

What You Need to Know: Medicare Advantage & Part D Plan and Program Monitoring, Measurement, and Compliance

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Overview

- ◆ Using Data to Monitor CMS Programs
- ◆ Key Results from the Part D Data Symposium
- ◆ Medicare Advantage and Prescription Drug Reporting Requirements – What's New for 2009
- ◆ Hot Off the Press – 2009 Performance Metrics
- ◆ Monitoring and Compliance – How We Use Data

A Collaborative Effort

- ◆ Numerous divisions within the Medicare Drug Benefit and C & D Data Group, each with specialized expertise and distinct roles
- ◆ Today's presentation represents a compilation of data-oriented work across the Group
- ◆ Special thanks to....
 - The Division of Clinical and Operational Performance (Vikki Oates, Chris Powers, Alice Lee-Martin)
 - The Division of Formulary and Benefits (Judy Geisler, Kady Flannery)
 - The Division of Drug Plan Policy and Quality (Alissa Deboy, Terry Lied)
 - The Division of Consumer Assessment & Plan Performance (Elizabeth Goldstein)

Why has CMS decided to do data collection?

- ◆ To make the Part C & D programs transparent
- ◆ To provide information to consumers
- ◆ To ensure appropriate oversight consistent with our responsibilities

Purpose of Data Collection

- ◆ The goal is to expand and improve the set of measures for Part C & D
- ◆ Measures should accomplish one or more of the following:
 - Improve CMS' information on the extent of compliance
 - Provide measures for consumer quality and performance of Medicare Advantage and Prescription Drug Plans
 - Indicate overall program performance and provide key information for policy-making

Part D Regulatory Authority

- ◆ 42 CFR 423.503(d)
 - CMS oversees a Part D plan sponsor's continued compliance with the requirements for a Part D plan sponsor.
 - If a sponsor no longer meets those requirements, CMS terminates the contract in accordance with 423.509.
- ◆ In addition, 42 CFR 423.505 outline a number of contract requirements that specify disclosure of information requirements on the part of Part D sponsors and the right to inspection by CMS.
 - These clearly outline CMS' ability to collect information for program monitoring with our requirements.

Part C Regulatory Authority

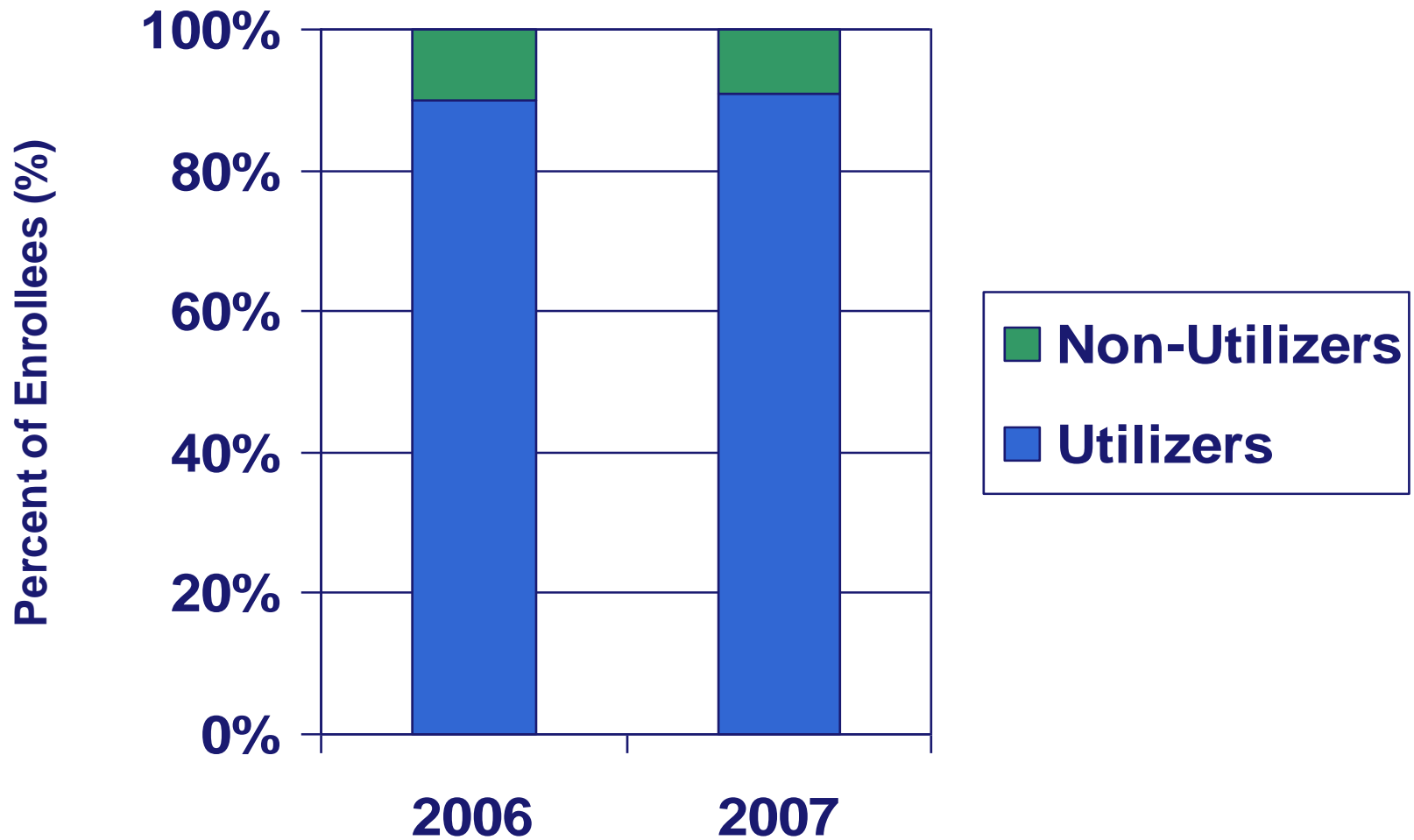
- ◆ 42 CFR 422.502(d)
 - CMS oversees an MA organization's continued compliance with the requirements for an MA organization.
 - If an MA organization no longer meets those requirements, CMS terminates the contract in accordance with 422.510.
- ◆ Additionally, 42 CFR 422.504 outlines similar contract provisions on the disclosure of information to CMS and right to inspection by CMS and OIG.

Key Results from the Part D Data Symposium

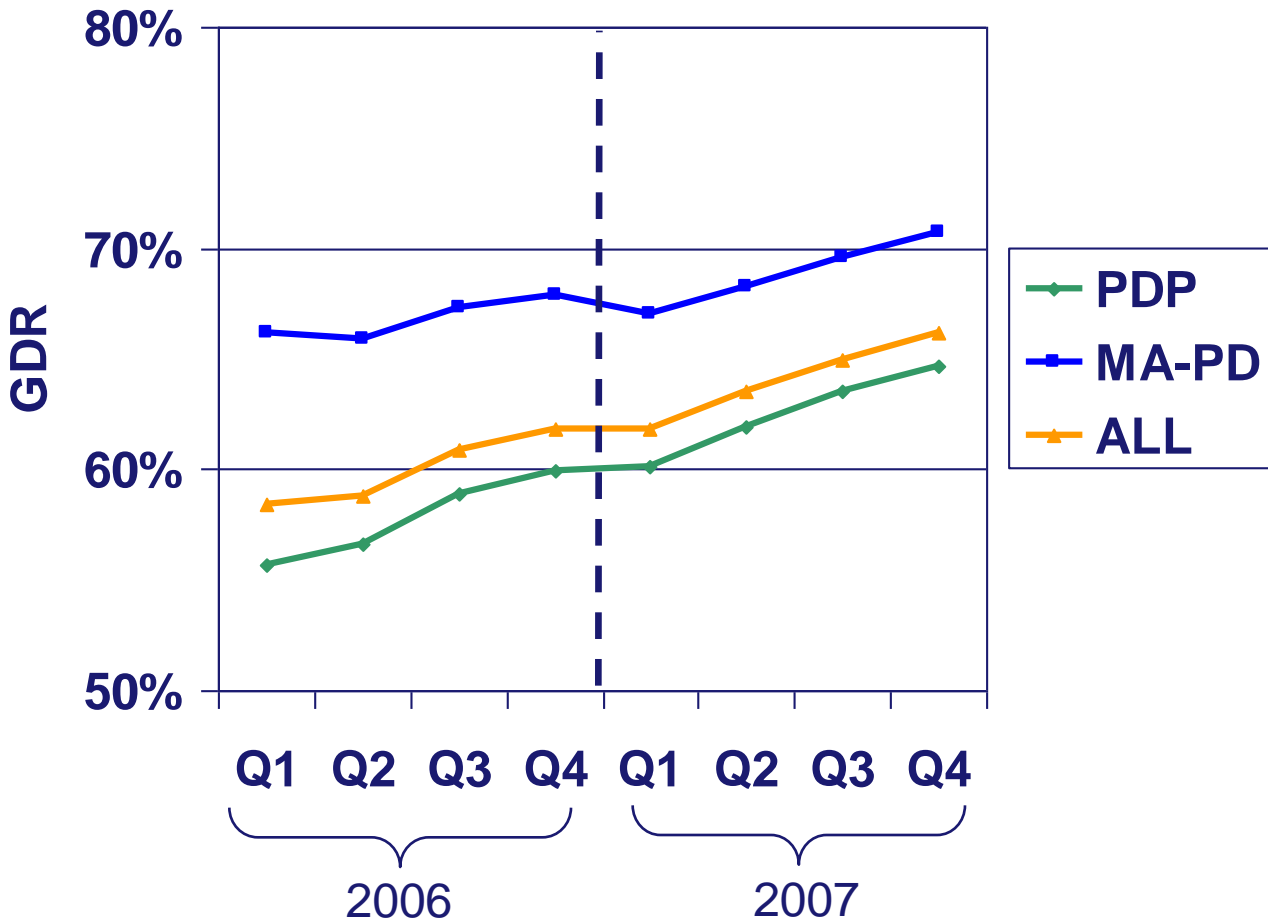
*From the Division of Clinical and Operational
Performance and the Division of Formulary and Benefits*



