

# Medicare 101 Part D Compliance Seminar

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CMS Region IX

Division of Medicare Health Plans Operations



# Topics to Cover

- Overall Findings
- Grievances (GV) and Exceptions Procedures (CE)
- Coverage Determinations (CD)
- Redeterminations (RE)
- Effectuation of Third Party Reversals (RV)
- Marketing and Beneficiary Information (MR)
- Overall Recommendations

# Overall Findings

- Failure to include CMS requirements in P&Ps
- Failure to implement CMS requirements
- Failure to have and/or use notification letters that meet CMS requirements
- Failure to meet CMS timeliness requirements

# Grievances and Exceptions

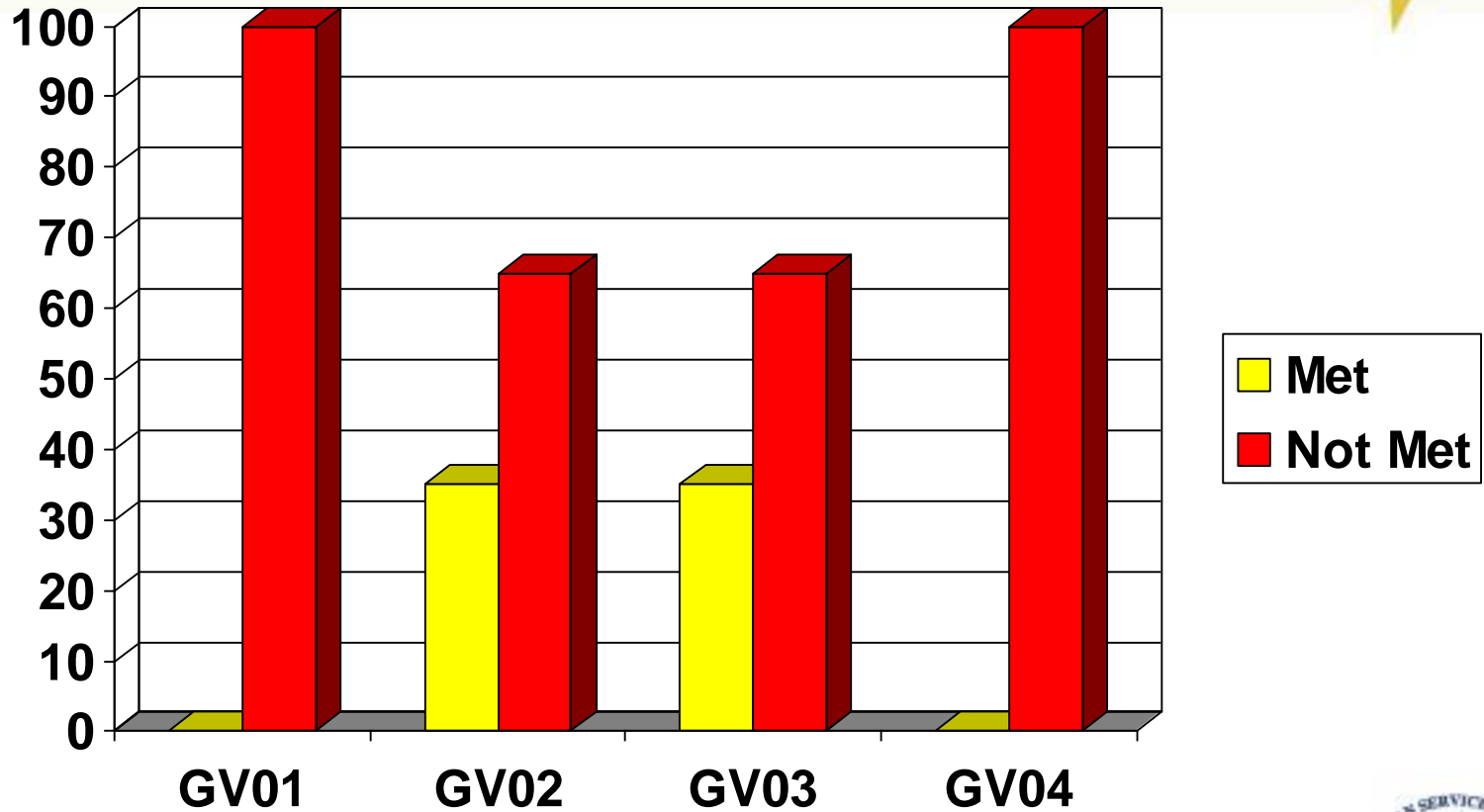
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# Grievance Elements

