

Internal Compliance CMS Audits

CMS Regional Office Staff

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CMS Expectation for Internal Monitoring & CMS Audits

- CMS expects plans to perform ongoing Internal Monitoring on all Medicare Operational Areas.
- Have procedures for ensuring prompt response to correct deficiencies and development of corrective action.
- Have a system in place for plan's compliance staff to work with the department managers and/or directors to identify and implement a corrective action plan.



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Session Overview

- Changes to the Audit Guides
- CMS Audit Process
- How CMS Selects Sample Cases
- Case File Documentation
- How CMS Determines a Finding
- What should be included in CAP
- CTM – Internal Monitoring
- Best Practices



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Audit Guides

- MA Audit Guide, Version 5
- MA-PD Audit Guide, Version 2
- PFFS Audit Guide, Version 2
- SNP Audit Guide, Version 1
- RPPO Audit Guide, Version 2



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Changes to the MA Audit Guide

- Chapter 2
 - Deleted Elements:
 - ER09
 - ER10
 - ER14
 - Element is no longer applicable
 - Combined Elements
 - ER05 and ER06



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Changes to the MA Audit Guide

- Chapter 2
 - Updated language:
ER16, DN05, DN06, DN08, and DN09
- Other Chapters
 - Updated language
MR08, OP04, RP05, and OP15



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Changes to the SNP Guide

- 3 MA elements replaced by SNP elements
- 1 MA elements removed with no replacement
- 4 New SNP elements
 - ER05, DN501, CN501 and CN502



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Changes to the RPPO Guide

- MR601 – Disclosure of Required Non-Deemable Information to Beneficiary
- AA601 – Access to Covered Services
- CS601 – Appropriate Compliance with Cost Sharing Rules for MA Regional Plans
- QY601 – Appropriate Utilization Management Program for RPPO Plans
- QY602 – MA Regional Plan Application of Local Coverage Policy Determinations Across Multiple Local Coverage Areas Within the Region



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Types of Audits

- Routine
- Focused
- Corporate
- Chronic Care Improvement Project (CCIP) and Quality Improvement Project (QIP) Reviews
- Ad Hoc Compliance Events



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Overview of Audit Process

- Step 1: CMS selects MAOs to audit for the year.
- Step 2: RO and MAO staff discuss date of audit (at least 3 months in future).



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Overview of Process (cont.)

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Samples reviewed in RO• Step 3: 12 weeks before audit, RO requests list of delegated entities. | <ul style="list-style-type: none">• Samples reviewed at MAO• Step 3: 9 weeks before audit, RO requests list of delegated entities. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|



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Overview of Process (cont.)

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Step 4: 10 weeks before audit, MAO sends list of delegated entities.• Step 5: 9 weeks before audit, CMS sends site visit confirmation letter. | <ul style="list-style-type: none">• Step 4: 7 weeks before audit, MAO sends list of delegated entities.• Step 5: 6 weeks before audit, CMS sends site visit confirmation letter. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



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Overview of Process (cont.)

- Step 6: 7 weeks before audit, MAO sends universes and other pre-site visit documentation to CMS.
- Step 7: 6 weeks before audit, CMS notifies MAO of selected cases for review.
- Step 6: 4 weeks before audit, MAO sends universes and other pre-site visit documentation to CMS.
- Step 7: 3 weeks before audit, CMS notifies MAO of selected cases for review.



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Overview of Process (cont.)

- Step 8: 3 weeks before audit, MAO sends complete case files to CMS for review.
- Step 9: 1 week before audit, CMS and MAO finalize agenda.
- Step 8: 1 week before audit, CMS and MAO finalize agenda.



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Overview of Process (cont.)

- Step 10: On-site review—discuss results of previously reviewed cases, gather additional information as necessary.
- Step 9: Review case files onsite and discuss with MAO. Gather additional information as necessary.



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Overview of Process (cont.)

- Step 10 (Step 9 if cases reviewed onsite): Within 14 days after exit conference, MAO submits any additional information requested during audit.
- Step 11: 45 days after exit conference, CMS issues audit report via HPMS.
- Step 12: 10 days after issuance of CMS report, MAO submits documentation, if disputing any findings.
- Step 13: 10 days after receipt of dispute of findings (if any), CMS sends response.



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Overview of Process (cont.)

- Step 14: 45 days after CMS audit report issued, MAO submits CAP via HPMS.
- Step 15: 30 days after CAP submission, CMS responds via HPMS.
- Further steps: CMS and MAO each have 30 days for subsequent submissions and responses until all CAP elements are accepted and released by CMS.



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Overview of Process (cont.)

- Dates cannot slip on either end.
- Both sides need adequate time to prepare/review.
- CMS' audits of MAOs now audited against SOP by Chief Financial Officer.



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P&P Crosswalk

- CMS Region 9 has created a comprehensive listing for of all the policies and procedures that directly affect Medicare managed care operations.



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Four Basic Steps



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What is a Universe?

- Universes are defined in Enclosure IV, “Universe Request.....”
- 27 universes from the following areas: organization determinations, appeals, enrollments, claims, credentialing and contracts
- CMS will randomly choose “cases” to audit for compliance.



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Universe Pitfalls

- Electronic Submission Formatting
- Misclassification
- No universe submitted when there were cases during the review period



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Misclassification Problem

- Request for Expedited Appeal
 - Should include cases that were converted to standard timeframe
- Denied Claims (Member liability only)
- Grievances (no Part D only)



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No Universe Problem

- No Unfavorable Appeals, but Maximus reports show some
- No Favorable Appeals, but large universe of pre-service and claims denials
- Cases discovered during staff interview



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Universe Problems

- 30% of Samples Misclassified / No Universe
- Submit New Universe
- Gather New Sample Files
- Risk Focus Audit



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What Can Plans Do to Avoid Universe Problems?

- Program systems to track and capture the Universes in Enclosure IV
- Pay attention to Universes on Enclosure IV
- MA-PD should perform ongoing Audits of your own operation areas



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What Can Plans Do to Avoid Universe Problems? (cont'd)

- Call your CMS Region IX Plan Manager with Universe questions



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Case File Documentation

- Enclosure I, “Minimum Documentation Requirements”: provides description of standard case documentation for each universe.
- CMS Region 9 has created Case File Cover Sheets to ensure all files contain necessary work documents to create complete files



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Case File Documentation: Pitfalls

1. Missing documentation
2. Unorganized documentation
3. Unnecessary documentation cluttering up the case file

What happens when there are documentation problems?

- If the necessary documentation is not provided within 14 days of the end of site visit, the plan is considered out of compliance for that element.
- Better to provide all documentation upfront (sent to RO or provided during site visit)

Case File Documentation

Case files should:

1. Be in chronological order;
2. Be clearly labeled;
3. Highlight relevant information;
4. Have tabs;
5. Contain all relevant documentation.



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Case File Documentation (cont.)

Suggestions:

1. Include all documentation requested in Enclosure I, "Minimum Documentation Requirements".
2. Include other documentation if needed to make sense of the case.
3. Attach a check sheet to each case.
4. Fill out worksheets prior to site visit.



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Negative Finding

- 95% Compliance Standard
- Sample Review vs. Entire “Universe”
- 90% Confidence Level
 - Less than 10% chance that a negative finding is due to chance rather than the universe being less than 95% compliant

Negative Finding

Sample Size	Universe Size	Negative Finding
10	20 or more	2+ Not Mets
15	21 or more	3+ Not Mets
30	41 or more	4+ Not Mets

- If Universe is Less than 20.....
you can't miss any.

Acceptable CAP

- Address Deficiency Cited
- Timetable for Correction
- Process for Validating Correction
- System for Ongoing Monitoring
- Progress Reports to CMS RO
- Involve RO Plan Manager Before Submitting Through HPMS



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Resources

Tools Utilized to Prepare for the CMS Audits

- Medicare Managed Care Manual
www.cms.hhs.gov
Health Plans General Information
- CMS MA Audit Guide
MMC Auditing
Audit Guide
MA Audit Guide, Version 5
- CMS MA-PD Audit Guide
PDP Auditing
Part D Audit Guide
MA-PD Sponsor Part D Audit Guide, Version 2



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Resources (cont.)

- CMS PDP Audit Guide
 - PDP Auditing
 - Part D Audit Guide
 - PDP Sponsor Part D Audit Guide, Version 2



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Complaints Tracking Module (CTM)



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What is CTM?

The Complaints Tracking Module (CTM) is a module within the Health Plan Management System (HPMS)

- Stores complaints received by 1-800-Medicare call centers and CMS Regional offices.
- Plans are required to resolve complaints in CTM.
- Complaints within CTM are used for various performance measures.



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Accessing CTM

- Complete the “Application for Access to CMS Computer Systems” located at:
<http://www.cms.hhs.gov/AccessToDataApplication>
- ATTENTION: Lori Robinson
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C4-14-21
Baltimore, MD 21244
- Email: HPMS_Access@cms.hhs.gov



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CMS Expectations

- Follow SOPs for all cases and turn around times for immediate, urgent, and non-urgent complaints.

Time Allowance for Plans to Resolve Complaints

Immediate	2 calendar days
Urgent	10 calendar days
Congressional	2-7 calendar days
All Other Complaints	30 calendar days



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Cases Stored in CTM

- Any inquiry that involves an enrollment, access to care, payment, or customer service issue with a plan.
- Plans are required to follow the procedures outlined in the CTM Plan SOP at all times.



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Examples of Plan Responses

- Type of Complaint: Any Beneficiary Complaint
- Incomplete Response: Unable to reach beneficiary
- Complete Response: Attempted to reach the beneficiary and complainant three times, left messages, no response, or wrong number. Performed research, cannot locate beneficiary. Letter issued and complaint resolved.



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Examples of Plan Responses

- When corresponding with ROs, plans should include a detailed description of the complaint resolution. For example, in cases that involve difficulty in obtaining medications instead of stating, “issue resolved,” the plan should respond:
“Reviewed systems, contacted pharmacy and beneficiary on <MMDDYYY>. Activated beneficiary immediately in pharmacy system and explained resolution.”



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Role of the Regional Office

- Track plan performance in processing and resolving complaints.
- Assist the plan with the understanding and implementation of standard operating procedures.
- Assist with unique complaints that cannot be resolved by the plan or 1-800-Medicare.



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Role of the Plan

- Plans should be the first point of contact for beneficiaries for the majority of Part C and D complaints.
- Check cases for timeliness.
- Establish internal controls for life-threatening cases.
- Ensure completeness in response.



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Best Practices from Medicare Organizations

- CIGNA HealthCare of Arizona, Inc.
 - David Hu, Medicare Compliance Officer
- Kaiser Foundation Health Plan, Inc.
 - Marcella Jordan, Director, Medicare & Federal Programs Compliance
 - Kerry Slinkard, Manager, National Medicare Compliance
- GEMCare Health Plan
 - Mike Myers, CEO



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Internal Compliance & CMS Audits

QUESTIONS?



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Pop Quiz





CIGNA HealthCare of Arizona Compliance Activities


1



Monitoring of Compliance

- **Where Do You Begin?**
- **What Do You Monitor?**
- **What Tools Are Available?**


2



Where Do You Begin?

- Great place to start is the Monitoring Guide.
- CMS uses this guide to perform their reviews of MA plans.
- Plans have advanced knowledge of what CMS could be looking for.
- Nothing should come as a surprise.

3



Element Code	Monitoring Guide Elements from the 2006 CMS Monitoring Guide Category	Number of Elements
ER	Enrollment	17
DN	Disenrollment	10
MR	Marketing	10
AA	Access and Accessibility	5
HA	Health Assessment	1
CC	Coordination of Care	4
CF	Confidentiality of Member Information	1
AD	Anti- Discrimination	1
DG	Oversight of Delegated Entities	1
QY	Quality Assurance	7
PR	Provider Relations	7
CN	Contracting	8
OC	Claim Organizational Determinations	7
OP	Pre-service Organizational Determinations	15
RE	Reconsiderations-General	2
RC	Claims Reconsiderations (Timeliness)	3
RP	Pre-Service Reconsiderations (Timeliness)	8
GV	Grievances	4
	Total Elements (highlighted elements equals to 69% of total)	111

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Identifying High Risk Areas

- **Eligibility (enrollment & disenrollment)**
- **Claims (including Part D)**
- **Organization Determination (including Part D)**
- **Appeal and Grievance (including Part D)**
- **Marketing (and Sales)**

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What Do You Monitor?

