certain models for 2012, and will continue for 2013



# Interpreters

- Interpreter, TTY/TDD requirement for call centers
  - 42 C.F.R. 422.111(h), 423.128(d)(1), and Medicare Marketing Guidelines
- 10,000 calls testing 6 languages were placed to 473 Part C and Part D sponsors over 8 weeks in 2011
- Measured percent of time that a caller was able to reach someone who could speak their non-English language and ask that person questions

Year	Part C	Part D
2009	66% Successful	60% Successful
2010	74% Successful	75% Successful
2011	89% Successful	89% Successful

# Bids and Benefits

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- MA and Part D sponsor to submit their bids in accordance with CMS actuarial guidelines based on generally accepted actuarial principles
  - 42 CFR §422.254(b) and 423.265(c)
- Examples of CMS compliance action in this area:
  - Failure to include supporting documentation that describes how the findings and observations have been addressed
  - Failure to follow Actuarial Standards of Practice (ASOP)
  - Basing Part D worksheet risk scores on the wrong risk model
  - Incorrectly crosswalking beneficiaries from a basic to an enhanced plan
  - Failure to update rebates paid to PBMs in the administrative cost projections

# ANOC/EOC Timeliness and Accuracy

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- Disclosure of benefits in a clear, accurate, and standardized form upon enrollment and 15 days prior to the annual coordinated election period
  - 42 C.F.R. §422.111 and 42 C.F.R. §423.128
- Late mailings have decreased
- Sponsors need to review for accuracy prior to mailings and immediately following mailings
  - In October 2011 CMS received notification of inaccuracies for CY2011 products
- CMS will continue to take compliance actions, including CMPs, for untimely and inaccurate documents

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# Thank you

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