- GV01 – Complaint Categorization (Grievances vs. Coverage Determinations)
- GV02 – Grievance Policies and Procedures
- GV03 – Grievance Process Training
- GV04 – Timely Notification of Grievance Disposition

# Audit Percentages



# GV01 – Complaint Categorization

- Failure to categorize complaints correctly

**Recommendation: Develop P&Ps that clearly explain differences between grievances and coverage determinations**

- Failure to differentiate between Part C & D complaints

**Recommendation: Develop system to differentiate between Part C & D grievances**

# GV01 – Complaint Categorization (cont.)

- Failure to communicate to members whether complaint is subject to grievance or coverage determination procedures

**Recommendation: Develop a method of communication to inform member whether complaint is subject to grievance or coverage determination procedures**

# GV02 – Grievance P&Ps

- Failure to demonstrate tracking of grievances

**Recommendation: Develop a system for tracking**

- **Date of receipt**
- **Mode of receipt**
- **Person or entity that filed**
- **Subject**
- **Disposition**
- **Date member notified**

# GV03 – Grievance Process Training

- Failure to provide training to staff and contractors

**Recommendation: Develop training for staff and contractors**

- Failure to provide evidence of training to CMS

**Recommendation: Implement and document training sessions**

# GV04 – Timely Notification

- Failure to include provisions in P&Ps for timely notification of grievance disposition

**Recommendation: Include provisions to notify member within 30 days and when sponsor extends 14-day timeframe**

- Failure to notify members of disposition timely

**Recommendation: Develop a process to notify members within 30 days**

# GV04 – Timely Notification (cont.)

- Failure to use notices consistent with CMS requirements

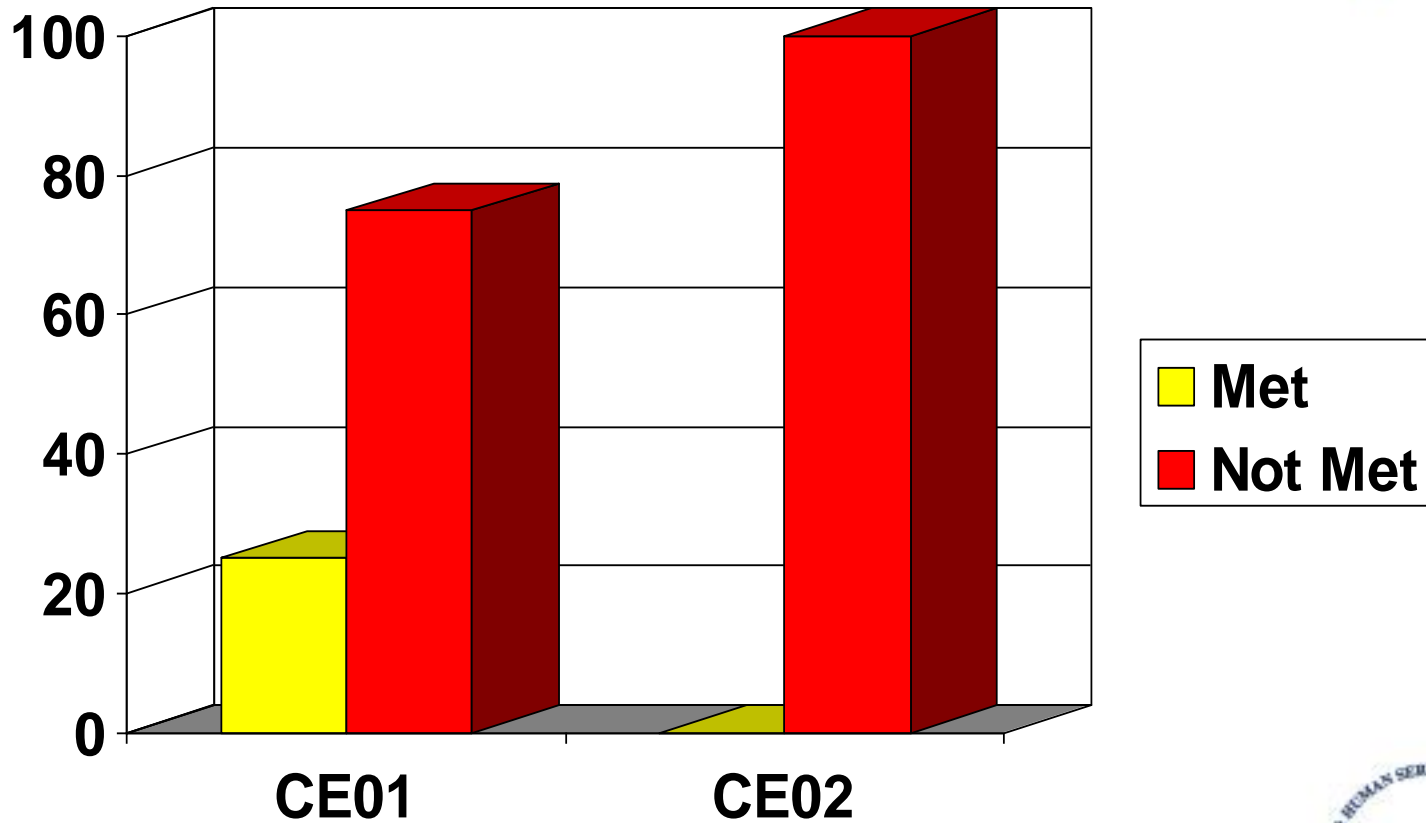
**Recommendation: Develop and use Notice of Plan's Decision Regarding a Grievance (Ch. 18, Appendix 8)**