The Majority of Part D Beneficiaries Utilized the Drug Benefit



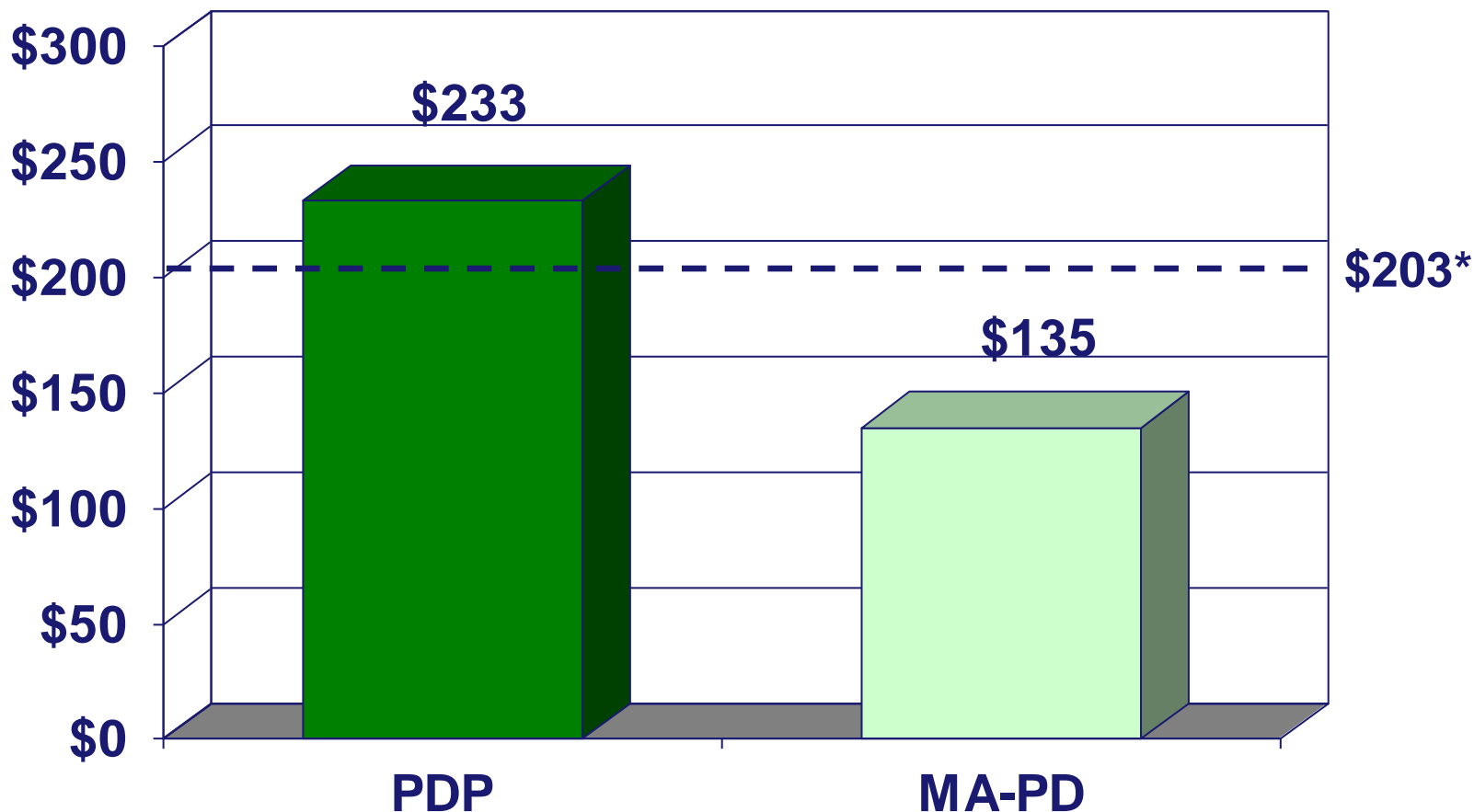
2006-2007 Trend of GDR by Quarter



Top 100, Utilizers, and GDR

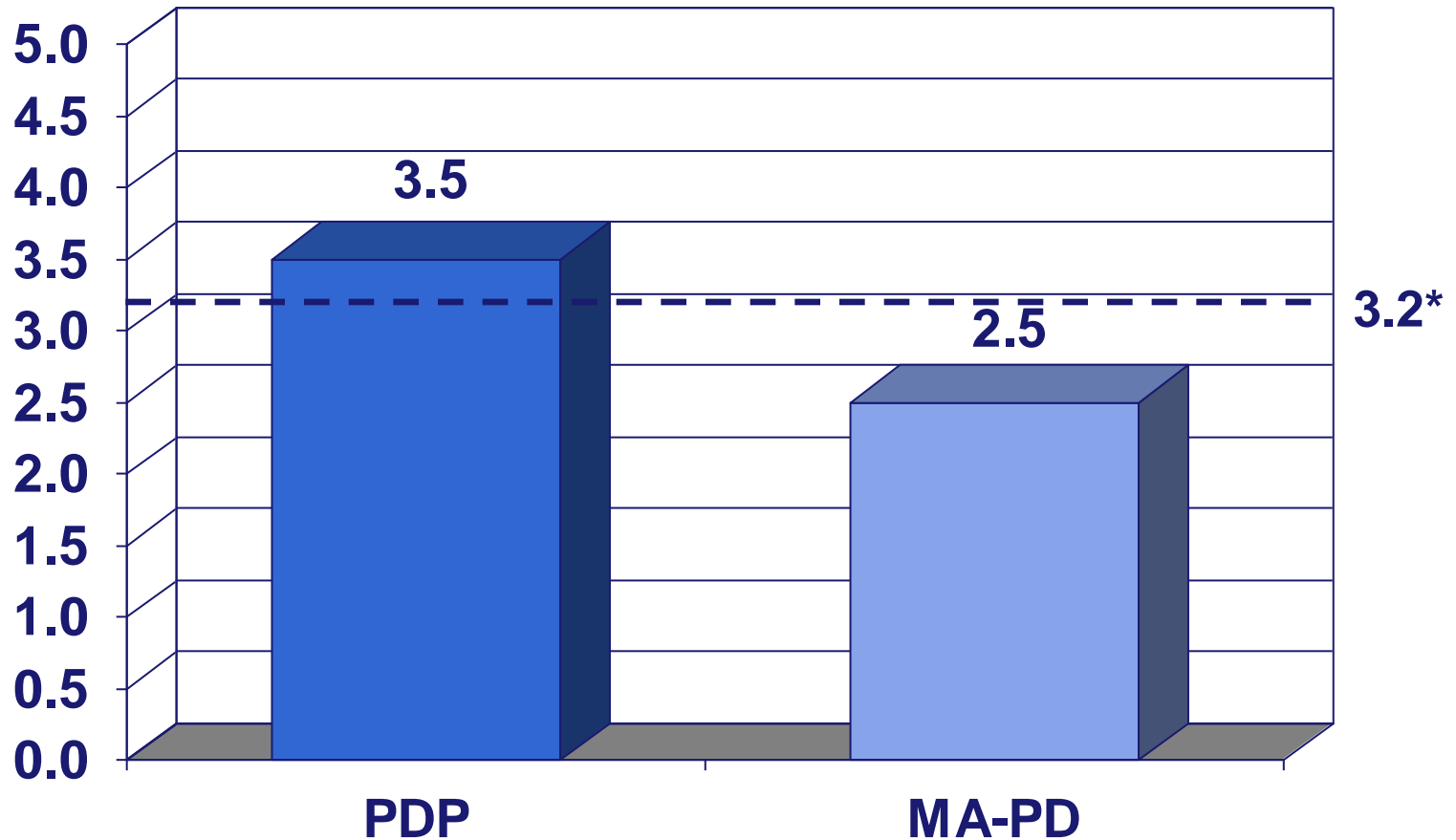
- ◆ Therapeutic classes of top drugs utilized in Part D were those used to treat the most prevalent conditions in this population.
- ◆ Differences were found between most commonly used drugs by LIS and Non-LIS beneficiaries.
 - Cardiovascular drugs most common overall, but LIS enrollees used more mental health drugs than Non-LIS.
- ◆ Initial evaluations have shown the successful implementation of Medicare Part D in both high levels of utilization and utilization of lower cost generic alternatives.

2006 Gross Drug Cost Per Member Per Month: *by Organization*



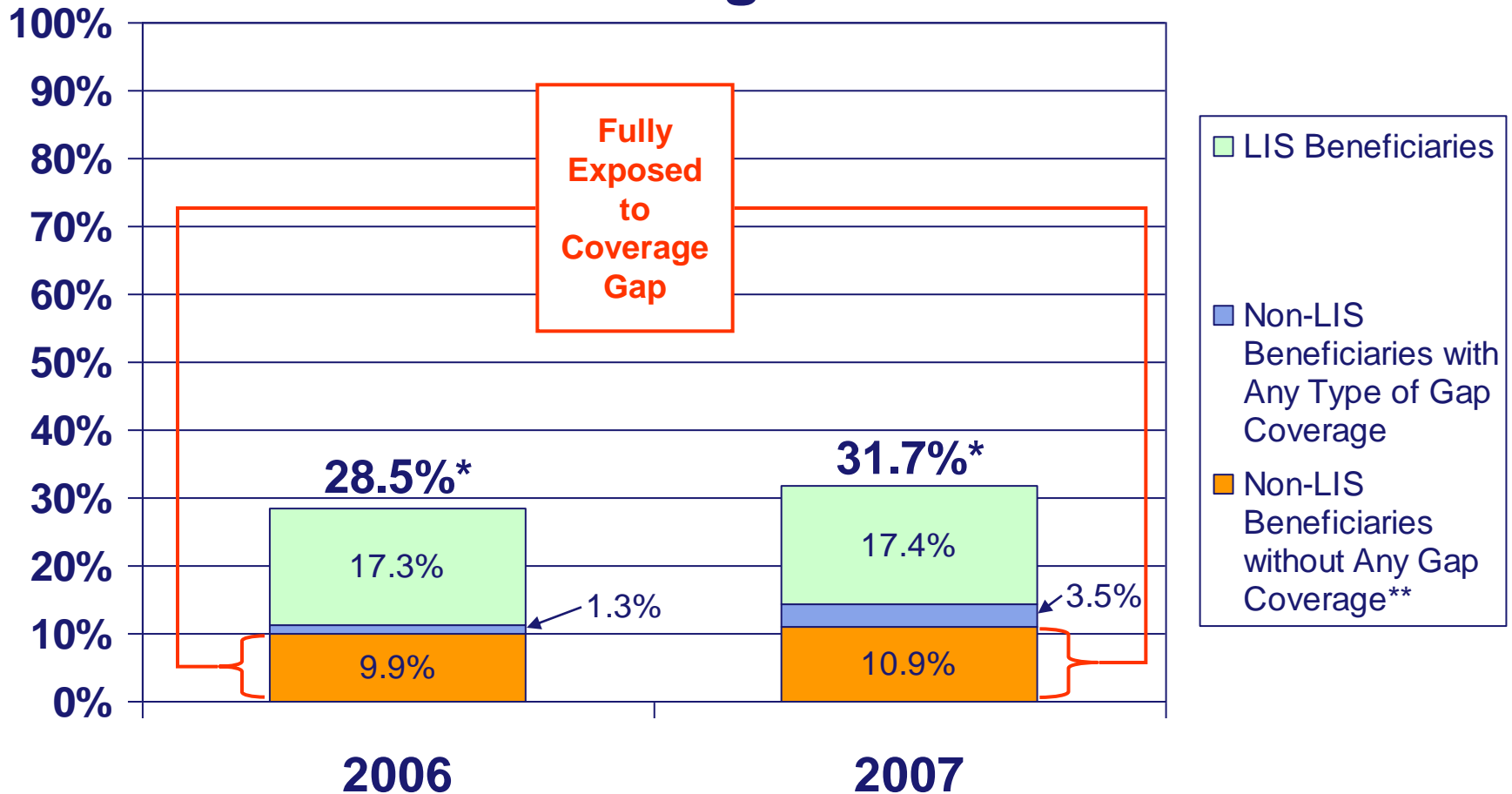
* Overall Average Cost Per Member Per Month

