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# ABA/Washington Health Law Summit

## Challenges for Medicare Advantage Organizations for 2014 and Beyond

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# Challenges for Medicare Advantage Organizations

- Audits, Oversight and Enforcement
- Payment Year 2011 RADV Audits
- Watch Areas

# Audits, Audits and More Audits

- Program Audits
- One-third financial audits
- RADV
- Data Validation
- Model of Care – SNPs

# Program Audits

- Focus on specific areas of operation:
  - 2013: Organization Determinations, Appeals and Grievances
  - Outbound Enrollment Verification Calls
  - Compliance Program Effectiveness
  - Model of Care for SNPs
  - 2012: Access to Care
  - Agent and Broker Oversight
  - Enrollment/Disenrollment

# Program Audit Conditions and Scoring

- Condition is a finding resulting in a Corrective Action Required (CAR) or an Immediate Corrective Action Required (ICAR).
- The determination that a condition is a CAR or an ICAR is dependent on the level of potential beneficiary harm.

# Immediate Corrective Action Required

- An ICAR is the result of noncompliance with specific requirements that has the potential to cause significant beneficiary harm in the areas of Part D formulary administration (Formulary); Part D coverage determinations, appeals, and grievances (CDAG); Part C organization determinations, appeals, grievances, and dismissals (ODAG).
- Significant beneficiary harm exists if the non-compliance resulted in the plan's failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to beneficiary health and safety due to non-existent or inadequate policies and procedures, systems, internal controls, operations or staffing.

# Corrective Action Required

- A CAR is the result of a material noncompliance with specific requirements that does not have the potential to cause significant beneficiary harm.
- A material non-compliance is usually due to nonexistent or inadequate policies and procedures, systems, internal controls, operations or staffing.

# Impact of Program Audits

- Website publication and inclusion in Star Ratings and Past Performance Reviews
- Audit scores remain on CMS website indefinitely
- CMS website will note that sponsors with a higher score, or more audit conditions, indicates worse performance. Sponsors with low audit scores, or a fewer number of conditions, should be viewed as a strong performing sponsor.

# Compliance and Enforcement Actions

- Compliance Letters
  - Notices of Non-Compliance
  - Warning Letters
  - Corrective Action Plans (CAPs)
- Enforcement Actions
  - Intermediate sanctions
  - Civil monetary penalties (CMPs)

# Recent Enforcement Actions

- 11/21/13 Health Alliance Plan notified of $423,200 CMP for Part C and Part D violations
- 10/14/13 Five sponsors notified of CMPs ranging from $23,410 to $86,530 for inaccurate ANOCs/EOCs
- 4/23/13 Intermediate sanctions (suspension of marketing and enrollment) imposed on Smart Insurance Company (PDP)

# Performance Categories

- 1. Compliance Letters
- 2. Performance Metrics (i.e., “star ratings”)
- 3. Multiple Ad Hoc Corrective Action Plans (CAPs) (i.e., findings of egregious violations that were discovered outside of the audit process, such as through beneficiary complaints)
- 4. Ad Hoc CAPs with Beneficiary Impact
- 5. Failure to Maintain Fiscally Sound Operation
- 6. One-Third Financial Audits (i.e., organizations with adverse audit opinions or disclaimed audit reports stemming from a CMS One-Third Financial Audit)
- 7. Performance Audits (i.e., significant number of findings during a CMS Performance Audit)
- 8. Exclusions (i.e., exclusion from: receiving auto-enrollees, appearing in Medicare & You, having certain formulary update opportunities, or participating in the Online Enrollment Center)
- 9. Enforcement Actions
- 10. Terminations and Non-Renewals (i.e., requests by an organization to rescind a contract with CMS after the annual non-renewal deadline or after the annual marketing and enrollment period has begun, mutual terminations to be effective mid-year, or terminations initiated by CMS)
- 11. Outstanding Compliance Concerns Not Otherwise Captured (i.e., compliance and enforcement actions largely developed but not yet formally issued by CMS)

# Past Performance – You can run, but you can't hide

- Every year CMS conducts a comprehensive review of the past performance of MA Organizations.
- Past performance review methodology is a tool that CMS uses to evaluate the performance of all Medicare contractors and to identify organizations with performance so impaired that CMS will deny an organization's application either to offer Medicare benefits under a new contract or in an expanded service area during the subsequent contract year.
- Poor performance at the parent organization is attributed to organizations with less than 14 months of operations.

# RADV Audits – They're Back!

- CMS is conducting medical record review to validate the accuracy of the CY 2011 Part C risk adjustment data and payments.
- The 30 MA Organizations selected for audit were notified November 5.

# CMS RADV Methodology

- Published on February 24, 2013
- Payment year 2011 is the first year for which payment recovery will be based on extrapolated estimates
- CMS will select up to 201 enrollees for medical record review from each contract selected for a contract-level audit

# CMS RADV Methodology

- Enrollee-based stratification to be employed
- MA organizations may submit multiple medical records for each hierarchical condition category ("HCC") being validated, although all diagnoses will be abstracted from the first medical record that validates the HCC under review.
- 99% confidence interval for estimated payment error
- FFS Adjuster to be applied (yet to be published)

# Watch Areas

- First Tier, Downstream and Related Entities
- Data Collection, Accuracy and Submission
- Attestations
- Accuracy of Beneficiary Materials
- Marketing
- Complaints - CTMs

# FDRs

- MA organizations are accountable to CMS for their FDRs
- Ensure CMS-required terms are in contracts
- Perform audits and exercise oversight
- Follow Offshore Subcontractor requirements
- Comply with Compliance Guidelines including Fraud, Waste and Abuse Training

# Data Collection, Accuracy and Submission

- MA organization must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires.
- Part C Plan Reporting Requirements: www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html
- www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html

# Attestations

- Attestation of Enrollment Information
- Attestation of Risk Adjustment Date Information
- Attestation of Benefit Plan

# Beneficiary Materials/Information

- Accuracy and timeliness of ANOCs and EOCs
- Timely issuance of errata sheets
- Complete and accurate website
- Administer benefits in accordance with CMS-approved bid
- Knowledgeable Customer Service Reps

# Marketing

- Anti-Discrimination
- Brokers and Agents
  - Must be trained and tested annually on Medicare rules, regulations, and specific plan products
  - Perform Oversight
  - Compensation rules

# CTMs

- Resolve at least 95% of CTMs designated as "immediate need" within two calendar days, complaints designated as "urgent" within seven days, and resolve at least 95% of all CTMs designated without an issue level within 30 days.
- Make interim contact with beneficiaries if their complaints will take more than seven days to resolve
- Complaint rates are part of star ratings