**Recommendation: Develop and use Notice of Decision to extend grievance deadline (Ch. 18, Appendix 7)**

# Exceptions Elements

- CE01 – Exceptions Procedures and Criteria (Tiered Cost-Sharing)
- CE02 – Exceptions Procedures and Criteria (Non-Formulary Drugs)

# Audit Percentages



# CE01 – Tiered Cost-Sharing

## CE02 – Non-Formulary Drugs

- **P&Ps failed to include:**

- Information on who can file an exceptions request
- Requirements of physician statement
- Provision stating physician statement must be requested immediately
- Provision stating plan does not limit the number of exception requests

**Recommendation: P&Ps must**

- Explain who can request exceptions
- Include requirements for physician statement
- Require immediate request for physician statement
- Not limit the number of member exceptions

# Coverage Determinations

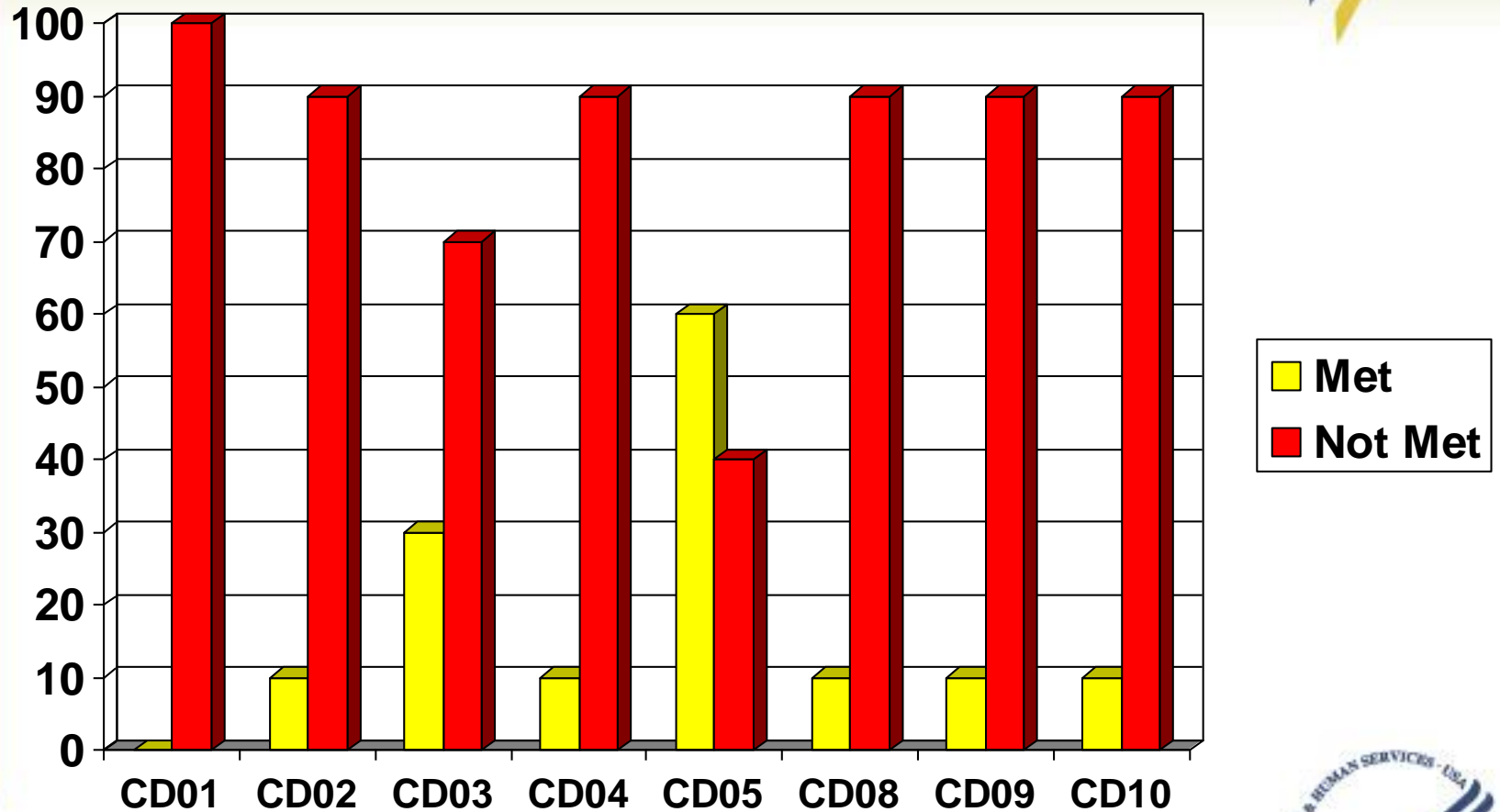
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# Coverage Determination Elements