2006 Prescriptions Per Member Per Month: *by Organization*



* Overall Average Number of Prescriptions Per Member Per Month

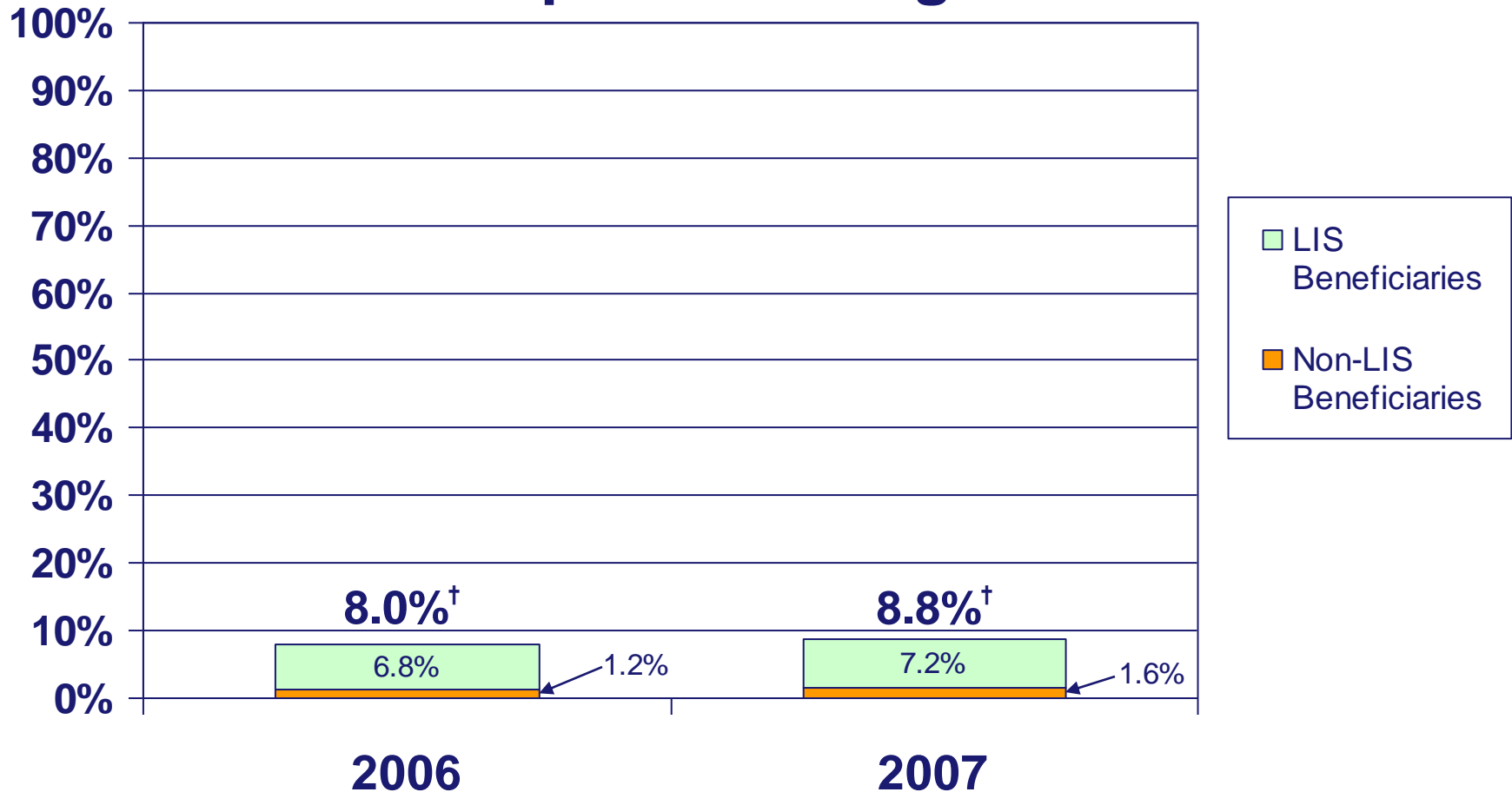
Beneficiaries Who Reached their Plan Initial Coverage Limit



* Overall Percent of Beneficiaries Reaching Their Plan's Initial Coverage Limit.

** Does not account for other types of coverage provided by other payors, such as State Pharmaceutical Assistance Programs.

Beneficiaries Who Reached the Catastrophic Coverage Phase



[†] Overall Percent of Beneficiaries Reaching the Catastrophic Coverage Phase

Cost/Utilization and ICL/Catastrophic

- ◆ Overall, in 2006 Part D enrollees had an average of 3.2 prescriptions per month with an average monthly cost of \$203.
- ◆ In 2006 and 2007, under one-third of all enrollees in each year exceeded their ICL, but this was meaningful to only about one-tenth of all enrollees.
- ◆ The percentages of enrollees who reached the ICL or entered the catastrophic phase are similar to external reports. However, most external reports cannot accurately identify enrollees who are fully exposed to the gap.
- ◆ Enrollees who were LIS, under 65, or female were more likely to exceed the ICL.
- ◆ Alternative benefit designs allowed for fewer beneficiaries to reach the ICL, compared to the number of beneficiaries that would have reached the ICL if only a defined standard benefit was offered.

Medicare Advantage and Prescription Drug Reporting Requirements – What's New for 2009

*From the Division of Drug Plan Policy and Quality and
the Division of Clinical and Operational Performance*



Why Reporting Requirements?

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

Part C Reporting Requirements

- ◆ CMS has received many inquiries about operations, costs, availability of services, beneficiary use of available services, patient safety, grievance rates, and other factors pertaining to the performance of MAOs under Part C
- ◆ To date, CMS has not been able to address many of these inquiries because of an absence of data
- ◆ Initiating data collection in these and other areas to improve its performance monitoring of MAOs

Examples of Part C Reporting Categories

◆ Beneficiary Utilization

- To determine if Part A & B rebates are being used to increase access to care and/or to improve care

◆ Procedures

- Plans with lower than expected rates of these procedures may have barriers to care. CMS will look for outliers in rates of “semi-elective procedures”

◆ Serious Reportable Adverse Events

- Plans with any of these events should take steps to get at root causes and implement procedures to guard against the events from happening again. CMS will compare MA organizations on these measures in order to identify outliers. CMS will then attempt to determine the reasons for unusually high or low rates on these measures

Examples of Part C Reporting Categories

- ◆ Provider Network Adequacy and Stability
 - To date CMS does not have mechanism for assuring continued network adequacy
- ◆ Grievances
 - Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of an MA organization, regardless of whether remedial action is requested.
 - MAOs are required to track and maintain records on all grievances received both orally and in writing
- ◆ Marketing Measures (Commission Structure, Agent Oversight, Training/Testing of Agents)

Notice and Comments

◆ Public Notice

- 2009 Call Letter and special User Group call
- Federal Register notice (PRA) published on June 27 with 60-day comment period
- PRA notice published on October 3 with 30-day comment period
- Changes made from both comment periods, final version to be available soon

◆ Examples of changes due to public comments:

- More limited reporting for Cost plans
- Certain items to be labeled as proprietary and not subject to public disclosure
- Less retrospective data collection
- Changes to due dates and frequencies
- Clarified definitions and added more supporting material

Other Changes

- ◆ Changes due to statutory and regulatory revisions that have occurred after June 26, 2008.
 - Special Needs Plans (SNPs) Care Management.
 - Section 164 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires all SNPs to have an evidenced-based model of care with appropriate networks of providers and specialists.
 - Several measures, including agent commission structure, training and testing of agents, and plan oversight of agents, were revised as a result of MIPPA and the finalization of our regulation entitled, “Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program” (CMS 4131-F)

Next Steps

- ◆ OMB approval anticipated in late Fall 2008
- ◆ MAOs to collect these data beginning on January 1, 2009
- ◆ Technical specs and HPMS user guide in December 2008
- ◆ Reporting will vary depending on the plan type and measure
 - Some measures will be reported annually, while others will be reported quarterly or semi-annually.
 - CMS also included 1876 cost plans in these reporting requirements. National PACE plans and 1833 cost plans are excluded from these reporting requirements
- ◆ All measures included in these technical specifications are subject to audit by 2010

Part D Reporting Requirements Refresher

- ◆ Retail, Home Infusion, and LTC Pharmacy Access
- ◆ Access to Extended Day Supplies at Retail Pharmacies
- ◆ Vaccines
- ◆ Medication Therapy Management Programs
- ◆ Generic Drug Utilization
- ◆ Grievances
- ◆ Pharmacy & Therapeutics (P&T) Committees/Part D Activities
- ◆ Transition

Part D Reporting Requirements Refresher

- ◆ Exceptions
- ◆ Appeals
- ◆ Overpayment
- ◆ Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions
- ◆ Long-Term Care (LTC) Rebates
- ◆ Licensure and Solvency, Business Transactions and Financial Requirements
- ◆ Drug Benefit Analyses