Now that you have identified the high risk areas.

What do you monitor in each of these areas?

- Monitoring is achieved through audits and metrics.
- The CMS monitoring guide is your main source of information on what to monitor.
- CMS has included audit worksheets for certain elements, which you may use to formulate your own audit worksheets (examples later).

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Monthly Audits

- Preservice Determinations (UM dept).
- Direct Member Reimbursement (Part D claims).
- Organization Determinations of the Claims Vendor (medical).
- Organization Determinations of Vendors who are responsible for issuing ODNs.
- Appeal and Grievance Audits.
- Enrollment and Eligibility Audits.
- Sales Audit.

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Spot Audits

- Sales applications of internal sales staff and brokers.
- Home Health and SNF-Detailed Explanation of Non-Coverage (DENC).
- Hospital-Detail Notice of Discharge (DND).

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Annual Risk Assessment

- A responsible individual or area is assigned the applicable section(s) of the monitoring guide.
- Responsible area provides attestation regarding compliance. If non-compliant, must provide corrective action.
- Attestation is followed up through audits and inquiries.
- Annual Risk Assessment is reported to senior management.



Appeal Audit Worksheet

Document in CIGNA HCAZ-Compliance Oversight.ppt - Microsoft Word

File Edit View Insert Format Tools Table Window CIGNA Help

Type a question for help

Monthly Medicare Appeal Audit
For Closed Appeals in December 2007

Purpose: To ensure that Medicare appeals are processed in accordance with CMS guidelines. The CMS guidelines are as follows:

1. An Organizational Determination Notice (ODN) is on file in every appeal case.
2. All appeal letters are date stamped to show the date it was received.
3. All appeal letters are received within 60 days of the ODN.
4. A good cause letter must be on file for appeals received in more than 60 days from the ODN.
5. All appeals are processed in accordance CMS guidance, including time requirements:
 - Expedited appeals:
 - o Prescription Drug: 72 hours (no extension)
 - o Medical: 72 hours (can request extension).
 - Pre-Service:
 - o Prescription: 7 calendar days (no extension);
 - o Medical: 30 calendar days (can request extension).
 - Claim:
 - o Prescription: 7 calendar days.
 - o Medical: 60 calendar days.
6. Upheld appeals will be forwarded to MAXIMUS within specific time frame. Appeal overturns will be paid or authorized within CMS specified appeal processing time frame.
7. Medical necessity denials are reviewed by a physician.
8. If appeal was overturned by CIGNA or MAXIMUS, claims or services are effectuated within CMS timeframes.

Work Performed: Selected 3 closed files from the month of December 2007. This represented 30% of all closed appeals. All files were reviewed to ensure compliance with the above guidelines.

Findings:

1. All files contain ODNs. ☺
2. All appeals were received within 60 days of the date of the ODN. ☺
3. All standard appeals were processed within either 30 or 60 days of receiving the appeal and all expedited appeals were processed within 72 hours of receiving the appeal. ☺
4. Medical necessity denials were reviewed by a physician. ☺
5. All overturned appeals are effectuated within established CMS standards. ☺
6. Appeals were processed in compliance with CMS regulations? ☺

Conclusion: Based on my review, the Medicare Appeal Department is compliant with appeals processing.

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Appeal Audit Sheet

WS-RP2 Unfavorable Standard Benefit - Appeal File Checkoff Sheet.doc - Microsoft Word

File Edit View Insert Format Tools Table Window CIGNA Help

Type a question for help

1 2 3 4 5 6 7 8

APPEAL FILE CHECK-OFF SHEET

WS-RP2 – Unfavorable Standard Benefit	Reviewer Name:	Initial
1. Member Name:		
2. Type of Service Requested:		
3. Reason for Denial:		
4. Entity That Made Denial Determination:		
4a. Who signed ODN?		
5. Date of Initial Denial:		
6. Date Reconsideration Request Received:		
6a. Appealed w/in 60 days?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6b. Good Cause?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
6c. Good Cause letter in file?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
6d. Who signed appeal? (Member, POA, AOR)		
6e. Proper POA, AOR, WOP?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
6f. Acknowledgement letter sent?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
6g. Medical Necessity Appeal?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
6h. Medical Necessity Review by MD?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
6i. Who reviewed appeal? (compare w/column 4a)		
7. Was an Extension Taken?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Date Extension Notice Mailed:		N/A <input type="checkbox"/>
9. Extension Notice Timely?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
10. Extension Justified?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
11. MAO Partial Reversal?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
12. Date Sent to IRE:		
13. Sent to IRE Timely?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Date Member Notified Case Sent to IRE:		N/A <input type="checkbox"/>
15. Member Notified Timely?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
16. MAO Adverse Decision Reversed by Outside Entity?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
17. Date & Time Decision Received by MAO:		
18. Date & Time Authorized:		N/A <input type="checkbox"/>
19. Date Provided		N/A <input type="checkbox"/>
20. Authorized / Provided Timely?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
21. IRE Notified?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
22. Effectuation Compliant?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
23. Reconsideration Process Timely & Appropriate?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

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Appeal Audit Sheet

WS-RP2 Unfavorable Standard Benefit - Appeal File Checkoff Sheet.doc - Microsoft Word

File Edit View Insert Format Tools Table Window CIGNA Help

Type a question for help

1 2 3 4 5 6 7 8

Column Explanations

2. Type of Service Requested: Describe what service the member requested. *(Note in the "Comments" column if there is any pattern established, such as denials for a certain type of service that should not be denied.) Note: If not available, leave blank.*

3. Reason for Denial: Enter the reason for denial as shown on the Notice of Denial of Medical Coverage. *(Note in "Comments" if there is any pattern established, such as incorrect denial reason.) If not available, enter "Unknown."*

4. Entity That Made Denial Determination: MAO = The MAO issued the denial determination. **Delegated Entity =** A delegated entity for pre-service organization determinations issued the denial determination. *Note: If not available, select "Unknown."*

5. Date of Initial Denial: Date the pre-service denial was initially issued to the member. *Note: If not available, leave blank.*

6. Date Recon Request Received: Date request initially received. For written requests, this would be the receipt date stamped on correspondence or form. If the MAO accepts oral requests, this would be documentation from telephone logs capturing the date the member called to request the reconsideration. *Note: If not available, select "Unknown." If the request was received outside the 60 calendar day time frame for requesting a reconsideration, note any problems with the MAO's "good cause" determination in the "Comments" column and use this information in evaluating element, "RE01: Acceptance of Standard Reconsideration Requests."*

[If MAO receive IRE exemption for Element RP02, do not complete Items 7,8,10,12,or 14.]

7. Was an Extension Taken? Y = An extension was taken. **N =** An extension was not taken. *Note: If not available, enter "N."*

Complete columns 8-10 only if an extension was taken.

8. Date Extension Notice Mailed: Enter the date the extension notice was mailed. Documentation indicating when the notice was mailed could include a copy of the actual notice mailed or a screen print that clearly identifies the member and indicates that an extension notice was sent and the date that the notice was sent. *Note: If not available and the denial is timely without taking the extension into account, enter the date in column 6 into this column and note that the MAO did not document the date the extension was mailed in "Comments." If not available and denial is not timely, leave blank.*

9. Extension Notice Timely? Y = Date extension notice is mailed is within 30 days after the date the request was received. **N =** Date extension notice mailed is more than 30 days after the date the request was received. *Note: The reviewer will compute this column. If not available, enter "N."*

10. Extension Justified? Y = Member requested the extension or the organization justified a need for additional information and the delay was in the interest of the member. **N =** Member did not request the extension, the organization did not justify a need for additional information, and the delay was not in the interest of the member. An example of a justified need would be: the MAO was awaiting receipt of additional medical evidence from non-contracted providers. *Note: If not available or not justified, but the denial is timely without taking the extension into account, enter "Y" in this column and explain in "Comments" that the extension was not justified. If not available and the denial is not timely without taking the extension into account, enter "N."*

11. MAO Partial Reversal? Y = The MAO partially reversed its original denial and partially upheld its original denial. **N =** The MAO did not partially reverse its original denial. *Note: If not available, select "Unknown."*

IF MAO receive IRE exemption for Element RP02, do not complete Items 7,8,10,12,or 14.]