- CD01 – Notices in Network Pharmacies
- CD02 – Coverage Determination P&Ps
- CD03 – Timely Notification of Coverage Determination of Drug Benefit
- CD04 – Timely Notification of Coverage Determination of Payment
- CD05 – Denial Notice Requirements for Coverage Determinations
- CD08 – Notice Content Requirements to Deny Request for Expedited Coverage Determination
- CD09 – Timely Notification of Expedited Coverage Determinations
- CD10 – Notice Content Requirements for Expedited Coverage Determinations

# Audit Percentages



# CD01 – Notices in Network Pharmacies

- Failure of network pharmacies to post or distribute the “Medicare Prescription Drug Coverage and Your Rights” notice

## Recommendation:

- Develop and submit notice (Ch. 18, Appendix 5)
- Ensure requirement is in the P&Ps and in contracts with pharmacies
- Monitor pharmacies to ensure compliance
- Maintain documentation of monitoring

# CD02 – Coverage Determination P&Ps

- Failure to include a provision in P&Ps for tracking coverage determinations and failure to develop and use a tracking mechanism

**Recommendation: Include the following in the tracking document and use this tracking document to monitor the process**

- Date of receipt
- Date of notification
- Disposition of request
- Date of disposition

# CD03 & CD04 – Timely Notification of Coverage Determinations of Drug Benefit and Payment

- Failure to notify members of the decision within 72 hours after receipt of request
- Failure to automatically forward cases to the IRE when decision/notification not timely

## Recommendation:

- Include these requirements in your P&Ps
- Revise Desk guides to reflect P&Ps
- Train staff to ensure understanding that cases without a timely decision are considered adverse decisions and must be forwarded to the IRE

# CD03 & CD04 – Timely Notification of Coverage Determinations of Drug Benefit and Payment (cont.)

- Failure to use CMS-approved member notification when case forwarded to IRE

**Recommendation: Develop notice of case status (Ch. 18, Appendix 6)**

- Payment not sent at all; payment sent late, error in payment amount

**Recommendation: Reimburse the member and track it to be sure the right amount is sent within 30 days**

# CD05, CD08, CD09, CD10

- Failure to use CMS-approved denial notice

**Recommendation: Include the requirement to use notice (Ch. 18, Appendix 1) in your P&Ps**

- Failure to use CMS-approved notice to inform members of decision not to expedite coverage determination

**Recommendation: Develop notice of right to an expedited grievance (Ch. 18, Appendix 3)**

- Failure to provide expedited coverage determination notices within 24 hours after receipt of request

**Recommendation: Track and monitor timeliness of decisions and notices**

# CD05, CD08, CD09, CD10 (cont.)

- Failure to recognize that untimely decisions/notifications are considered adverse decisions and must be forwarded to the IRE