Part D Reporting Requirements for 2009 and 2010

- ◆ Current 2008 requirements to remain in effect for CY2009 (currently collecting data in 15 categories)
- ◆ Proposed changes for CY2010
 - Streamlining of existing sections
 - Adding new sections associated with MIPPA
- ◆ Public comment period for the CY2010 Reporting Requirements via the Paperwork Reduction Act (PRA) process projected for January 2009
- ◆ Auditing in 2010

Part D Reporting Requirements

- ◆ Technical Specifications provide additional guidance for Plans
 - More detailed definitions
 - Lists of validation edits and QA checks
 - New version to be released in next few weeks
 - Data element definitions
 - Validation and QA thresholds
 - Analyses
 - Other clarifications, e.g. FAQ

Example: 2007 Pt. D Grievances

Type	Total Grievances	Rate / 1,000 Enrollees	Percentage
MA-PD Aggregate	823,833	113.9	81.4%
PDP Aggregate	187,560	11.1	18.5%
Employer Direct Aggregate	942	7.7	0.1%
Total	1,012,335		

Example: 2007 Pt. D GDR

Type	Q1	Q2	Q3	Q4	YTD
PDP Aggregate	60.1%	62.1%	63.4%	64.9%	62.7%
MA-PD Aggregate	65.6%	68.3%	68.1%	70.7%	68.1%
Combined	61.5%	63.7%	64.7%	66.3%	64.1%

Improved Accuracy in Plan Reporting

- ◆ Initial QA by CMS:
 - Missing data submissions
 - Statistical tests for outliers
 - Data entry errors
- ◆ Frequent resubmissions, failure to resubmit data flagged
- ◆ Sponsors contacted if identified as outliers
 - - Review and resubmit data if necessary
 - - Additional data may be requested to support
- ◆ Data “locked” after 4-6 weeks for analysis and reporting
 - - Submissions after this point may be excluded

2009 Medicare Plan Ratings: November 2008 Release for Open Enrollment

*From the Division of Clinical and Operational
Performance and the Division of Consumer Assessment
and Plan Performance*



Why Plan Ratings?

- ◆ To allow Medicare beneficiaries to compare Plans' cost, quality, and performance
 - Detailed information on the web
 - Member Quality Ratings in Medicare & You

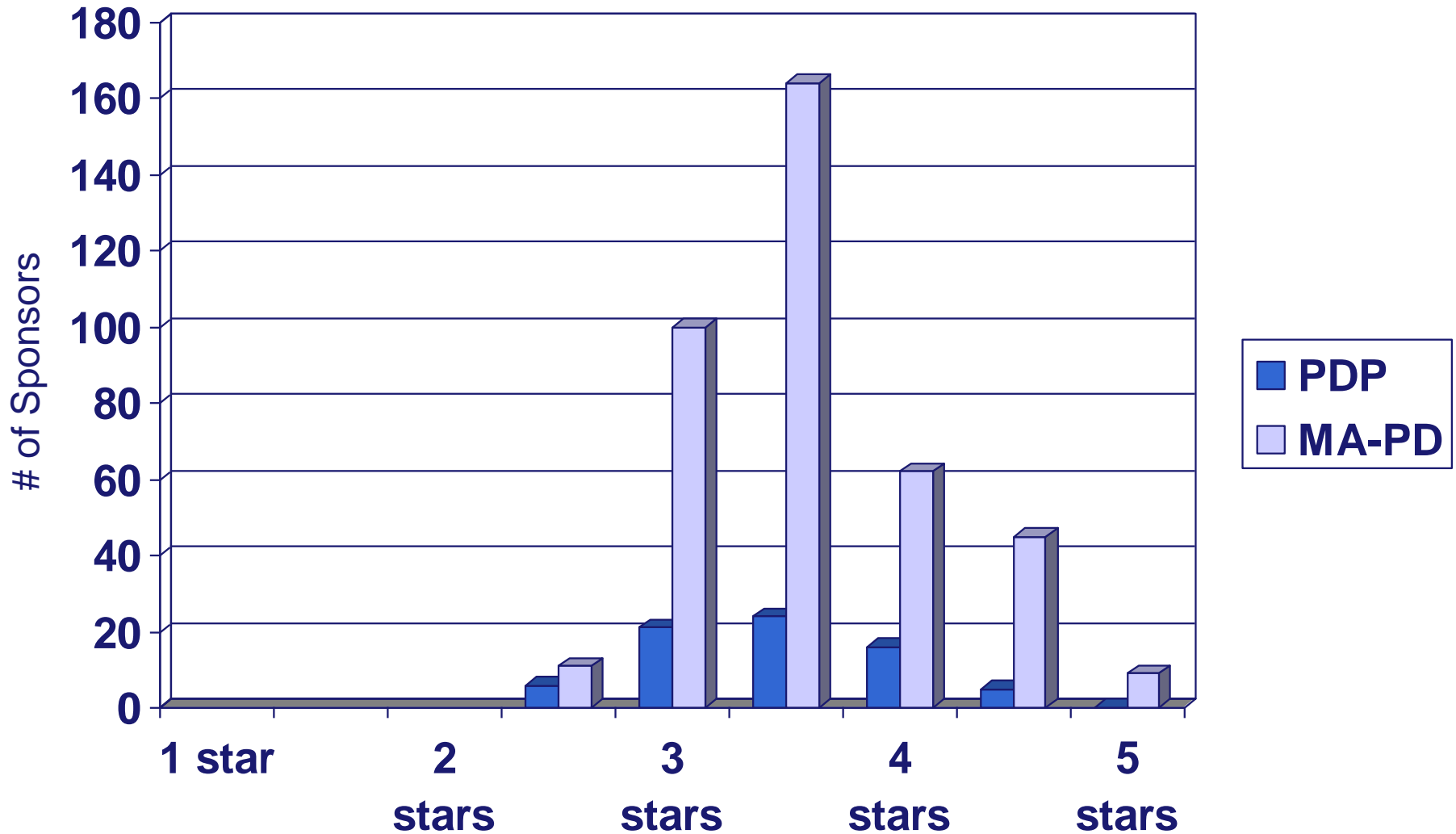
Four levels of Plan Ratings

- ◆ Overall Summary Ratings for Part C and D: Summarizes all measures from the domains into a single rating (stars)
- ◆ Domain level: Groups related measures into an area for a single rating (stars)
- ◆ Individual measure level: Single rating for a performance measure (stars)
- ◆ Data for each measure: Detailed data used to rate the contract's performance (rates, numbers, or percentages)

Part C and D Overall Summary Scores

- ◆ Separate overall composite scores calculated for Part C and Part D
- ◆ Summarizes a contract's performance across domains and underlying individual measures
- ◆ Rating based on adjusted averages of the individual measures
- ◆ Consistency in good performance will receive higher ratings
- ◆ Ratings will include half-stars to provide more differentiation between contracts

2009 Part D Summary Score Distributions



New CY2009 Part D Domains

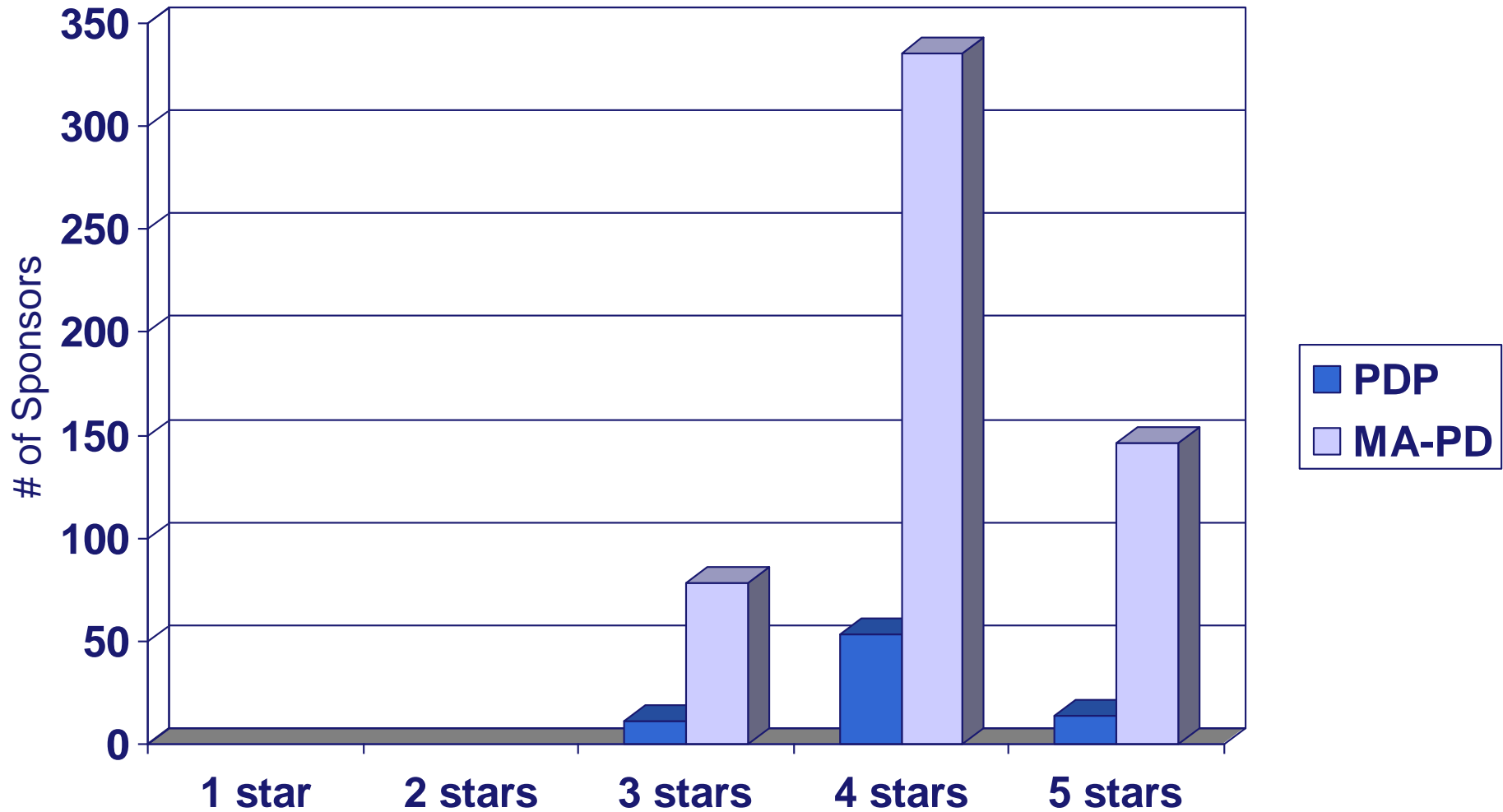
CY2008 – 3 domains

- ◆ Drug Plan Consumer Service
- ◆ Using Your Plan to get Your Prescriptions Filled
- ◆ Drug Pricing Information

