Sneak Peak: PILOT Protocol – Provider Network Adequacy

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Background

- Enrollee Access and Availability
  - MA organizations are required to make benefits available and accessible to each enrollee
    - *Social Security Act, Section 1852 (d)(1)*

Background (cont.)

- Provider Network requirements
  - MA organizations must maintain and monitor a network of appropriate providers
  - Network must provide adequate access to covered services to meet the needs of the enrollees
    - *42 CFR § 422.112 – Access to Services*
  - MA organizations must communicate significant changes to its network(s) to all affected enrollees at least 30 days prior to the effective date of the change
    - *42 CFR § 422.111(e) – Changes to provider network*

Background (cont.)

- Provider Directory requirements
  - MA organizations must disclose the number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services
    - *42 CFR § 422.111(b)(3) – Access*
  - MA organizations are required to establish and maintain provider networks that are accurately reflected in up-to-date directories.
    - *Pub. 100-16, Chapter 4, Section 110.1.1 – Provider Network Standards*

Provider Network Adequacy (PNA) Pilot Program

PILOT for CY 2015

- Conducted in conjunction with other CY 2015 program area audits
- To be implemented late summer or early fall

- Purpose: To evaluate performance in the 2 areas outlined below related to Provider Network Adequacy.
  - Provider/Facility Networks
  - Provider Directory
- CMS will utilize the Network Management Module to help conduct our review of provider/facility networks.

Network Management Module

- The Network Management Module (NMM) is a stand-alone module, located in the Health Plan Management System (HPMS), which may be utilized by MA Organizations to submit Health Services Delivery (HSD) Provider and Facility Tables for evaluation against CMS HSD criteria.

Network Management Module (cont.)

- Health Service Delivery (HSD) Tables
  - The HSD Reference File outlines, by county, the minimum standards which must be met to pass the HSD submission. The areas evaluated include (but are not limited to):
    - Minimum number of providers (by provider type) for each county
    - Maximum travel time between beneficiaries and provider types
    - Maximum distance between beneficiaries and provider types
    - Minimum number of Medicare approved hospital beds for certain facilities
- Automated Criteria Check (ACC) Report
  - Results show where the submitted HSD tables do not meet the network criteria standards

PNA Audit Data Requests

- Pre-Audit Issue Summary (PAIS)
  - Sponsor disclosed and self-identified issues of non-compliance related to the audit
- Beneficiary Impact Analyses
  - Provide issues reported in the PAIS
- Provider Directory

PNA Audit Data Requests (cont.)

- HSD tables
  - Provider HSD Table
    - Data included must meet following conditions:
      - Providers must not be in state/county codes where the Medicare Beneficiary could not reasonably access services and are outside the patterns of care
      - Providers must not have opted out of Medicare
      - Physicians and specialists must not be pediatric providers

PNA Audit Data Requests (cont.)

- Provider HSD Table
  - Data included must meet following conditions (cont.):
    - Psychiatry/Rehabilitation Medicine must only be provided by a licensed physician
    - Psychiatrists must only be licensed physicians and no other type of practitioner
    - Physician Assistant and Nurse Practitioner services are limited to primary care

PNA Audit Data Requests (cont.)

- Facility HSD Table
  - Data included must meet the following conditions:
    - Facilities must not be in state/county codes where the Medicare Beneficiary could not reasonably access services and are outside the patterns of care
    - Medicare-certified providers
    - Facilities offering more than one service and/or provides services in multiple counties should be listed multiple times
- Exception Requests
  - For deficiency notice cases

PNA Audit Data Request Due Dates

- Within 5 business days of the engagement letter:
  - Pre-audit Issue Summary (PAIS)
  - Impact analyses for PAIS
  - Provider Directory
- Within 10 business days of the engagement letter:
  - HSD tables loaded into NMM
- The NMM will provide you with a report on all areas where your network is deficient
- Within 14 business days of receipt of the deficiency notice:
  - Submit exception requests

PNA Audit Elements

Provider/Facility Networks

- HSD table validations
  - Representative sample of each county type within a network
    - Sample based on enrollment size of organization
- Select targeted cases from the MA Provider ACC report and MA Facility ACC report
- Deficiency notice sent to Sponsor outlining network deficiencies found within sample

PNA Audit Elements (cont.)

- Exception request submissions
  - Types:
    - Insufficient number of providers in service area
    - No providers/facilities that meet the specific time and distance standards in service area
    - Patterns of care in the service area do not support need for the requested number of provider/facility type
    - Services will be provided by an alternate provider type/Medicare-certified
    - Alternative Arrangements for Regional PPOs
- Apply compliance standards
  - Minimum Number of Providers/Facility
  - Maximum Travel Time and Distance

PNA Audit Elements (cont.)