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Appeal File Check-off Form

Appeals File Checkoff Sheet.doc - Microsoft Word

File Edit View Insert Format Tools Table Window CIGNA Help

Type a question for help

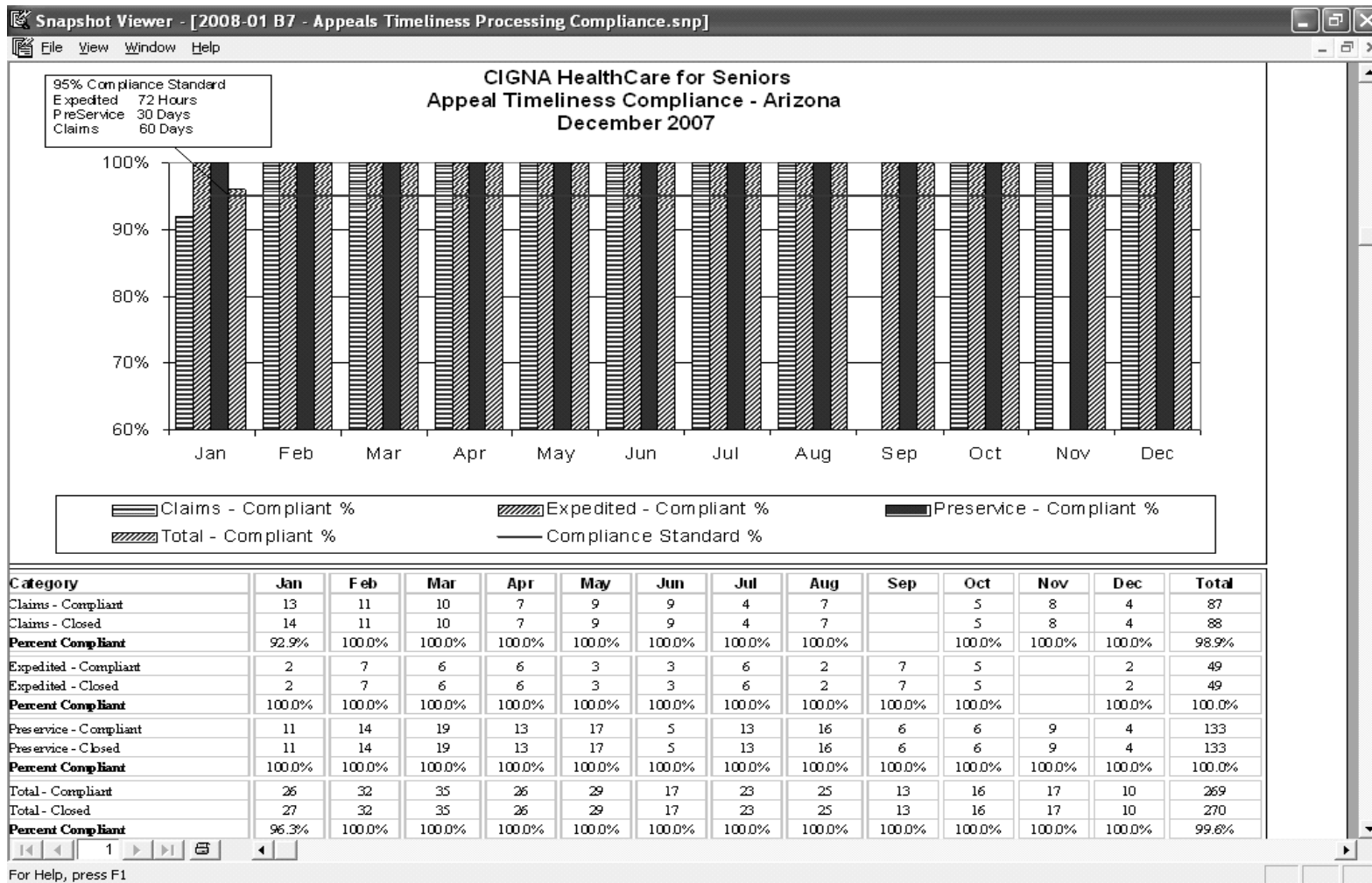
APPEALS FILE CHECK-OFF SHEET

Member Name: <input type="text"/>	Reviewer Name: _____			Initial
	Date Required for Unshaded Areas	Yes ✓	No ✓	Comments
Type of Appeal: Claim - Medical				
1. ODN on File?				
2. Date ODN Issued/Appeal Received. Within 60 days of ODN?				
3. If no to #2, Good Cause Letter on File?				
4. Did the member sign the appeal?				
5. If not signed/called by the member, representation letter/POA/Waiver of Payment on file?				
6. Type of appeal filed. Check One	Standard		Expedited	
7. Was expedited request approved? (for nonphysician supported request only)				
8. If No to #7, is denial/acknowledgment letter to expedite appeal on file?				
8a. If Yes to #8, was the letter issued timely?				
9. If standard appeal, Acknowledgment letter sent for standard appeal?				
10. If Medical Necessity Denial, was the appeal reviewed by a physician?				
11. Date CIGNA completed review of the appeal. Within Time?				
12. Upheld or Overturned? Check One	Upheld		Overturned	
13. If overturned, date effectuated. On Time?				
Medical	Prescription			
Expedited – auth or provide within 72 hrs	Expedited – auth or provide within 72 hrs			
Standard – auth or provide within 30 days	Standard – auth or provide within 7 days			
Claim – make pmt within 60 days	Claim –auth within 7 days and make pmt			

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Monthly Appeal Metric





Monthly Metric Grid

Microsoft Excel - 2008 MOCQC Metric Frequency.xls															
File Edit View Insert Format Tools Data Window Help															
Type a question for help															
Metric Report Title															
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
	Metric Report Title	Area of Responsibility	J	F	M	A	M	J	J	A	S	O	N	D	
1			a	e	a	p	a	u	u	u	e	c	o	e	
2	A	Claims and Delegated Activities	X	X	X	X	X	X	X	X	X	X	X	X	X
3		Avidity HCS Non contracted Clean Claims Processed Within 30 Days	X	X	X	X	X	X	X	X	X	X	X	X	X
4		Avidity HCS Clean/Non clean Contracted/Non contracted Claims Processed Within 30 Days	X	X	X	X	X	X	X	X	X	X	X	X	X
5		Avidity HCS Clean/Non clean Contracted/Non contracted Claims Processed Within 60 Days	X	X	X	X	X	X	X	X	X	X	X	X	X
6		ASHN Claims Processing Timeliness	X	X	X	X	X	X	X	X	X	X	X	X	X
7		CBH Contracted/Non contracted Claims Processed Within 60/30 Days	X	X	X	X	X	X	X	X	X	X	X	X	X
8		CBH Claims Accuracy and Phone Metrics	X	X	X	X	X	X	X	X	X	X	X	X	X
9		CDH Claims Processing Timeliness	X	X	X	X	X	X	X	X	X	X	X	X	X
10		Inspiris Claims Processing Timeliness	X	X	X	X	X	X	X	X	X	X	X	X	X
11		MSI Claims Processing Timeliness	X	X	X	X	X	X	X	X	X	X	X	X	X
12		NIA Claims Processing Timeliness	X	X	X	X	X	X	X	X	X	X	X	X	X
13		Phoenix Delegated ODN Audits - (AHCS, ASHN, CBH, CDH, DMR, INSP, NIA, PSC)	X	X	X	X	X	X	X	X	X	X	X	X	X
14	B	Coverage Determination and Appeal Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
15		PSC Standard Coverage Determination Timeliness Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
16		PSC Expedited Coverage Determination Timeliness Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
17		PSC IRE Submission Timeliness Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
18		DMR Standard Coverage Determination Timeliness Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
19		DMR IRE Submission Timeliness Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
20		Medicare Appeals Audit	X	X	X	X	X	X	X	X	X	X	X	X	X
21		Appeals Timeliness Processing Compliance	X	X	X	X	X	X	X	X	X	X	X	X	X
22		MAXIMUS Upheld vs. Overturned	X	X	X	X	X	X	X	X	X	X	X	X	X
23	C	Grievance Processing	X	X	X	X	X	X	X	X	X	X	X	X	X
24		Medicare Grievance Audit	X	X	X	X	X	X	X	X	X	X	X	X	X
25		Grievance Timeliness Processing Compliance	X	X	X	X	X	X	X	X	X	X	X	X	X
26		Grievance Delay Log	X	X	X	X	X	X	X	X	X	X	X	X	X
27	D	Eligibility	X	X	X	X	X	X	X	X	X	X	X	X	X
28		Eligibility Audit Results	X	X	X	X	X	X	X	X	X	X	X	X	X
29		Enrollment Form Issues	X	X	X	X	X	X	X	X	X	X	X	X	X
30		Disenrollment Metrics	X	X	X	X	X	X	X	X	X	X	X	X	X
31		Deceased Overpayments	X	X	X	X	X	X	X	X	X	X	X	X	X
32	E	Customer Service Call Center	X	X	X	X	X	X	X	X	X	X	X	X	X
33		Telephone Statistics Grid	X	X	X	X	X	X	X	X	X	X	X	X	X



Medicare Operations and Compliance Committee

- Headed by the Medicare Compliance Officer, the Medicare Operations and Compliance Committee (MOCC) is responsible to ensure the organization complies with all Medicare Advantage rules and regulations.
- The MOCC meets monthly to review compliance metrics and addresses issues of non-compliance.
- The MOCC reports up to the Medicare Compliance Committee (MCC). The MCC is made up of senior management and meets on a quarterly basis.

16



The End

17

Compliance with the Medicare Advantage program

Mike Myers
President and CEO GEMCare Health Plan Inc.

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Agenda

- Introduction – GEMCare Health Plan
- Medicare Advantage Program Objectives
- Continuous Improvement Process
- Compliance Plan/Program
- Oversight and Monitoring
- CMS Expectations

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GEMCare Health Plan Inc.

- GEMCare Health Plan is a for profit, Knox Keene licensed Medicare Services Health plan, owned by Golden Empire Managed Care, A Medical Group Inc, and Managed Care Systems, LP.
- Knox Keene Licensed in February 2006
- Signed Medicare Contracts September 2006
- Commenced Operations January 2007
- Membership is over 6000 as January 2008

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3

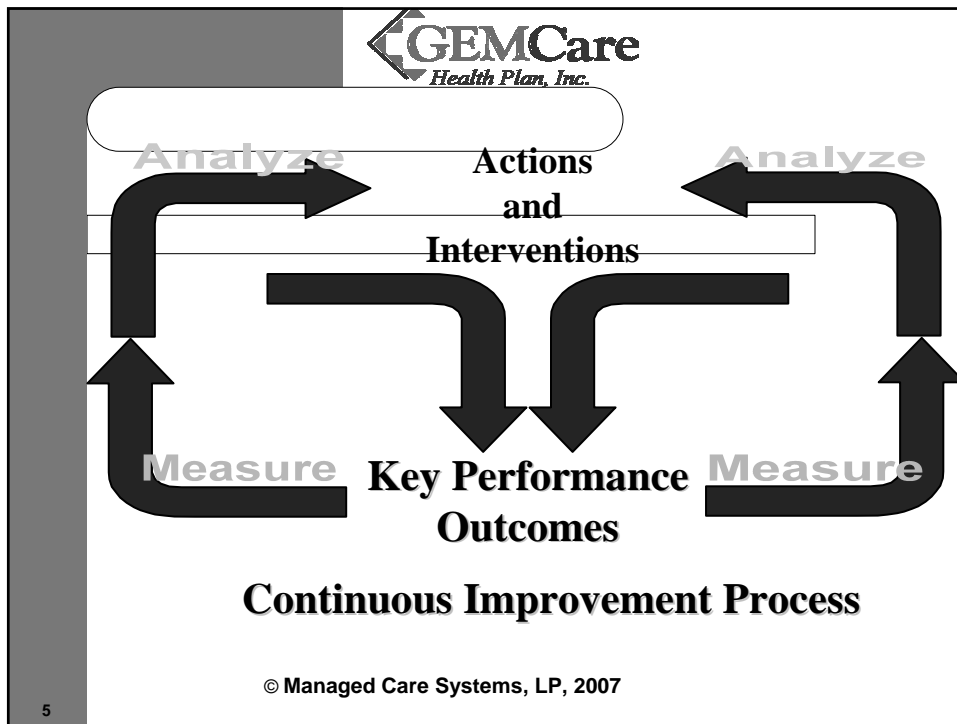


Medicare Advantage “Program Objectives”

- CMS is a business partner not the “compliance police”
- An organizational commitment to MA Program Compliance
- ~~No silos~~
 - Interdepartmental Communication/Education and Training
- Outcomes Orientation
 - Audit – Audit - Audit
 - Continuous Improvement Process

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4



-
- GEMCare**
Health Plan, Inc.
- Compliance Plan/Program**
- Oversight & Monitoring
 - Fraud & Abuse Detection & Reporting
 - Education & Communication
- © Managed Care Systems, LP, 2007
- 6
- The slide is titled 'Compliance Plan/Program' and lists three main components: Oversight & Monitoring, Fraud & Abuse Detection & Reporting, and Education & Communication. The GEMCare logo is at the top left, and the copyright notice is at the bottom.

Oversight & Monitoring

- Functional Area Self Reporting & Internal Audit
 - Medicare Monitoring and Review Guide
- Member and Marketing Material Review and Submission
- Sales Monitoring and Allegation Follow-up

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Fraud & Abuse Detection & Reporting

- Fraud “800” Hotline and Private E-mail
- Education & Training
- Member Complaints

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Education, Communication & Training

- Web Based
- MOCC
- Regulatory Requirements
 - Internal
 - Provider Network
 - Provider Communication
- Sales & Marketing
- Members

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Oversight and Monitoring Tool

OMT™

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Oversight and Monitoring Tool Purpose

- The Oversight & Monitoring Tool **OMT™** was created as a means of monitoring its Compliance with the established regulations set forth by CMS.
- The **OMT™** was built around the concept of monthly self-reporting by Functional Team Members of GHP and providing CMS “real time” access to the plan’s performance

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OMT™ Keys to success

- Organizational commitment to MA program compliance
- IT/IS resources and commitment
- User training and adoption
- Follow up and CIP

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OMT™ Reporting Schedule

The Reporting Schedule is used to inform users as to when they should report KPI and element compliance. Automated emails containing the list of outstanding KPIs and/or elements are sent to every user prior to the due dates.

https://gemcarehealthplan/omt/Documents/OMT_Reporting_Calendar.xls - Microsoft Internet Explorer