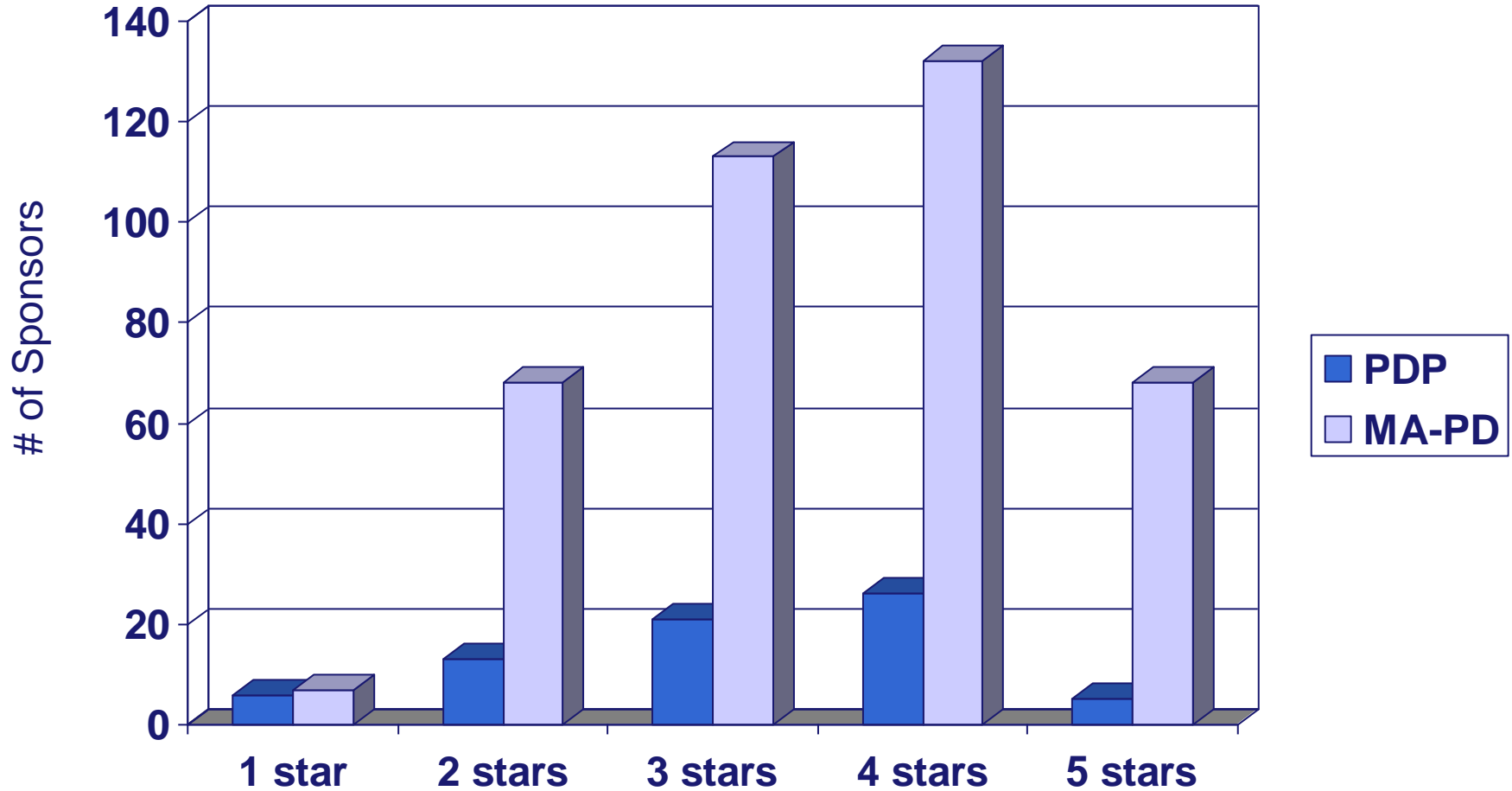
CY2009 – 4 domains

- ◆ Drug Plan Customer Service
- ◆ Member complaints and staying with drug plan
- ◆ Member experience with drug plan
- ◆ Drug pricing and patient safety

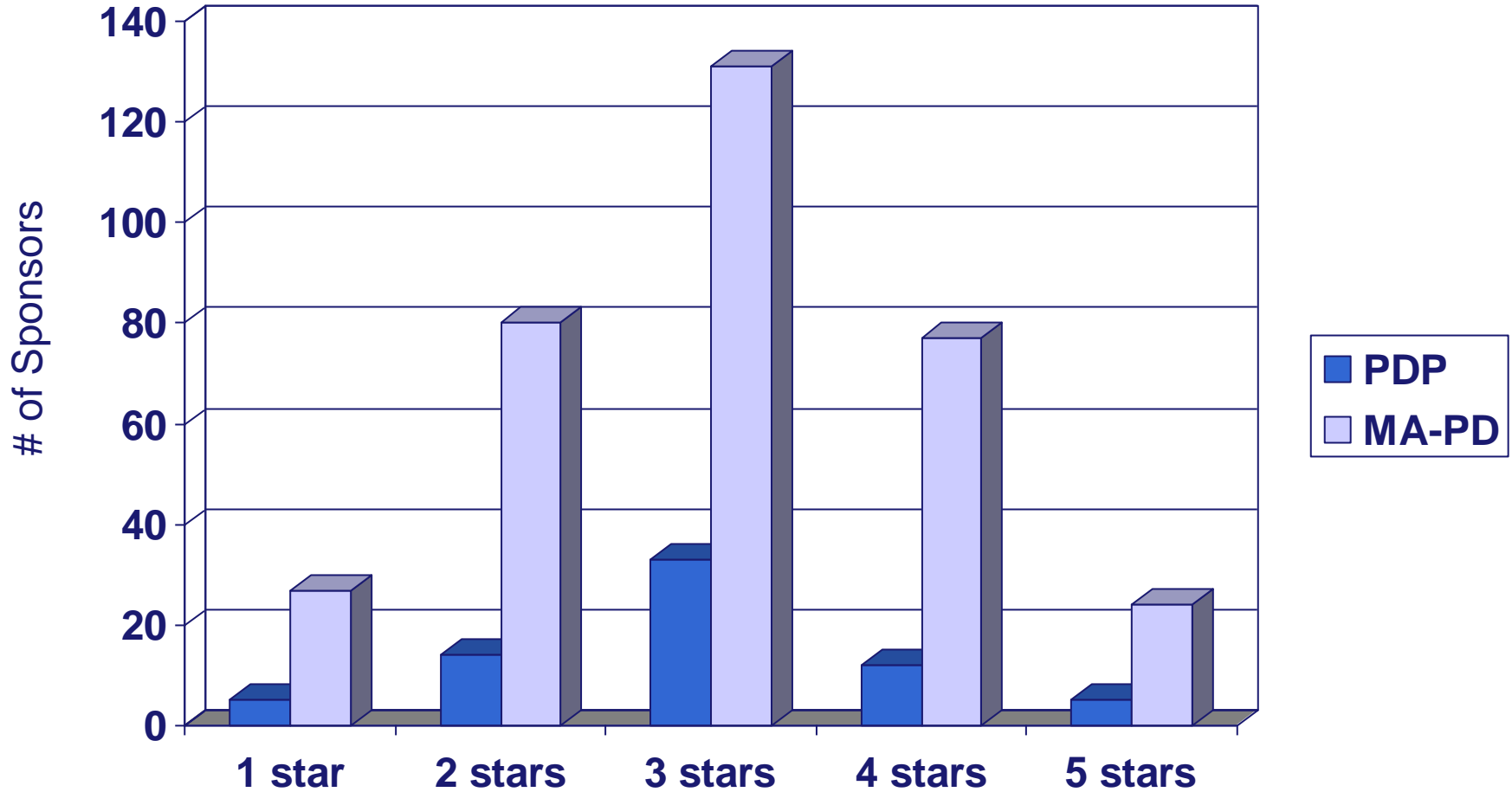
Part D – Drug Plan Customer Service



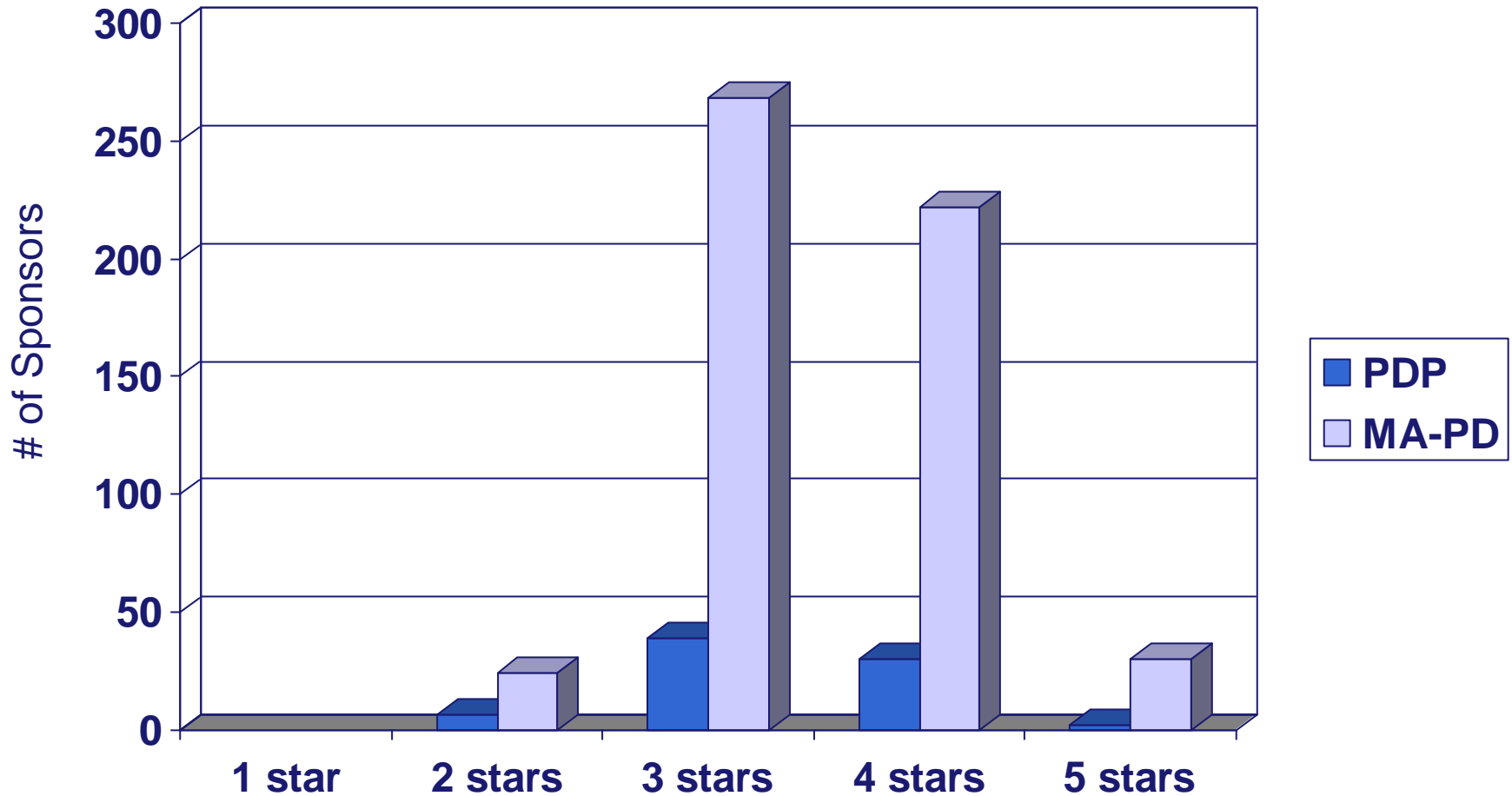
Part D – Member complaints and staying with drug plan