**Recommendation: Train staff to ensure understanding that cases without a timely decision are considered adverse decisions and must be forwarded to the IRE**

**Recommendation: Develop notice of case status (Ch. 18, Appendix 6)**

# Redeterminations

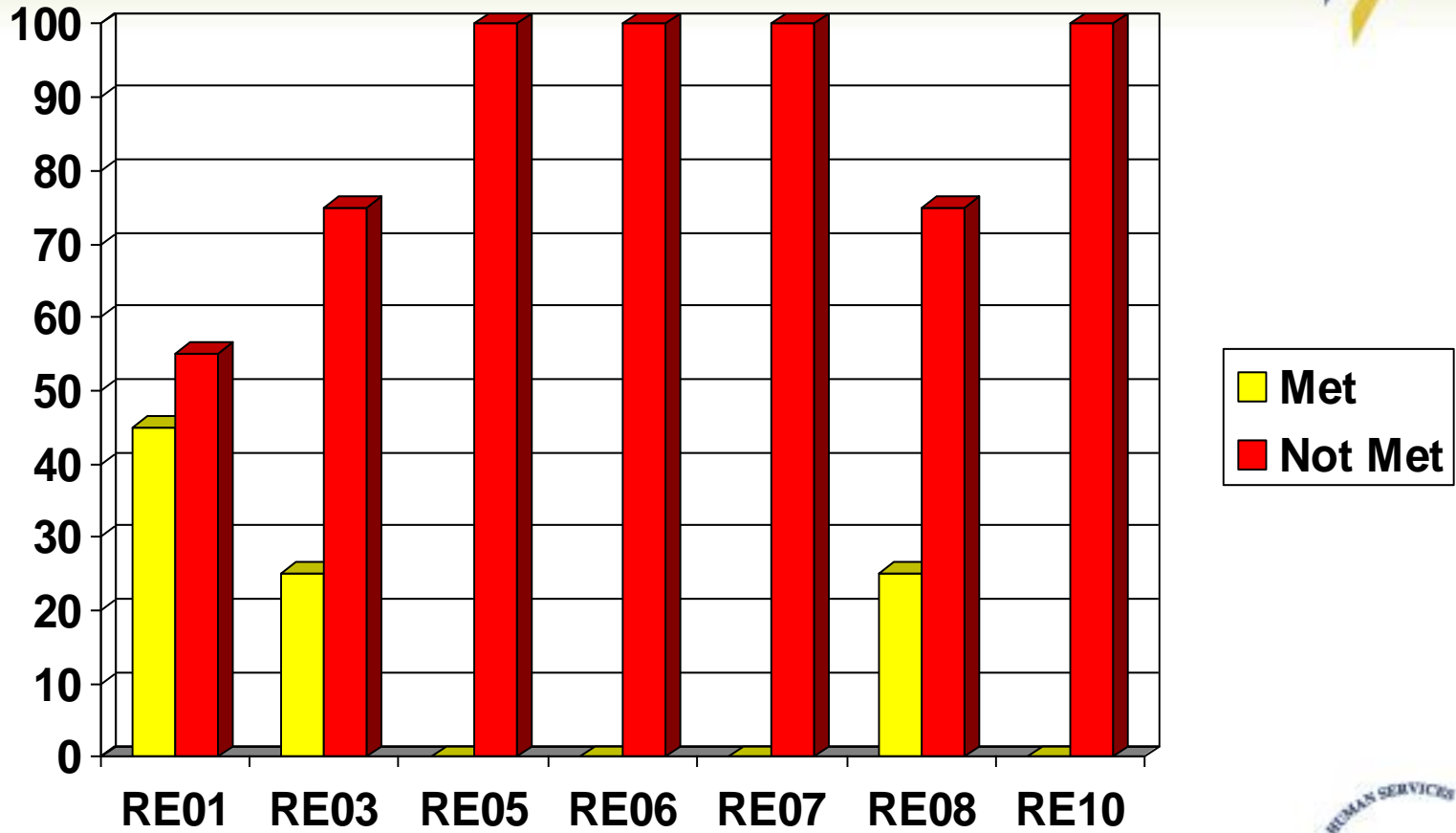
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# Redetermination Elements

- RE01 – Request for Redeterminations (Standard)
- RE03 – Decision to Accept or Deny Request for Expedited Redetermination
- RE05 – Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit
- RE06 – Timely Notification and Effectuation of Standard Redetermination Concerning Payment
- RE07 – Timely Notification of Expedited Redetermination and Request for Medical Information
- RE08 – Expedited Coverage Determination Reversals
- RE10 – Timely Transfer to IRE Upon Reconsideration Request