File Edit View Insert Format Tools Data Go To Favorites Help

Address https://gemcarehealthplan/omt/Documents/OMT_Reporting_Calendar.xls

A10 Review Preliminary Snapshot

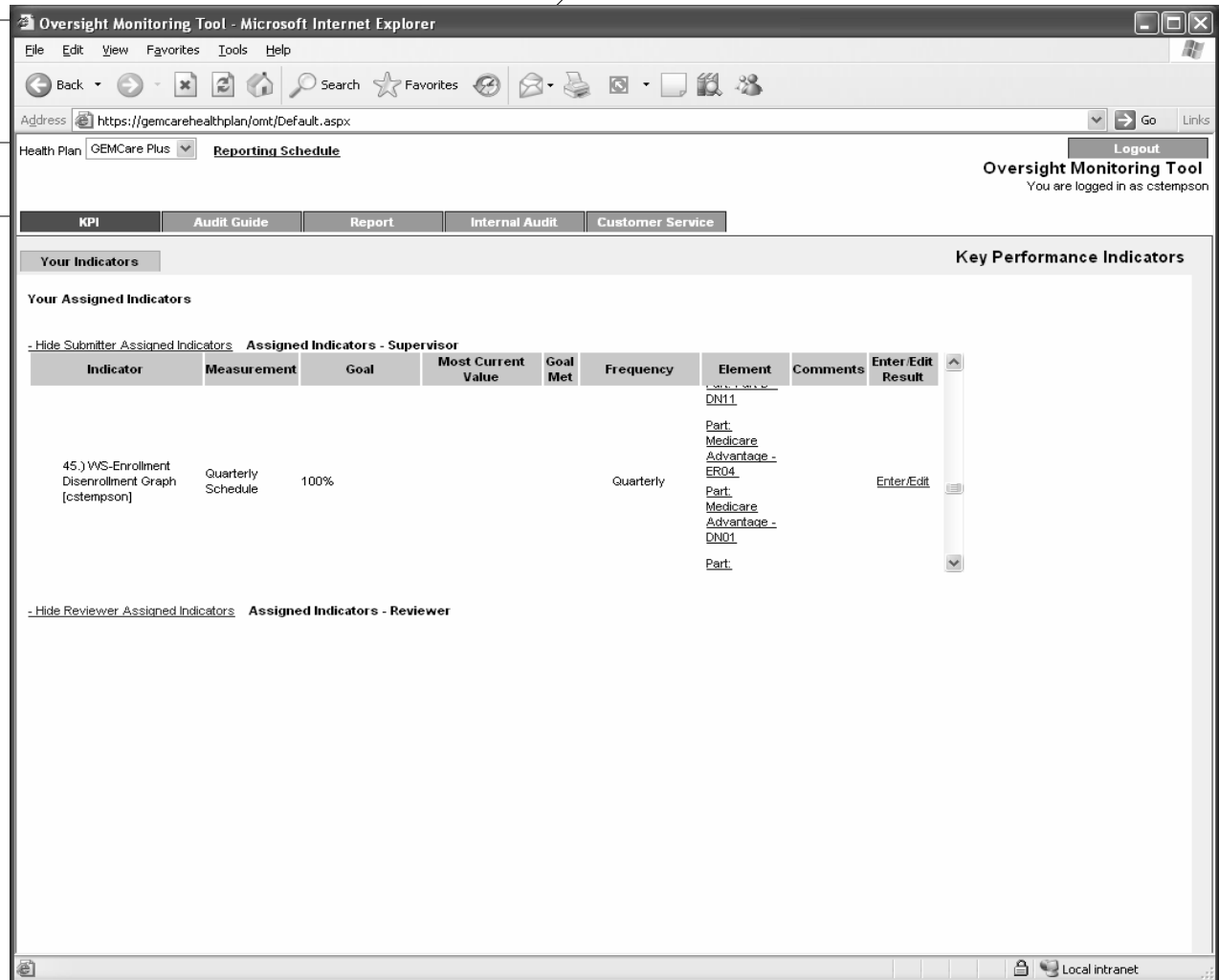
	A	B	C	D	E	F	G	H	I	J	K
1	COMPLIANCE - OMT REPORTING CALENDAR 2007										
2		April 07	May 07	June 07	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	
3											
4	KPI Submissions	11th	9th	6th	11th	8th	5th	10th	7th	5th	
5	KPI Review Completed	13th	11th	8th	13th	10th	7th	12th	9th	7th	
6	KPI Compliance Review	16th	14th	11th	16th	13th	10th	15th	12th	10th	
7	Audit Guide Element Review	13th	11th	8th	13th	10th	7th	12th	9th	7th	
8	Audit Guide Element Review Completed	19th	16th	13th	19th	15th	12th	17th	14th	12th	
9	Audit Guide Element Compliance Review	20th	18th	15th	20th	17th	14th	19th	16th	14th	
10	Review Preliminary Snapshot	23rd	21st	18th	23rd	20th	17th	22nd	19th	17th	
11											
12											
13											
14	COMPLIANCE - MOCC Meetings 2007										
15		April 07	May 07	June 07	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	
16	MOCC Meetings	24th	23rd	27th	25th	22nd	26th	24th	28th	19th	
17											
18											
19											
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Sheet1 / Sheet2 / Sheet3 / Unknown Zone

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OMT™ Key Performance Indicators (KPI)

KPI's are used to monitor key aspects of compliance. Their reporting frequencies are specified by the Compliance officer.



The screenshot shows the Oversight Monitoring Tool (OMT) web application interface. The browser window title is "Oversight Monitoring Tool - Microsoft Internet Explorer". The address bar shows the URL: <https://gemcarehealthplan/omt/Default.aspx>. The page displays the "Reporting Schedule" for "GEMCare Plus".

Navigation tabs include: **KPI**, **Audit Guide**, **Report**, **Internal Audit**, and **Customer Service**.

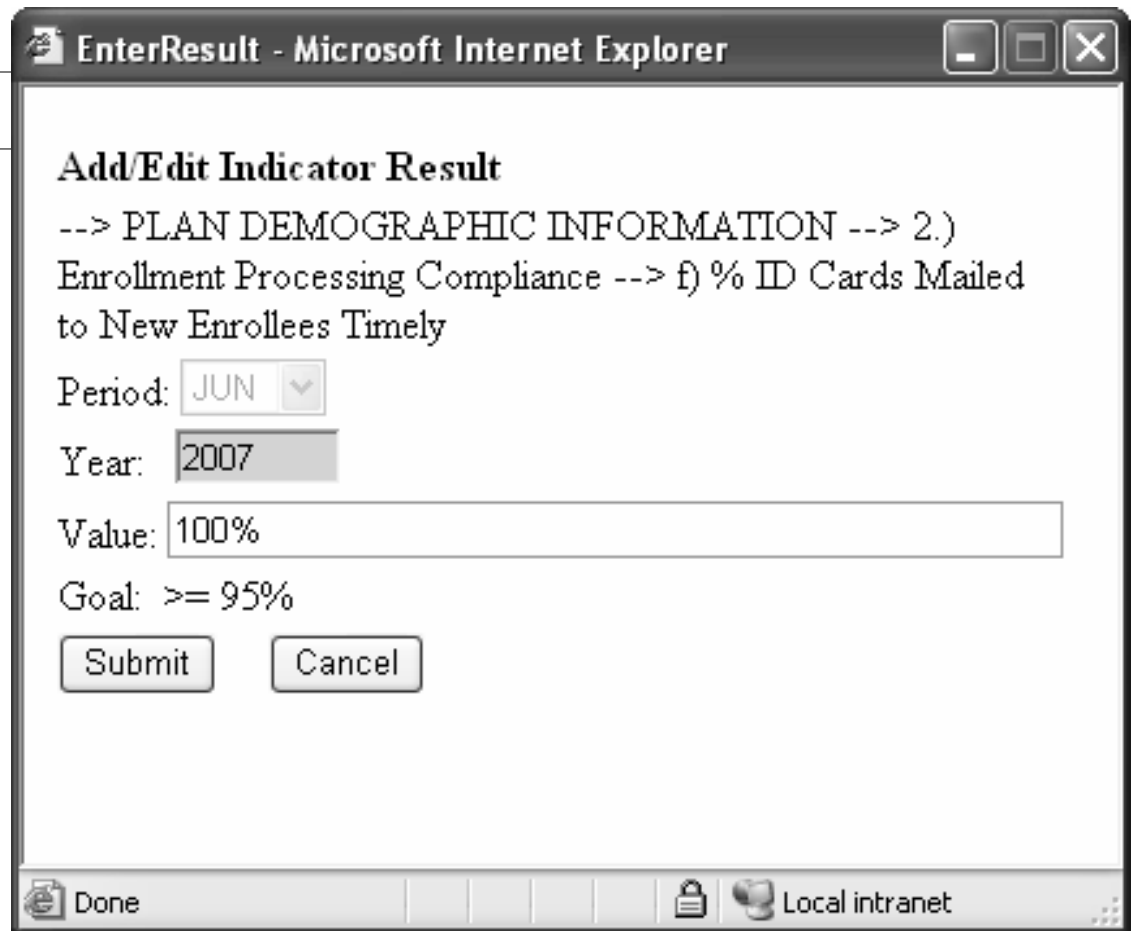
The main content area is titled "Key Performance Indicators" and shows "Your Assigned Indicators". A table lists assigned indicators for a supervisor:

Indicator	Measurement	Goal	Most Current Value	Goal Met	Frequency	Element	Comments	Enter/Edit Result
45.) WS-Enrollment Disenrollment Graph [cstempson]	Quarterly Schedule	100%			Quarterly	Part: Medicare Advantage - ER04 Part: Medicare Advantage - DN01 Part: Medicare Advantage - DN11		Enter/Edit

Below the table, there are links for "Assigned Indicators - Reviewer" and "Assigned Indicators - Supervisor".

OMT™ KPI Reporting

The submitters input the values.
Reviewers must approve the results before the results are considered valid and reported.



EnterResult - Microsoft Internet Explorer

Add/Edit Indicator Result

--> PLAN DEMOGRAPHIC INFORMATION --> 2.)
Enrollment Processing Compliance --> f) % ID Cards Mailed to New Enrollees Timely

Period: JUN

Year: 2007

Value: 100%

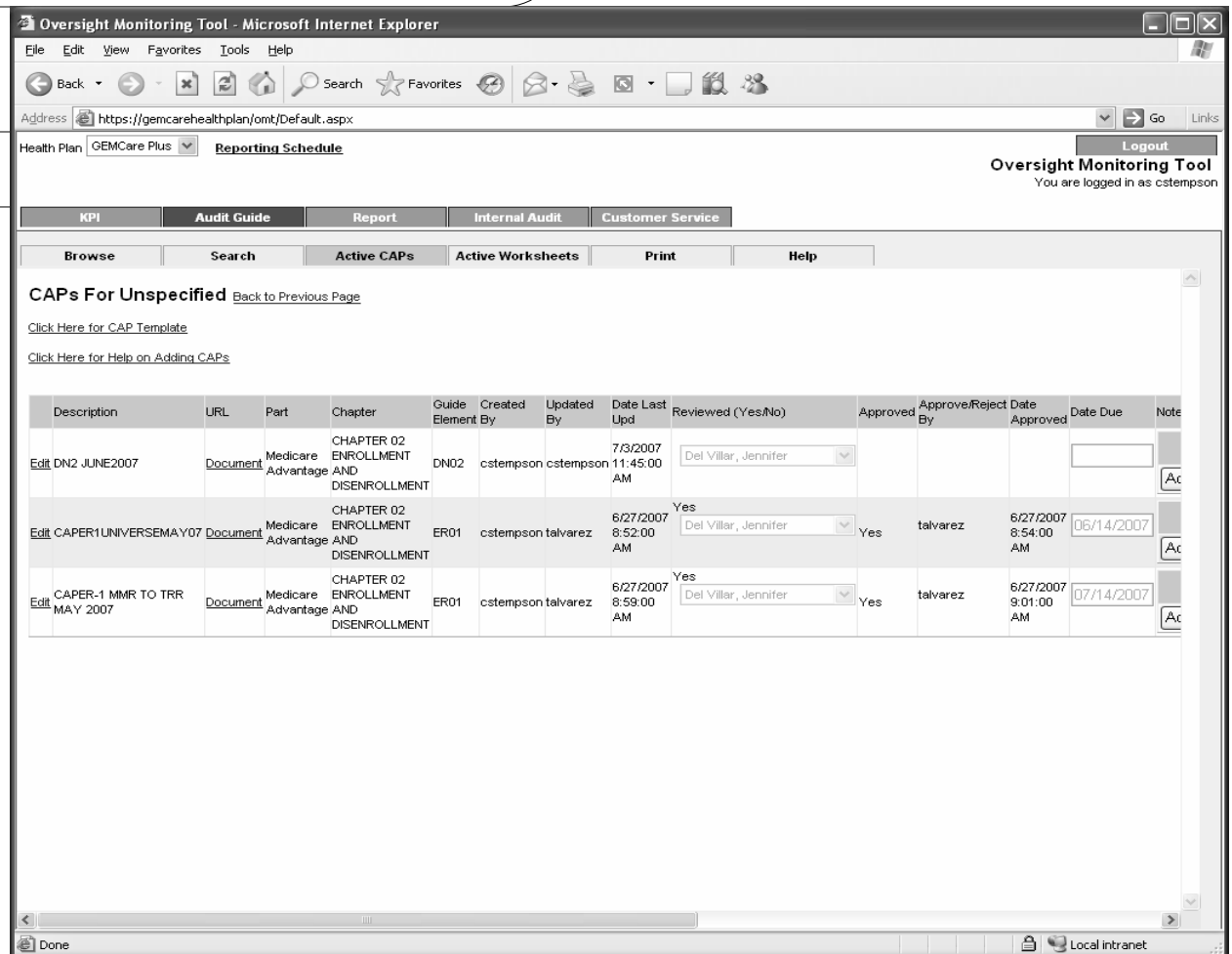
Goal: >= 95%

Submit Cancel

Done Local intranet

OMT™ Correction Action Plan (CAP)

Any issue that requires continuous improvement will have a CAP. The CAP is only closed once the issue is resolved.