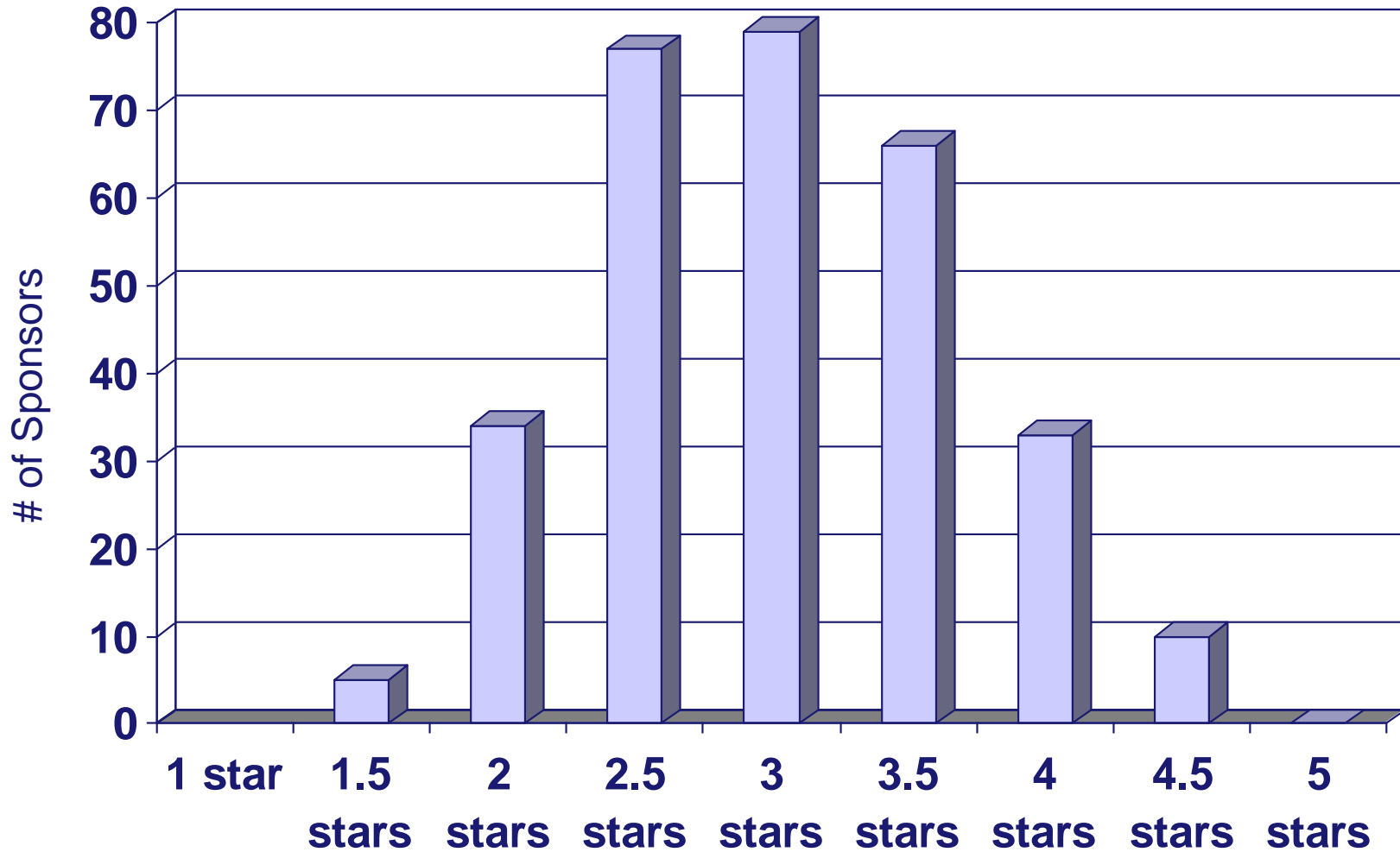
Part D – Member satisfaction with drug plan