- Provider Directory
  - Select sample of providers/facilities from HSD tables
    - Representative sample of each county type within a network
      - Based on enrollment size of organization
  - Call selected providers/facilities to determine if they are still accepting Medicare patients.
  - Apply compliance standards
    - Consistency with HSD table

PNA Program Audit Results and Scoring

- Results will be shared with the Sponsor during week 2 of audit
  - Preliminary summary of findings at exit conference
  - Draft audit report
- Scoring
  - Same scoring methodology as existing program areas
  - No formal score included in final report
  - Pilot year does not impact the overall audit score

Questions

CMS Part C & D Audit mailbox:

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Sneak Peak: PILOT Protocol – Medication Therapy Management

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Background

- Medicare Modernization Act of 2003 amended Title 18 of the Social Security Act
  - Requires Medicare Part D sponsors to have a Medication Therapy Management Program (MTMP)
- Medicare Part D Bid
  - CMS approved MTMP required
- CY 2015 Part D Reporting Requirements
  - http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html
- CY 2015 MTMP Submission memo
  - http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html

Medication Therapy Management Program

- MTMP Purpose
  - Optimize therapeutic outcomes
  - Reduce risk of adverse events
- Sponsors auto-enroll targeted beneficiaries
- Sponsors provide, at minimum, quarterly Target Medication Reviews (TMR)
- Sponsors provide Annual Comprehensive Medication Reviews (CMR)

Medication Therapy Management Program (cont.)

- Targeted Beneficiary Criteria
  - Must meet all of the following:
    - Multiple chronic diseases
      - Sponsors must require 2 or 3 chronic diseases
      - If specific list of chronic diseases used for eligibility determination, sponsors must include at least 5 of the 9 CMS Core Chronic Conditions
    - Multiple Medicare Part D covered drugs
      - ≥ 2 and ≤ 8
    - Likely to exceed an annual cost limit for Part D covered drugs

Medication Therapy Management Program (cont.)

- 9 CMS Core Chronic Conditions:
  - Alzheimer's Disease
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Dyslipidemia
  - End-Stage Renal Disease (ESRD)
  - Hypertension
  - Respiratory Disease (such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung disorders)
  - Bone Disease-Arthritis (such as Osteoporosis, Osteoarthritis, or Rheumatoid Arthritis)
  - Mental Health (such as Depression, Schizophrenia, Bipolar Disorder, or Chronic and Disabling Disorders)

Medication Therapy Management Program Pilot Audit

- PILOT for CY 2015
  - Conducted during week 1 with FA program area audit
  - To be implemented late summer or early fall
- Purpose: To examine the implementation of the sponsor's CMS approved Medicare Part D MTMP by reviewing the following 3 audit elements
  - Enrollment
  - Comprehensive Medication Reviews
  - Targeted Medication Reviews

MTMP Audit Data Requests

- Pre-Audit Issue Summary (PAIS)
- Impact Analyses
- CMS Approved MTMP Description
- MTMP Enrollee Universe
- MTMP Opt-Out Member Universe
- Prescription Drug Event (PDE) Universe

MTMP Audit Data Requests (cont.)

- Pre-Audit Issue Summary (PAIS)
  - Sponsor disclosed and self-identified issues of non-compliance
- Impact Analyses
  - Issues reported in PAIS
    - All and potentially all impacted beneficiaries across all of the Sponsor's contracts
    - 3 months prior to date of the audit start notice

MTMP Audit Data Requests (cont.)

- CMS Approved MTMP Description
  - Contract level
  - Covers the audit time period
  - Specific requirements used to identify targeted beneficiaries, including:
    - Chronic conditions
    - Number of required Part D covered drugs
    - Required annual cost limit

MTMP Audit Data Requests (cont.)

- MTMP Enrollees Universe*
  - Includes all members as required under Title 42 CFR Part 423 currently enrolled in the MTMP, who have not opted out
- MTMP Opt-out Members Universe*
  - Includes all members who were auto-enrolled into the MTMP as required under Title 42 CFR Part 423, but who opted out during the audit review period
- Prescription Drug Event (PDE) Universe*
  - Includes final action prescription drug event (PDE) data accepted by CMS
  - Record layout is similar to the PDE Inbound File layout

**Submit each universe as MS Excel (.xlxs) files*

MTMP Audit Data Request Due Dates

- Within 5 business days of the engagement letter
  - Pre-audit Issue Summary (PAIS)
  - Impact Analyses for PAIS
- Within 15 business days of the engagement letter
  - CMS approved MTMP Description
  - Prescription Drug Event Universe
  - MTMP Enrollee Universe
  - MTMP Opt-out Member Universe

MTMP Audit Elements

- Enrollment
  - Select 30 cases for audit:
    - 10 cases non-enrolled members
    - 10 cases opt-out members
    - 10 cases cognitively impaired members
  - Apply compliance standards:
    - Appropriate targeting and enrollment into the MTM program
    - Appropriate disenrollment
    - Appropriate identification and handling of cognitively impaired members

MTMP Audit Elements (cont.)

- Comprehensive Medication Review (CMR)
  - Select 15 cases for audit: MTMP enrolled members who received a CMR
  - Apply compliance standards:
    - Timely CMR
    - Written summaries of CMR provided to members
    - Beneficiary and prescriber interventions provided
    - Appropriate staff utilized for CMR

MTMP Audit Elements (cont.)

- Targeted Medication Review (TMR)
  - Select 15 cases for audit: MTMP enrolled members who received a TMR
  - Apply compliance standards:
    - Timely TMRs
    - Quarterly TMRs performed
    - Appropriate interventions when warranted by TMR
    - Appropriate staff utilized for TMR

MTMP Audit Results and Scoring

- Audit Results
  - Daily updates on discovered conditions during week 1
  - Preliminary summary of findings at exit conference
  - Draft audit report
- Scoring
  - Same scoring methodology as existing program areas
  - No formal score included in final report
  - Pilot year does not impact the overall audit score

Questions

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