The screenshot shows the Oversight Monitoring Tool interface in Microsoft Internet Explorer. The browser address bar displays <https://gemcarehealthplan/omt/Default.aspx>. The page title is "Oversight Monitoring Tool" and it indicates the user is logged in as "cstempson".

The main content area displays "CAPs For Unspecified" with a table of active CAPs. The table has the following columns: Description, URL, Part, Chapter, Guide Element, Created By, Updated By, Date Last Upd, Reviewed (Yes/No), Approved, Approve/Reject By, Date Approved, Date Due, and Note. There are three rows of CAPs listed.

Description	URL	Part	Chapter	Guide Element	Created By	Updated By	Date Last Upd	Reviewed (Yes/No)	Approved	Approve/Reject By	Date Approved	Date Due	Note
Edit DN2 JUNE2007	Document	Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	DN02	cstempson	cstempson	7/3/2007 11:45:00 AM	Del Villar, Jennifer					
Edit CAPER1UNIVERSEMAY07	Document	Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER01	cstempson	talvarez	6/27/2007 8:52:00 AM	Del Villar, Jennifer	Yes	talvarez	6/27/2007 8:54:00 AM	06/14/2007	
Edit CAPER-1 MMR TO TRR MAY 2007	Document	Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER01	cstempson	talvarez	6/27/2007 8:59:00 AM	Del Villar, Jennifer	Yes	talvarez	6/27/2007 9:01:00 AM	07/14/2007	



OMT™ CAP Form

https://gemcarehealthplan/omt/Documents/CAP_CAR_OMT_Template.doc - Microsoft Internet Explorer

File Edit View Insert Format Tools Table Go To Favorites Help

Address https://gemcarehealthplan/omt/Documents/CAP_CAR_OMT_Template.doc

1 2 3 4 5 6 7

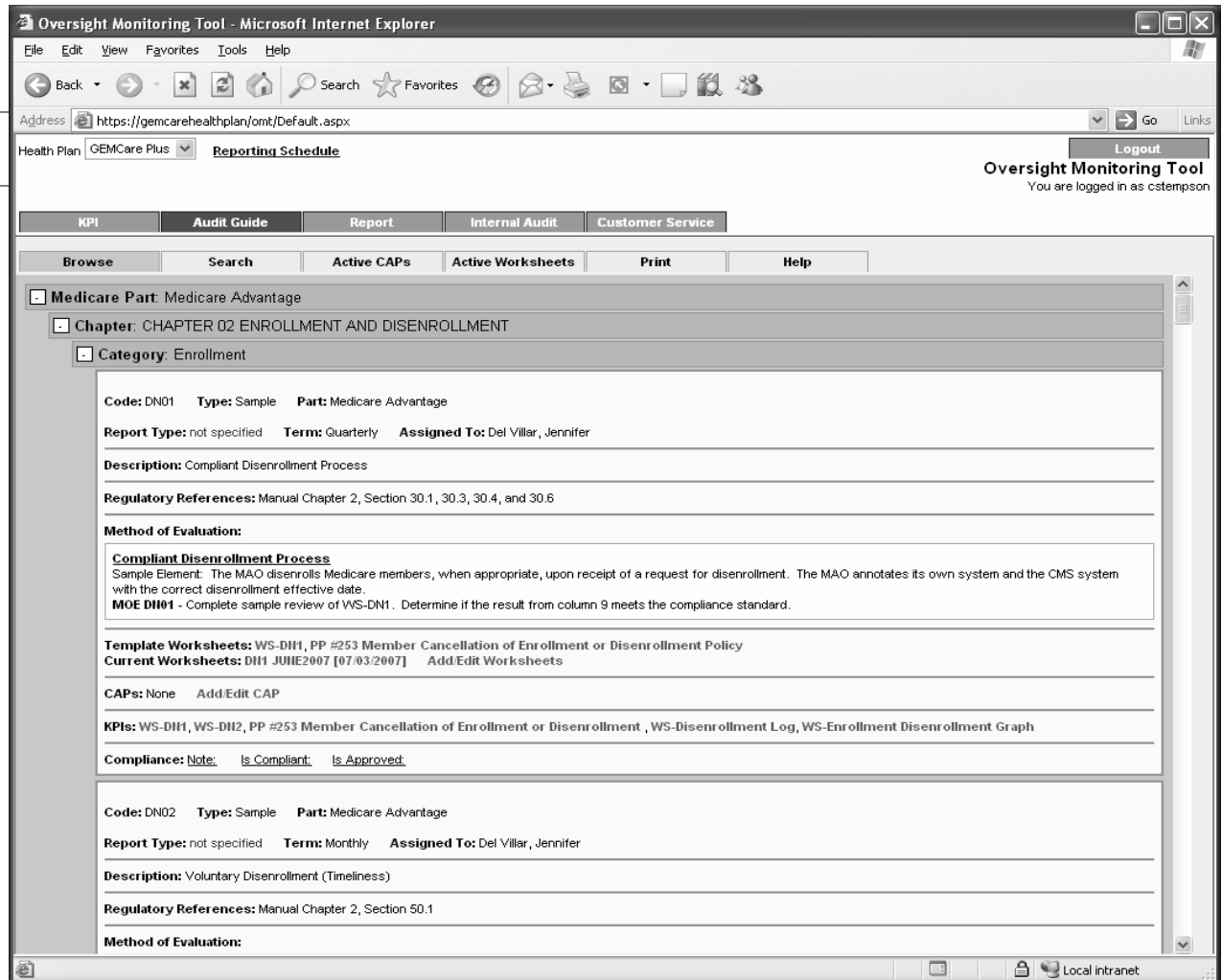
**Compliance & Internal Audit
Corrective Action Plan**

Element No:	Reporting Period:
Responsible Person (Stakeholder):	Origination: <input type="checkbox"/> Internal Audit & No _____ <input type="checkbox"/> HIPAA <input type="checkbox"/> Investigations <input type="checkbox"/> KPI KPI No. and Full Description _____ <input type="checkbox"/> Other _____
Corrective Action Recommendation (CAR): <i>[Completed by Compliance Dept.]</i>	
Corrective Action Plan (CAP): <i>[Completed by Stakeholder]</i>	
Supporting Documentation:	
Target Completion Date:	
<input type="checkbox"/> Approve <input type="checkbox"/> Reject	
Teresa Ramos, Compliance Officer _____	

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OMT™ Audit Guide Module

The Audit Guide specifies rules of compliance as set forth by CMS.

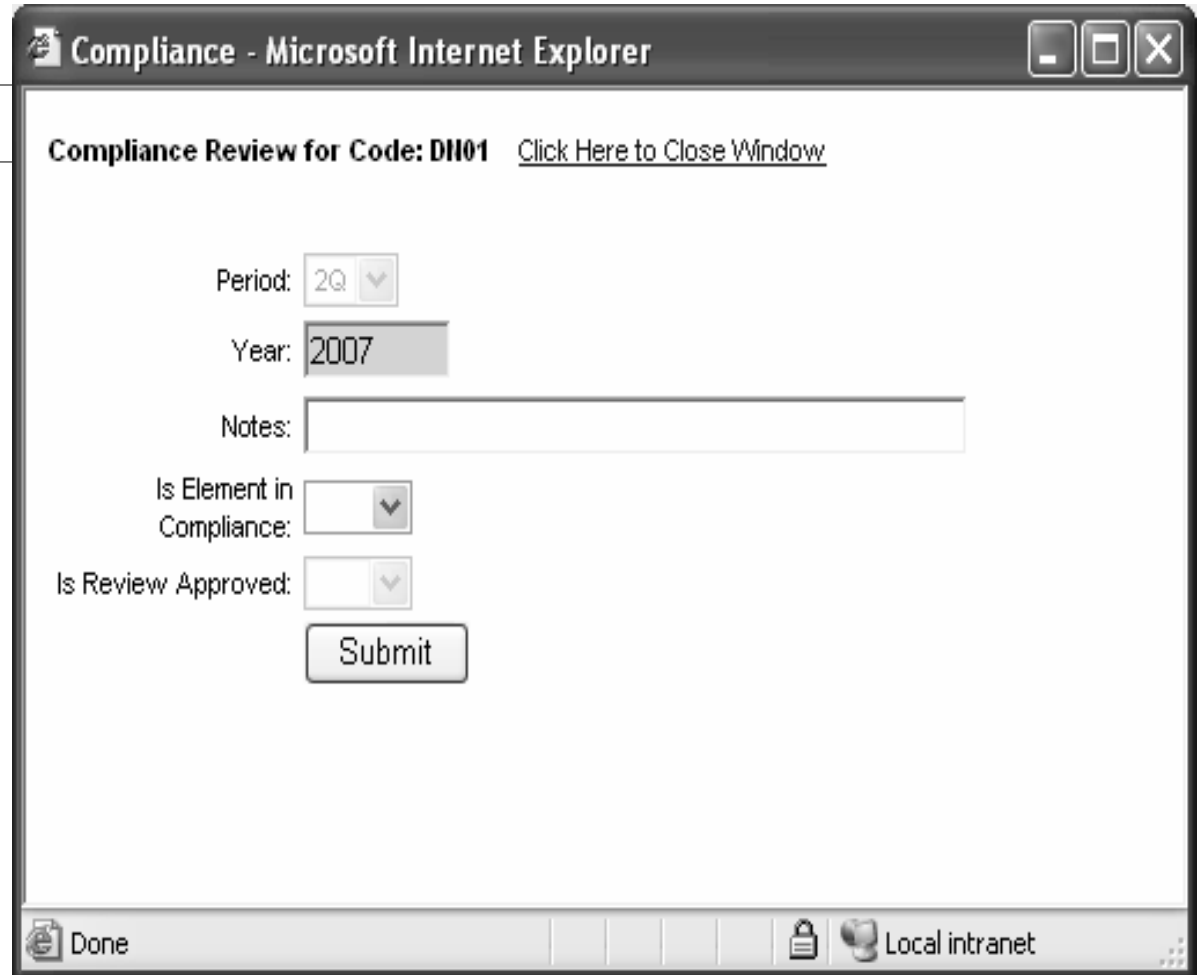


Code: DN01 **Type:** Sample **Part:** Medicare Advantage
Report Type: not specified **Term:** Quarterly **Assigned To:** Del Villar, Jennifer
Description: Compliant Disenrollment Process
Regulatory References: Manual Chapter 2, Section 30.1, 30.3, 30.4, and 30.6
Method of Evaluation:
Compliant Disenrollment Process
 Sample Element: The MAO disenrolls Medicare members, when appropriate, upon receipt of a request for disenrollment. The MAO annotates its own system and the CMS system with the correct disenrollment effective date.
MOE DI01 - Complete sample review of WS-DN1. Determine if the result from column 9 meets the compliance standard.