Part D – Drug pricing information and patient safety



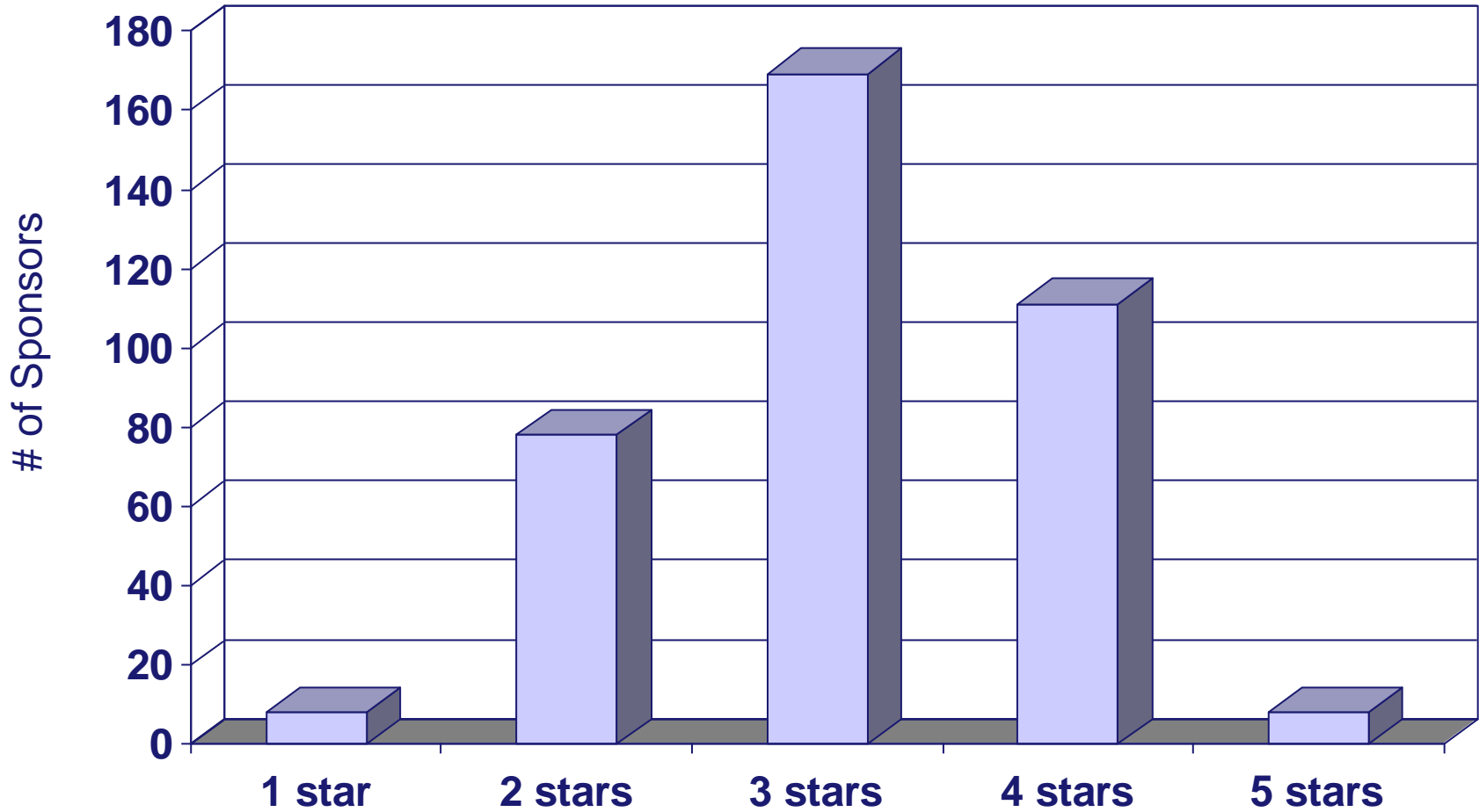
2009 Part C Summary Score Distributions



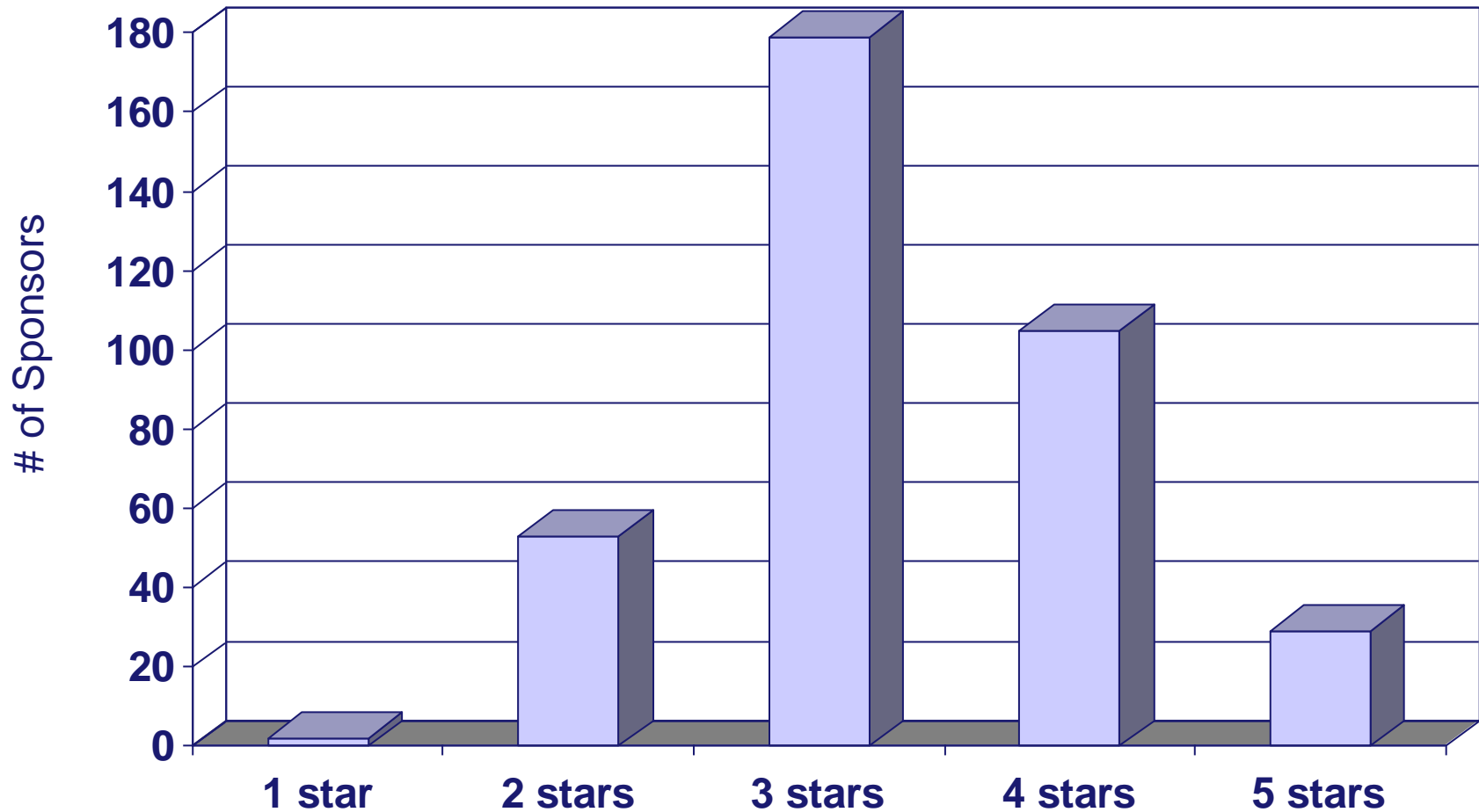
CY 2009 Part C Domains

- ◆ The domains remain the same as CY 2008; however, domain titles have been revised as a result of consumer feedback
 - Staying Healthy: Screenings, Tests and Vaccines
 - Getting Timely Care from Doctors and Specialists
 - Ratings of Health Plan Responsiveness and Care
 - Managing Chronic (Long-Lasting) Conditions
 - How Well and Quickly Health Plans Handled Appeals

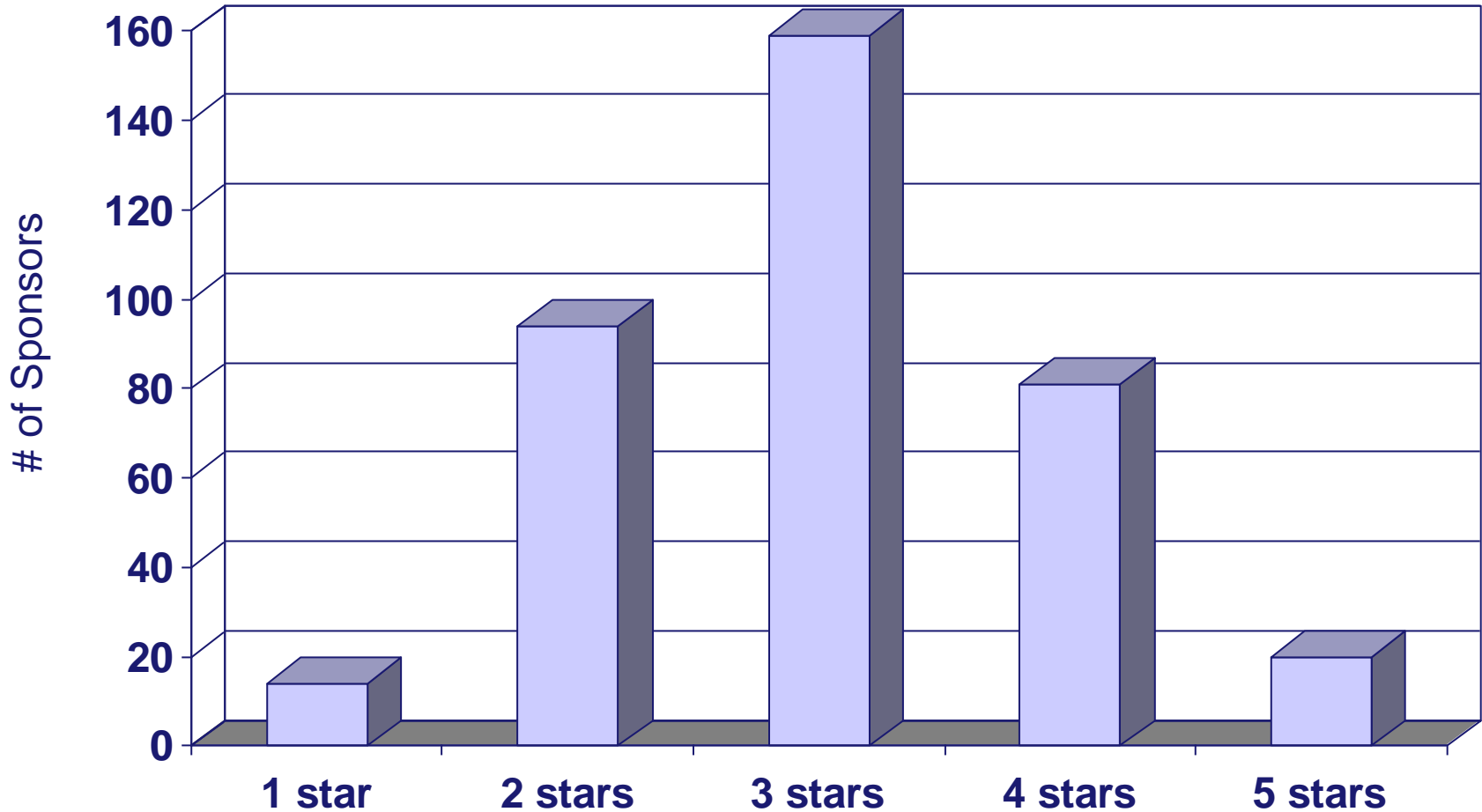
Part C – Staying Healthy: Screenings, Tests and Vaccines



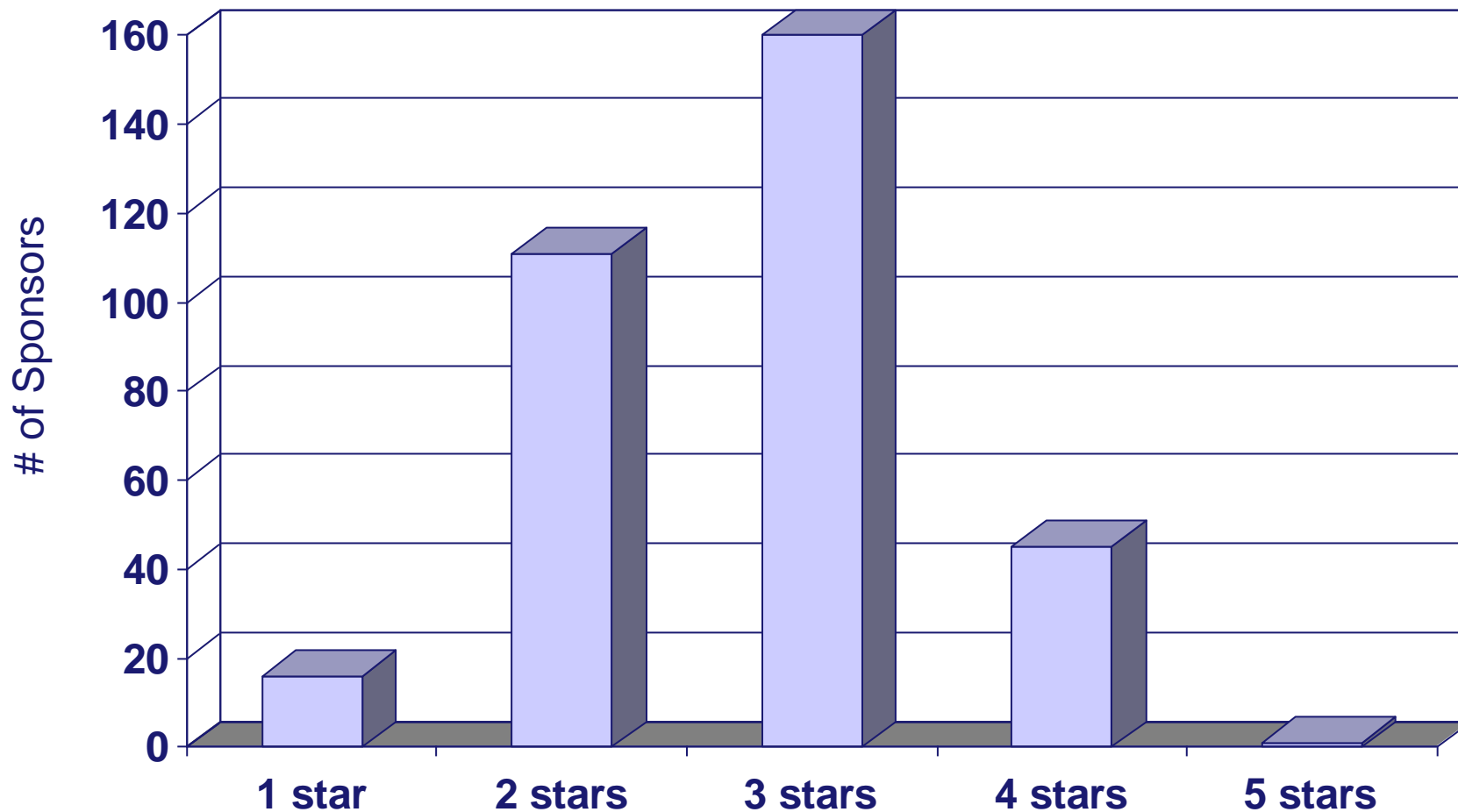
Part C – Getting Timely Care from Doctors and Specialists