# Audit Percentages



# RE01 – Request for Redeterminations (Standard)

- Accepting standard redetermination requests from prescribing physician without obtaining Appointment of Representative (AOR) form

**Recommendation: Develop P&Ps for accepting and addressing requests for standard and expedited redeterminations**

**Recommendation: Obtain AOR form when necessary (Ch. 18, Appendix 2)**

# RE03 – Decision to Accept or Deny Request for Expedited Redetermination

- Failure to correctly categorize requests as redeterminations

**Recommendation: Ensure P&Ps distinguish between coverage determinations and redetermination requests**

**Recommendation: Conduct training to ensure staff understands how to correctly categorize redetermination requests**

# RE05 & RE06 – Standard Redetermination of Drug Benefit and Payment

- Failure to notify members of redetermination and failure to effectuate a favorable decision within 7 calendar days of receipt

**Recommendation: Develop internal tracking mechanism for notification and effectuation**

- Failure to forward cases to IRE within 24 hours of the expiration of adjudication timeframe

**Recommendation: Ensure that P&Ps clearly state timeframes**

# RE05 & RE06 – Standard Redetermination of Drug Benefit and Payment (cont.)

- Failure to use and send notice consistent with CMS-issued model notice, Request for Reconsideration, to member with each adverse redetermination notice

**Recommendation: Develop Request for Reconsideration (Ch. 18, Appendix 13)**

# RE07 – Expedited Redetermination and Request for Medical Information

- Failure to notify members of redetermination within 72 hours of receipt

**Recommendation: Develop internal tracking mechanism for notification and effectuation**

- Failure to state in P&Ps that medical information must be requested within 24 hours of the member's initial request

**Recommendation: Include this requirement in P&Ps**

# RE07 – Expedited Redetermination and Request for Medical Information (cont.)

- Failure to use and send a notice consistent with CMS-issued model notice, Request for Reconsideration, to member with each adverse redetermination notice

**Recommendation: Develop Request for Reconsideration (Ch. 18, Appendix 13)**

# RE08 – Expedited Coverage Determination Reversals

- Failure to authorize and provide the benefit under dispute within 72 hours after receiving the request for an expedited redetermination

**Recommendation: Establish P&Ps that state timeframes**

**Recommendation: Develop a system for authorizing and providing benefit**

# RE10 – Timely Transfer to IRE Upon Reconsideration Request

- Failure to transfer case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file