Code: DN02 **Type:** Sample **Part:** Medicare Advantage
Report Type: not specified **Term:** Monthly **Assigned To:** Del Villar, Jennifer
Description: Voluntary Disenrollment (Timeliness)
Regulatory References: Manual Chapter 2, Section 50.1
Method of Evaluation:

OMT™ Element Reporting

Users assigned to elements are responsible for reporting elements compliance according to set reporting frequencies. For example, DN01 is reported quarterly.



Compliance - Microsoft Internet Explorer

Compliance Review for Code: DN01 [Click Here to Close Window](#)

Period: 2Q

Year: 2007

Notes:

Is Element in Compliance:

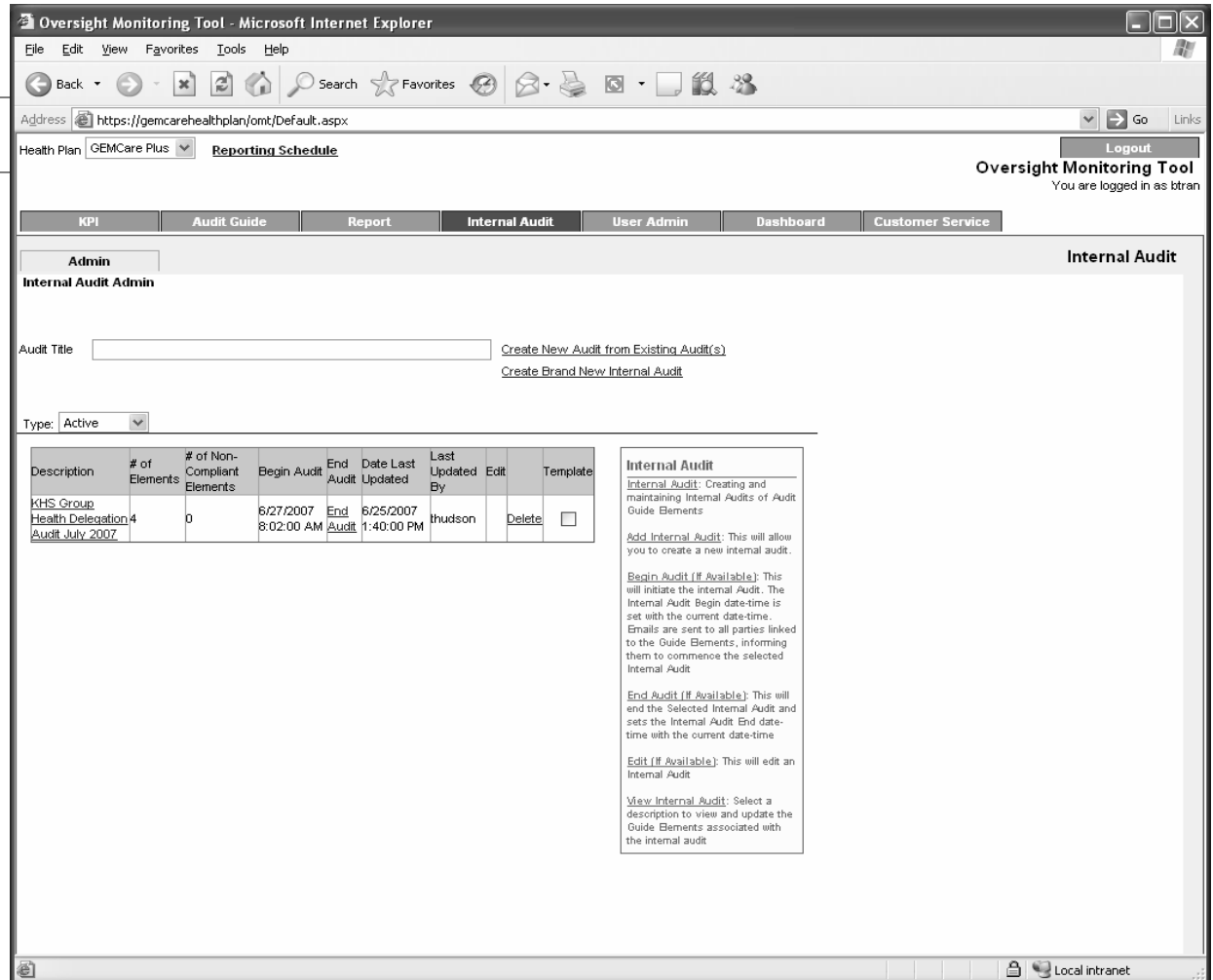
Is Review Approved:

Submit

Done Local intranet

OMT™ Internal Audit

The Internal Audit module is used by the Compliance team to verify the accuracy of items reported in the OMT™.



The screenshot shows the 'Oversight Monitoring Tool' interface in a Microsoft Internet Explorer browser window. The address bar shows the URL: https://gemcarehealthplan/omt/Default.aspx. The page title is 'Oversight Monitoring Tool' and it indicates the user is logged in as 'btran'. The navigation menu includes: KPI, Audit Guide, Report, Internal Audit (selected), User Admin, Dashboard, and Customer Service. The 'Internal Audit' section is active, showing an 'Admin' tab and 'Internal Audit Admin' options. There is a text input field for 'Audit Title' and two links: 'Create New Audit from Existing Audit(s)' and 'Create Brand New Internal Audit'. A dropdown menu for 'Type' is set to 'Active'. Below this is a table with the following data:

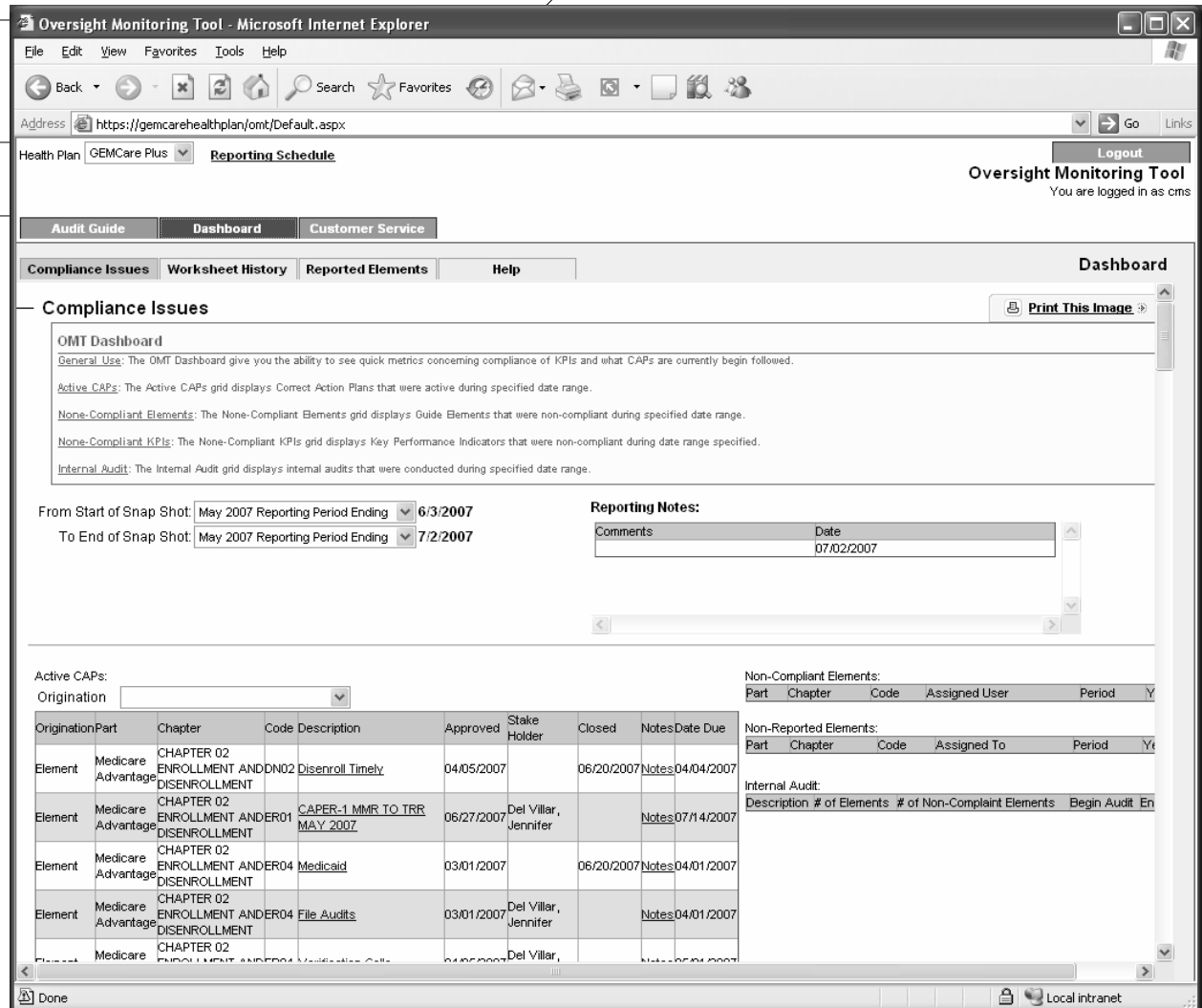
Description	# of Elements	# of Non-Compliant Elements	Begin Audit	End Audit	Date Last Updated	Last Updated By	Edit	Template
KHS Group Health Delegation Audit July 2007	4	0	6/27/2007 8:02:00 AM	End Audit	6/25/2007 1:40:00 PM	thudson	Delete	<input type="checkbox"/>

To the right of the table is a sidebar titled 'Internal Audit' containing several links and their descriptions:

- [Internal Audit](#): Creating and maintaining Internal Audits of Audit Guide Elements
- [Add Internal Audit](#): This will allow you to create a new internal audit.
- [Begin Audit \(if Available\)](#): This will initiate the internal Audit. The Internal Audit Begin date-time is set with the current date-time. Emails are sent to all parties linked to the Guide Elements, informing them to commence the selected Internal Audit
- [End Audit \(if Available\)](#): This will end the Selected Internal Audit and sets the Internal Audit End date-time with the current date-time
- [Edit \(if Available\)](#): This will edit an Internal Audit
- [View Internal Audit](#): Select a description to view and update the Guide Elements associated with the internal audit

OMT™ Dash Board

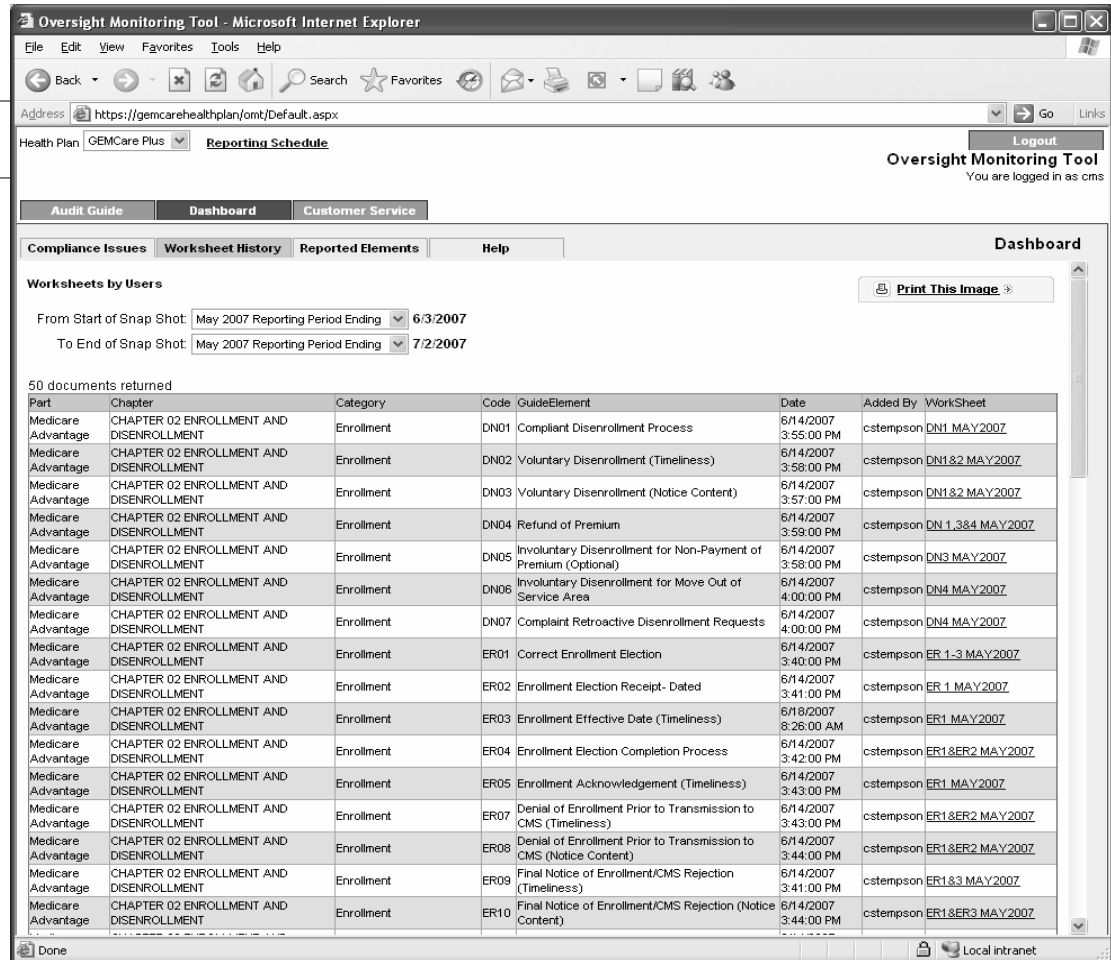
The Dash Board contains snapshots of the OMT™. The Compliance Issues section (See Figure on the right) shows outstanding items such as CAPs, non-compliant elements, and non-reported elements.



The screenshot shows the OMT Dashboard interface. At the top, there's a navigation bar with tabs for 'Audit Guide', 'Dashboard', and 'Customer Service'. Below this, there are sub-tabs for 'Compliance Issues', 'Worksheet History', 'Reported Elements', and 'Help'. The main content area is titled 'Compliance Issues' and includes a 'Print This Image' button. It contains several informational sections: 'General Use', 'Active CAPs', 'None-Compliant Elements', 'None-Compliant KPIs', and 'Internal Audit'. There are also date pickers for 'From Start of Snap Shot' and 'To End of Snap Shot', and a 'Reporting Notes' section with a table for 'Comments' and 'Date'. At the bottom, there are two tables: 'Active CAPs' and 'Non-Compliant Elements'. The 'Active CAPs' table has columns for Origination, Part, Chapter, Code, Description, Approved, Stake Holder, Closed, Notes, and Date Due. The 'Non-Compliant Elements' table has columns for Part, Chapter, Code, Assigned User, and Period. There is also a section for 'Non-Reported Elements' and 'Internal Audit'.

OMT™ Worksheet History Module

The Worksheet History section contains all worksheets submitted during the specified reporting period

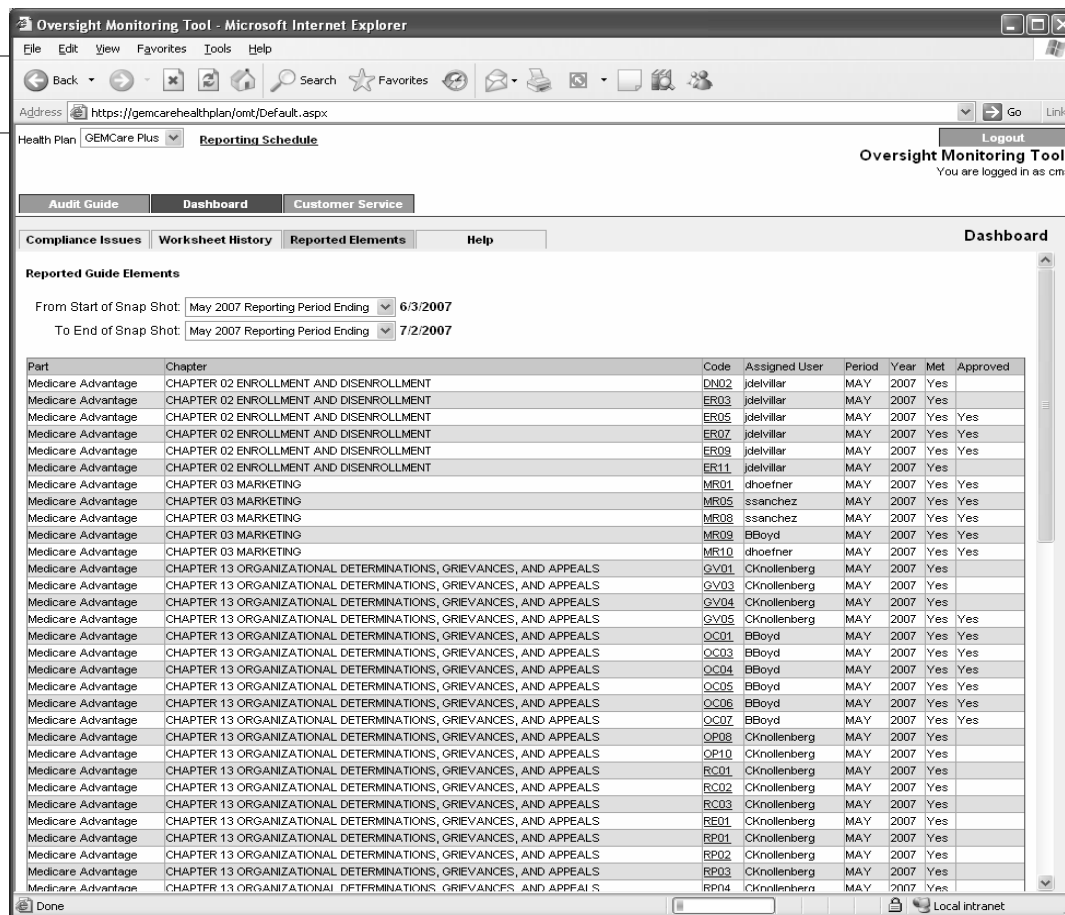


50 documents returned

Part	Chapter	Category	Code	GuideElement	Date	Added By	WorkSheet
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN01	Compliant Disenrollment Process	6/14/2007 3:55:00 PM	cstempson	DN1 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN02	Voluntary Disenrollment (Timeliness)	6/14/2007 3:58:00 PM	cstempson	DN1&2 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN03	Voluntary Disenrollment (Notice Content)	6/14/2007 3:57:00 PM	cstempson	DN1&2 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN04	Refund of Premium	6/14/2007 3:59:00 PM	cstempson	DN 1,3&4 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN05	Involuntary Disenrollment for Non-Payment of Premium (Optional)	6/14/2007 3:58:00 PM	cstempson	DN3 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN06	Involuntary Disenrollment for Move Out of Service Area	6/14/2007 4:00:00 PM	cstempson	DN4 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	DN07	Complaint Retroactive Disenrollment Requests	6/14/2007 4:00:00 PM	cstempson	DN4 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER01	Correct Enrollment Election	6/14/2007 3:40:00 PM	cstempson	ER 1-3 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER02	Enrollment Election Receipt- Dated	6/14/2007 3:41:00 PM	cstempson	ER 1 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER03	Enrollment Effective Date (Timeliness)	6/18/2007 8:26:00 AM	cstempson	ER1 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER04	Enrollment Election Completion Process	6/14/2007 3:42:00 PM	cstempson	ER1&ER2 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER05	Enrollment Acknowledgement (Timeliness)	6/14/2007 3:43:00 PM	cstempson	ER1 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER07	Denial of Enrollment Prior to Transmission to CMS (Timeliness)	6/14/2007 3:43:00 PM	cstempson	ER1&ER2 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER08	Denial of Enrollment Prior to Transmission to CMS (Notice Content)	6/14/2007 3:44:00 PM	cstempson	ER1&ER2 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER09	Final Notice of Enrollment/CMS Rejection (Timeliness)	6/14/2007 3:41:00 PM	cstempson	ER1&3 MAY 2007
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	Enrollment	ER10	Final Notice of Enrollment/CMS Rejection (Notice Content)	6/14/2007 3:44:00 PM	cstempson	ER1&ER3 MAY 2007

OMT™ Reported Elements Module

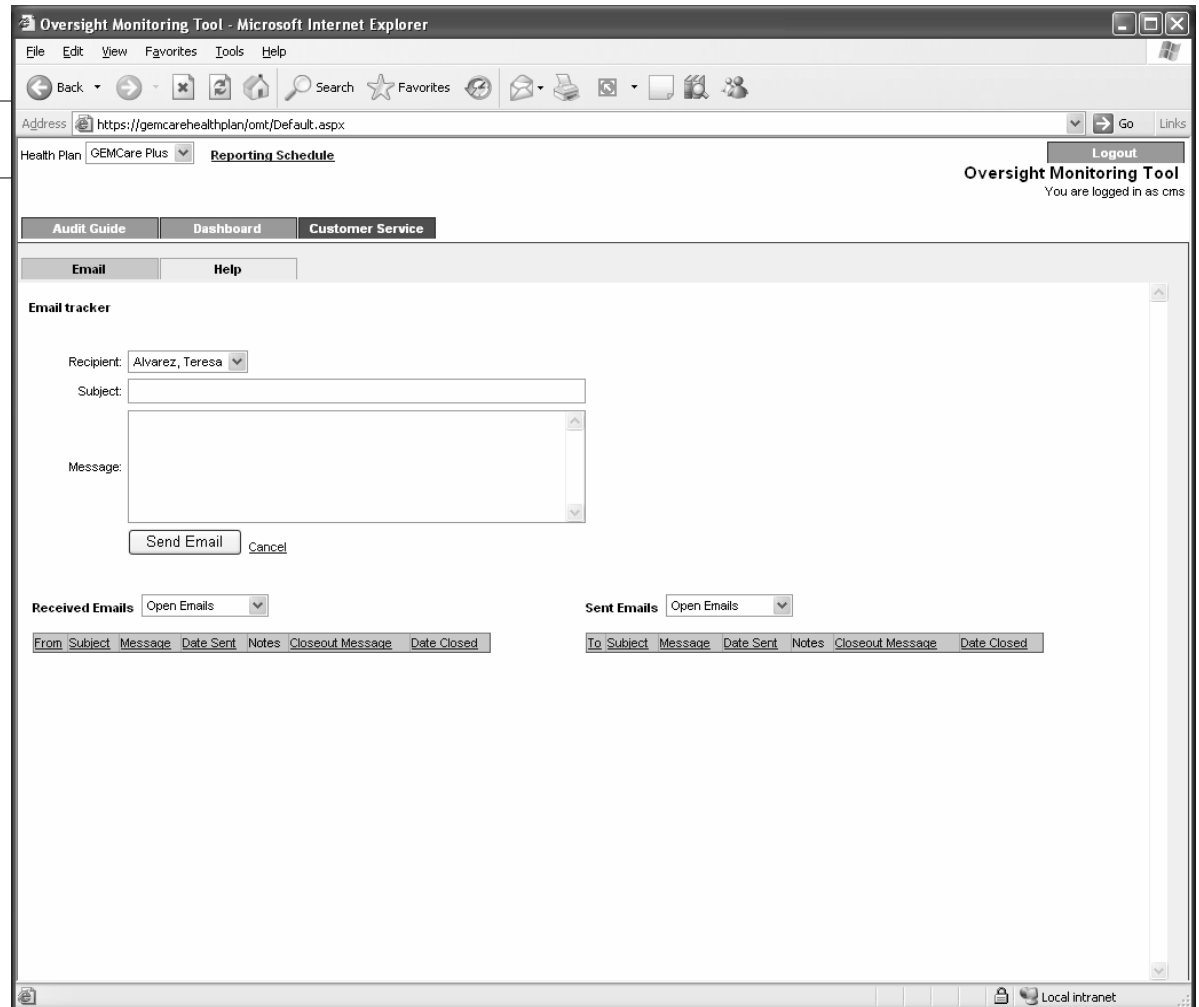
The Reported Elements section contains all elements reported during the specified reporting period.