**Recommendation: Establish P&Ps that state timeframes**

# Effectuation of Third-Party Reversals and Marketing and Beneficiary Information

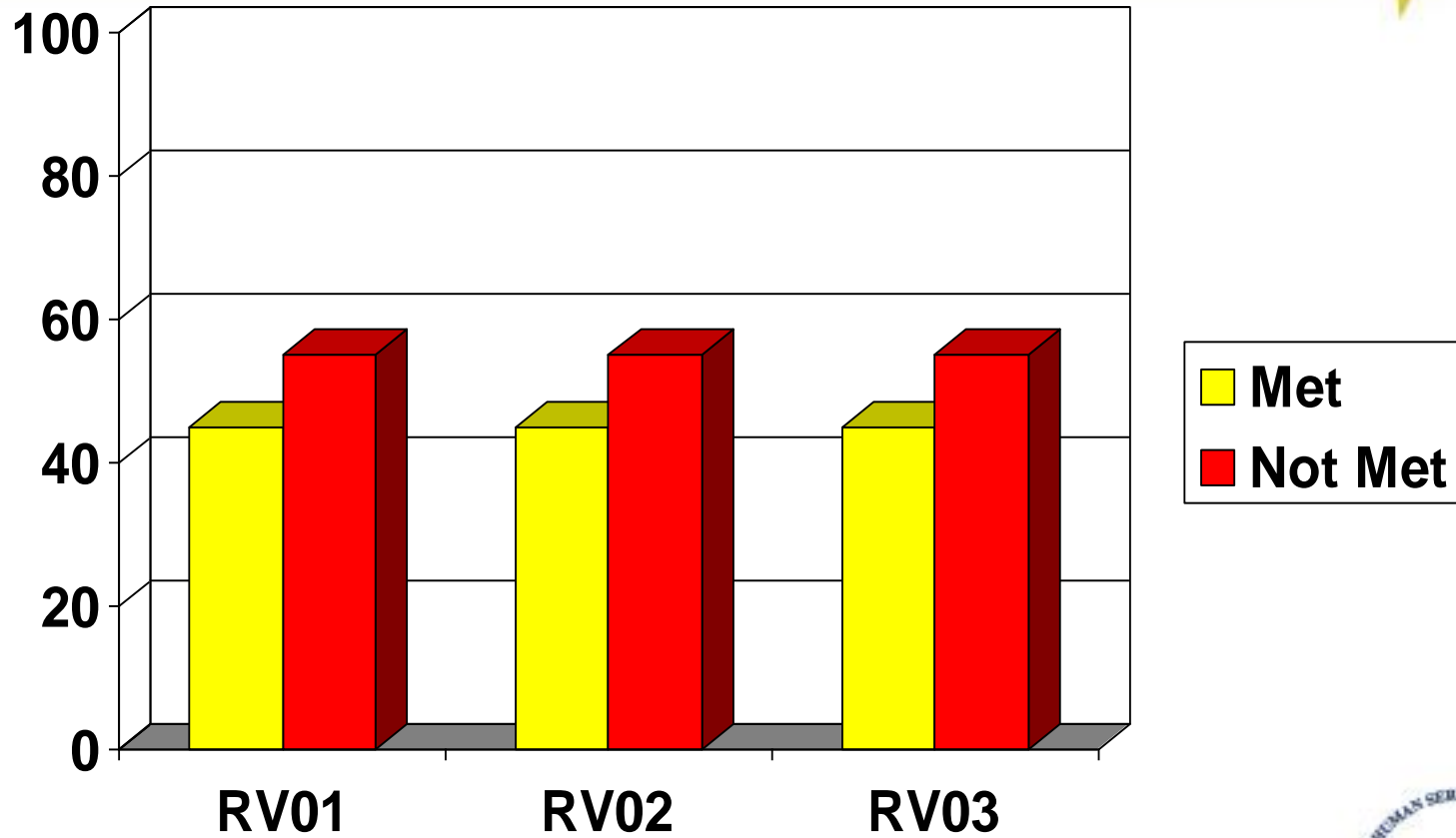
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# Effectuation of Third-Party Reversals Elements

- RV01 – Effectuation of Third-Party Reversals-Benefits (Standard)
- RV02 – Effectuation of Third-Party Reversals-Payment (Standard)
- RV03 – Effectuation of Third-Party Reversals-Benefits (Expedited)

# Audit Percentages



# RV01, RV02, RV03

- P&Ps failed to include:
  - A provision stating plan will authorize and provide benefit no later than 72 hrs for standard decisions and 24 hrs for expedited decisions from date plan receives notice of reversal
  - A provision stating that plan will authorize payment within 72 hrs and make payment within 30 days after receiving reversal notice

**Recommendation: Ensure P&Ps state timeframes for authorizing and providing benefits and for authorizing and making payments**