Part	Chapter	Code	Assigned User	Period	Year	Met	Approved
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	DN02	jdelvillar	MAY	2007	Yes	
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER03	jdelvillar	MAY	2007	Yes	
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER05	jdelvillar	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER07	jdelvillar	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER09	jdelvillar	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 02 ENROLLMENT AND DISENROLLMENT	ER11	jdelvillar	MAY	2007	Yes	
Medicare Advantage	CHAPTER 03 MARKETING	MR01	dhoefner	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 03 MARKETING	MR05	ssanchez	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 03 MARKETING	MR08	ssanchez	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 03 MARKETING	MR09	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 03 MARKETING	MR10	dhoefner	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	GV01	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	GV03	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	GV04	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	GV05	Cknollenberg	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OC01	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OC03	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OC04	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OC05	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OC06	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OC07	BBoyd	MAY	2007	Yes	Yes
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OP08	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	OP10	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	RC01	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	RC02	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	RC03	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	BE01	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	BE01	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	BE02	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	BE03	Cknollenberg	MAY	2007	Yes	
Medicare Advantage	CHAPTER 13 ORGANIZATIONAL DETERMINATIONS, GRIEVANCES, AND APPEALS	BE04	Cknollenberg	MAY	2007	Yes	

OMT™ Customer Service Module

The Customer Service Module allows a user to send requests to other users of the OMT™. All requests are logged and tracked. The CSM is similar to a work order in that the recipients must closeout all requests sent to them

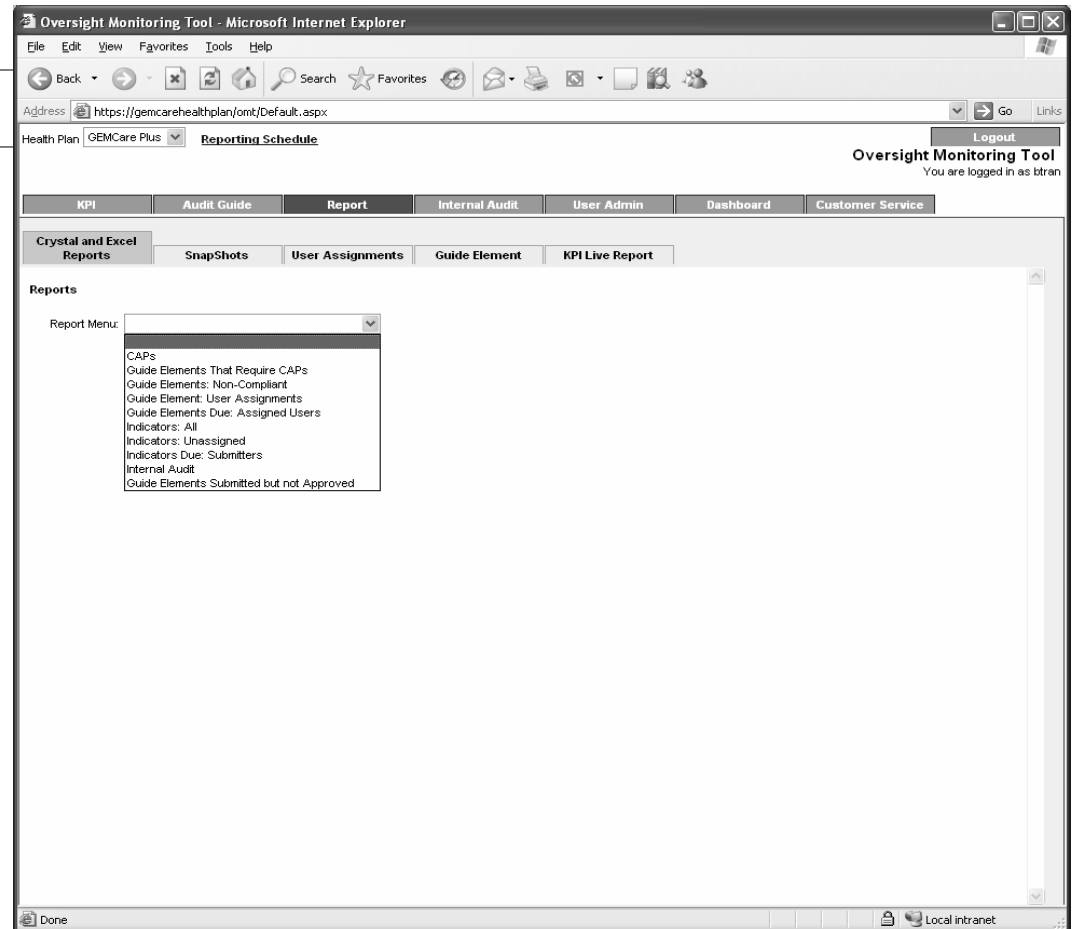


The screenshot shows the Oversight Monitoring Tool interface in Microsoft Internet Explorer. The browser title is "Oversight Monitoring Tool - Microsoft Internet Explorer". The address bar shows "https://gemcarehealthplan/omt/Default.aspx". The page header includes "Health Plan: GEMCare Plus" and "Reporting Schedule". A "Logout" button is visible in the top right corner. The main navigation tabs are "Audit Guide", "Dashboard", and "Customer Service". The "Customer Service" tab is active, showing an "Email" section with a "Help" link. The "Email tracker" section includes a "Recipient" dropdown menu (set to "Alvarez, Teresa"), a "Subject" text box, and a "Message" text area. Below these are "Send Email" and "Cancel" buttons. At the bottom, there are two tables for "Received Emails" and "Sent Emails", each with a "Open Emails" dropdown menu and a table header with columns: "From", "Subject", "Message", "Date Sent", "Notes", "Closeout Message", and "Date Closed".

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OMT™ Management Reports Module

OMT™ users have access to various reports for facilitating compliance reporting and for providing trend analysis.



CMS Expectations

- Company commitment to the MA program and compliance
- Corrective Action Plan Implementation and Continuous Improvement Focus
- Resource Commitment
 - Appropriate staffing levels
 - Education and training

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QUESTIONS

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Kaiser Foundation Health Plan, Inc.

Medicare Monitoring Program

Presentation
CMS Region IX Training
March 6 and 7, 2008

Agenda

- **Background**
- **Approach/Implementation**
- **Methodology**
- **Reporting**
- **Lessons Learned**
- **Benefits Achieved**
- **Questions and Contacts**

■ An effective Medicare monitoring program is essential for:

- Participation in Medicare (e.g., it is required by the Office of the Inspector General (OIG) for Medicare participation)
- Understanding and managing performance of CMS-required activities
- Maintaining an organization's image and reputation
- Ensuring that changing CMS requirements are incorporated into operations

■ Kaiser Permanente's design for an effective monitoring program:

- Comprehensive scope – include all Part C and Part D requirements
- Proactive identification of issues – monitoring should be an **indicator system**
- Near real-time data – monitoring should provide a **current picture** of performance
- Identification of **better/best practices by sharing results across regions**

Approach/Implementation



- **Identified compliance requirements**
 - Part C “Monitoring Review Guide”
 - Part D “Audit Guide”
- **Constructed and validated metrics with operational leaders**
- **Secured executive sponsorship from highest level of organization**
 - Messaging from CEO that the work was critical and needed to get done

Approach/Implementation



- **Developed tiered communication plan from CEO and CCO, down through supervisor level regarding importance of work**
- **Delivered regular reports on progress of implementation**
- **Engaged functional areas**
 - Focused on highly visible areas for initial rollout, e.g., Claims, Member Services, Marketing, Membership Administration, and Pharmacy
 - Collaborated on metric content review

Approach/Implementation



- **Required identification of accountable parties for *each* metric**
- **Identified existing software (ActiveStrategy) as system of record for all metrics**
 - KP already using ActiveStrategy software for internal business performance metrics
- **Provided system training**
- **Initiated reporting**
- **Scheduled business reviews**

Methodology



- **CMS uses its own audit tool**
 - Part C “Monitoring Review Guide” and Part D “Audit Guide”
- **Metric goals aligned to CMS methodology**
 - **Metric goals/targets** correlate with CMS audit methodology
 - “Met”/“Not Met” expressed as percentages
 - *Example:* Goal percentage for C-GV05 (written responses to oral and written grievances)
 - Universe of 21 – 250,000
 - Sample size of 15
 - Allowed 2 “Not Mets” → 13/15 = 87%
 - **At least one metric for every element**
 - May be multiple metrics per element to reflect the element’s multiple requirements

■ Mapping to the CMS elements

- Part C Medicare Monitoring metrics map to the CMS Monitoring Review Guide worksheets
- Scoring at the element level, as with CMS
 - Metric(s) roll up to the element

5			Results			[Complete Column 6 only if Grievance was	[Complete Columns 7-9 only if an extension was taken]											
6	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
7	Record #	Member Name or HIC#	Issue Description	Case Correctly Categorized?	Date and Time Grievance	Expedited Grievance?	Was Extension Taken?	Date Extension Notice Mailed	Extension Notice Timely?	Extension Justified?	Resolution Description	Issue Resolved?	Date and Time Member Notified	Member Notified Timely?	Notification Timely?	Notice Content Correct?	Method of Notification Correct?	Comments
11	4																	
12	5																	
13	6																	
14	7																	
15	8																	
16	9																	
17	#																	
18	#																	
19	#																	
20	#																	
21	#																	
22	#																	
23	#			15														
24	#			15														
25	Met/Not Met			Met														
26	CMS Element Transfer Results ASE			GV01											GV03	GV04	GV05	
27				GV01.1											GV03.1	GV04.1	GV05.1 GV05.2	

Same sample used for C-GV01 thru C-GV05

C-GV01.1:
Member concerns correctly categorized

C-GV05.1: Written response to written grievances

C-GV05.2: Written response to oral grievances when requested

13/15 = 87%

13
15
Met

- **Quarterly reporting process**
- **Data input**
 - Business owners enter data and, for metrics not meeting their goal, complete Variance Reports
- **Business Review of compliance metrics**
 - Partnership between Compliance and Operations
 - Formalized process at the National level
 - Various processes at the Regional and departmental levels
 - Business owners accountable for data and results of corrective actions

■ *Example: Stoplight chart*

- “No” (red cell) = not compliant

	<u>Region A</u>	<u>Region B</u>	<u>Region C</u>	<u>Region D</u>	<u>Region E</u>	<u>Region F</u>	<u>Region G</u>	<u>Region H</u>
<u>C-GV01</u> Grievances - categorization	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<u>C-GV03</u> Grievances - timeliness	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
<u>C-GV04</u> Grievances - notice content	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<u>C-GV05</u> Grievances - written response	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

■ **Example: Scorecard exception report**

- Variance Report information for non-compliant metrics

Status	Name	Actual	Target	Var	Date	Owners
▼	<u>C-GV03.1 Grievance decisions with timely notification (sample) (Qtr) (Region A)</u>	84 %	87 %	(3) %	Dec 07	<u>Metric Owner</u>

Variance Report Comments:

Unanticipated illness created a staffing issue that constrained resources. In addition, a newly identified training issue contributed to the grievance underperformance. Retraining conducted to improve case timeliness and quality. Staffing issue resolved in September - fully staffed again and have cross-trained a back-up person to prevent reoccurrence. We anticipate no issue in Q4.

Lessons Learned



- **Executive sponsorship**
 - Critical to success
- **Robust communication plan**
 - Essential for operational engagement
- **Identification of accountable parties**
 - Should be done early on to facilitate implementation

Benefits Achieved



- **Operations is self-monitoring**
- **Joint reporting to Compliance and Operations**
- **Line of sight into non-compliant areas**
- **Ability to be pro-active**
- **Ability to identify and correct deficient areas prior to a CMS audit**
- **Ability to monitor CAP effectiveness**

After only 3 quarters of reporting, the experience has been very successful

■ Questions?

■ Contact information

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