# RV01, RV02, RV03 (cont.)

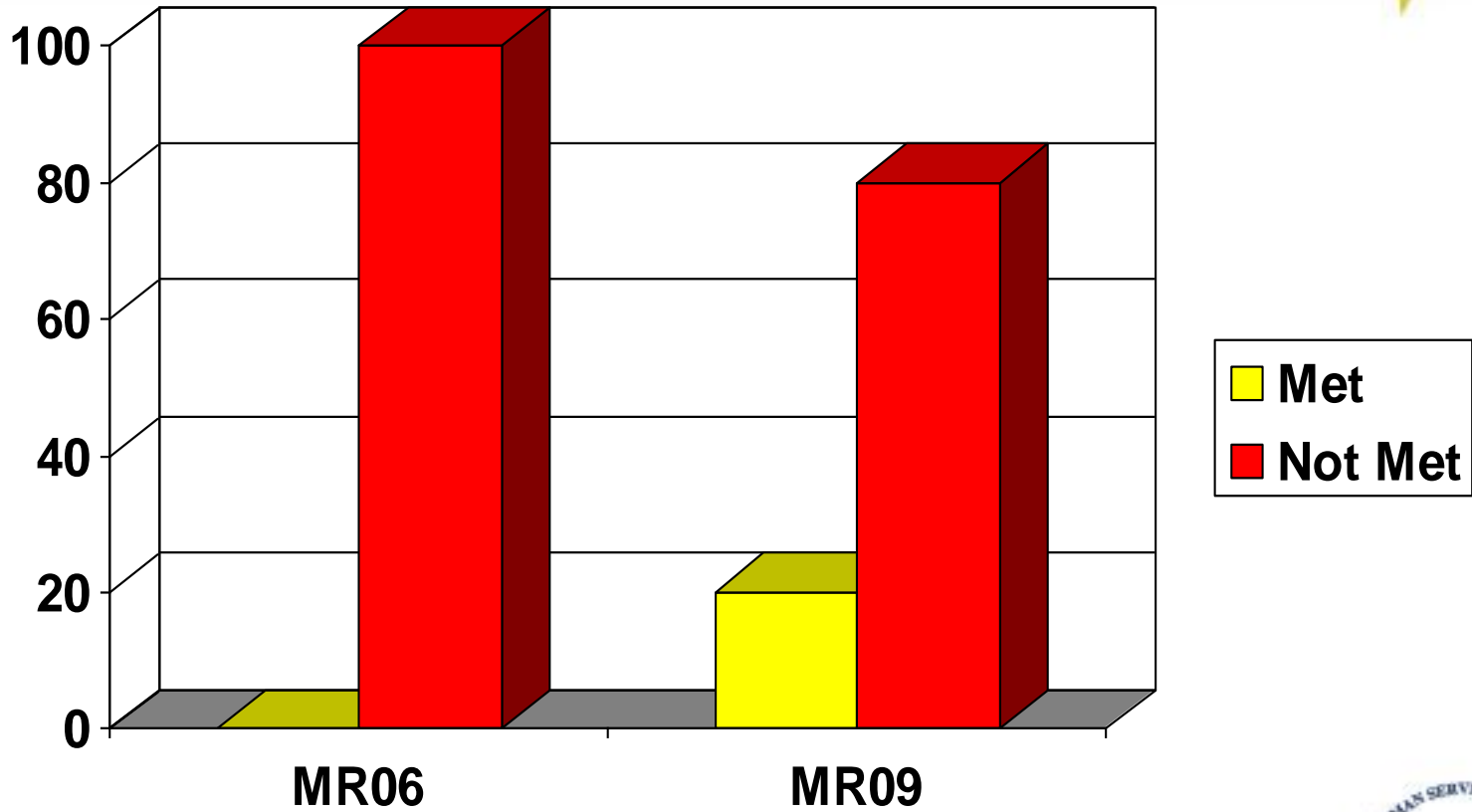
- Failure to send Notice of Effectuation to IRE or higher appeal entity; must use a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D IRE

**Recommendation: Develop and send Notice of Effectuation to IRE (Ch. 18, Appendix 9)**

# Marketing and Beneficiary Information Elements

- MR06 – Plan Responsibility for Persons Employed or Contracted to Perform Marketing
- MR09 – Provision of Notices Regarding Formulary Changes

# Audit Percentages



## MR06 – Plan Responsibility for Persons Employed or Contracted to Perform Marketing

- **Failure to provide a written disclosure statement to all potential members prior to enrollment or at the time of enrollment**

*“The person that is discussing plan options with you is either employed by or contracted with <plan name>. The person may be compensated based on your enrollment in a plan.”*

**Recommendation: Develop notice and include requirement in P&Ps**

# MR09 – Provision of Notices Regarding Formulary Changes

- P&Ps fail to include required provisions regarding:
  - 60-day written notice or 60-day supply of Part D drug
  - Retrospective notice for drugs that are immediately removed

**Recommendation: Ensure P&Ps state requirements regarding member notifications**

# Overall Recommendations

- Review your P&Ps **NOW** to be sure they include all CMS requirements and timeframes
- Revise desk guides to reflect P&Ps and train staff
- Remember that plans are responsible when functions are delegated to PBM
- Establish a system or schedule for regular internal auditing

# Links to Resources

- **PDP Audit Guide:** <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDPAuditGuide.pdf>
- **MA-PD Audit Guide:** <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/MAPDAuditGuide.pdf>
- **Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals:** <http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PartDManualChapter18.pdf>
- **Part D Appeals Process:** <http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PartDAppealsFlowchart.pdf>
- **Regulations:** [http://www.access.gpo.gov/nara/cfr/waisidx\\_05/42cfr423\\_05.html](http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr423_05.html)
- **Corrective Action Requirements:** <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/CAP/list.asp#TopOfPage>

**Questions?**