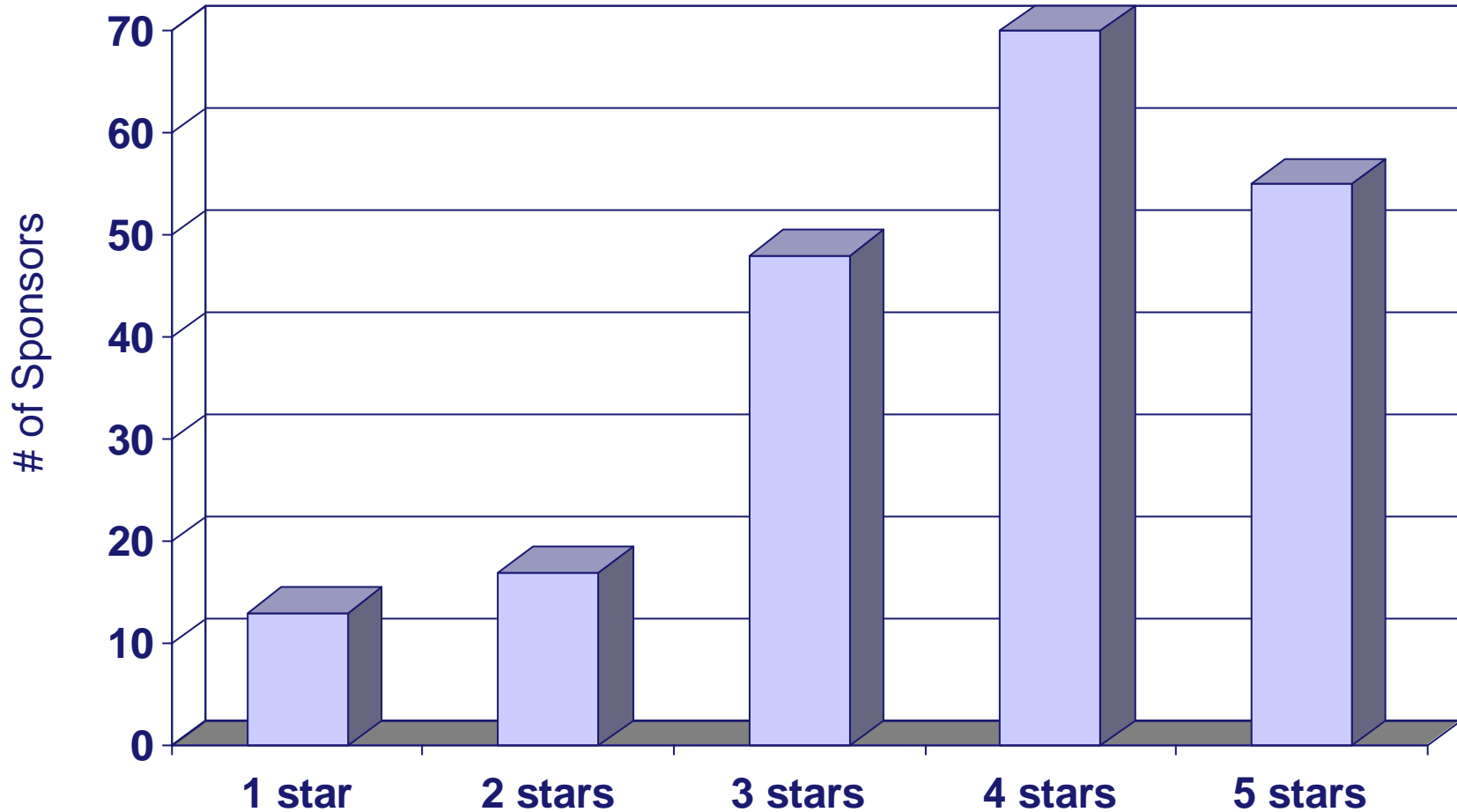
Part C – Ratings of Health Plan Responsiveness and Care



Part C – Managing Chronic (Long-Lasting) Conditions



Part C – How Well and Quickly Health Plans Handled Appeals



Other Improvements for CY2009

- Measure and domain labels revised from continued consumer testing
- New website functionality
 - Print on demand of plan ratings available by state or contract
 - Links to other information resources, e.g. Medicare appeals

Part C & D Monitoring and Compliance



Translating Performance Measurement and Monitoring into Compliance

◆ Compliance Strategy

- Take deadlines seriously
- Look for outliers, missed thresholds
- Take note of single instances of problems, but emphasize patterns of non-compliance
- Put aside the battering ram (CAP, enrollment sanctions) when a soft nudge (notice of non-compliance) is sufficient
- But don't hesitate to take significant action where warranted
- Consistent application of standard and choice of compliance action across all contracts

Compliance Tools

Executive Conference Call/Meeting

Notice of Non-Compliance

- May include request for business plan

Warning Letter

- May include request for business plan

VariousSuppressions and Exclusions:

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

Request for Corrective Action Plan (CAP)

New Applications/SAE Denials

Audit Selection

Enforcement and Termination

Compliance Actions Stage

- ◆ Notices are generally issued in the order of the progressive compliance action model
- ◆ However, depending on the severity and circumstances, some violations may require CMS to begin an action at any point in the continuum
- ◆ Progressive model allows accounts to be alerted and resolve issues quickly before escalation to more severe compliance measures

Examples of Compliance Action from Data Analysis and Monitoring

- ◆ Low Income Subsidy Match Rate
 - Failure to successfully submit data
 - Failure to exceed the 95% match rate
 - Number and type of prior compliance actions on this topic drive the next action

- ◆ Reporting Requirements
 - Missed deadlines and non-submissions
 - Data outlier, e.g., extreme number of grievances
 - We issued outlier warning notices and required sponsors to analyze their performance and report back

In-depth Example: Grievance Data from Reporting Requirements

- ◆ CMS calculated the number of grievances per 1,000 enrollees for each sponsor
 - Source: 2006 grievance data from Part D Reporting Requirements
- ◆ Sponsors with a grievance ratio among the top 5% were issued outlier warning notices
- ◆ Required to report back to CMS
 - What were the primary underlying enrollee concerns that prompted grievances filed with your plans under this contract?
 - What are your current procedures for handling grievances that you have received, and do these procedures differ in any way from those you had in place during 2006?
 - What actions have you taken, or are you are planning to take, to improve your grievance rate and prevent your organization from being an outlier in the future? How do these actions relate to the underlying issues that prompted the grievances in the first instance?

In-depth Example: Grievance Data from Reporting Requirements, cont.

- ◆ After their self-analysis many sponsors reported they had uncovered data anomalies and process problems
- ◆ Sponsors found it very useful feedback and have reported process improvements
 - Led sponsors to refine their processes for identifying, tracking, and reporting grievances and to address underlying problems that attributed to the grievances in the first instance
- ◆ CMS will conduct similar, but category-specific analysis for 2007
- ◆ Sponsors that are outliers two years in a row will be targeted for audit

Additional Examples

- ◆ Call center monitoring
 - Inadequate call center hours
 - We identified when call centers were not open during all expected timeframes
 - Failure to meet call center standards
- ◆ CTM Cases
 - Failure to close 95% of immediate need cases timely
- ◆ Formulary Submissions
 - Missed deadlines or other poor performance
- ◆ Performance Metrics (star ratings)
 - Low ratings multiple years in a row in the same category

Example: Jan 2007 – June 2008 Data and Ad Hoc CAPs and Warning Letters

Basis for Action	CAP	Warning Letter
Data-Driven	0	377
Ad hoc	72	28
Combined	72	405

Compliance Actions Tracker

- ◆ CMS maintains history of compliance notifications in a compliance tracker database
- ◆ This allows for:
 - Longitudinal analysis of account performance to identify trends
 - Holistic compliance profile for each account
 - Alert AM's of prior plan compliance actions and inform CMS of related issues
- ◆ An organization's overall compliance history may be used as:
 - Determining frequency of monitoring activities
 - Factor in approving future contract applications
 - Considering appropriateness of enforcement referral

Questions?

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2008 Annual Election Period Marketing Surveillance

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November 14, 2008



CMS' Commitment to Transparency and Beneficiary Protection

- September 15, 2008 CMS Press Release
 - “The regulations give insurers bright-line guidance on what types of marketing activities are acceptable and what types are not acceptable. Medicare beneficiaries can be assured that we will monitor marketing activities and move aggressively with enforcement measures or other actions if these rules are violated.”
 - *CMS Acting Administrator Kerry Weems*

Medicare Improvements for Patients and Providers Act (MIPPA)

- Effective in July 2008, this law made a number of changes to the Medicare Advantage (MA) and Part D Programs (PDP).
- Specifically, the law enacted numerous provisions designed to protect Medicare beneficiaries from deceptive or high-pressure marketing tactics, which applies to:
 - private insurance companies;
 - agents and brokers; and
 - any contractors or downstream entities (i.e. field marketing organizations).

New Marketing Regulations

- Issued September 15, 2008
- The rule recodifies and modifies existing marketing regulations and finalizes six new marketing provisions which prohibit
 - Meals at promotional and sales events;
 - Unsolicited contact by plans and their agents (includes telemarketing);
 - Cross-selling of non-health care related products; and
 - Sales presentations and distribution of applications at educational efforts.

2008 AEP Marketing Surveillance Strategy

- The new MIPAA marketing regulatory provisions prevent agents and brokers from engaging in sales and marketing activities that may pressure beneficiaries to make plan choices for reasons other than those that best meet their health care needs.
- Comprehensive surveillance strategy established to detect, prevent, and respond to incidents of marketing violations.

2008 AEP Marketing Surveillance Strategy

Communication

Surveillance



Compliance and Enforcement

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES



Communication



Communication: MA and PDP Organizations

- Communication issued via
 - Marketing Regulations;
 - Guidance Documents;
 - Press Releases; and
 - HPMS Memoranda.
- Shared goals to ensure organizations understand
 - Required compliance responsibilities in light of the new MIPPA marketing provisions; and
 - CMS' robust surveillance objectives.



Communication: State Partners

- Memorandum of understanding (MOU) with all 50 States outlining collaboration and information sharing.
- Communication strategy paper for Regional Office Department of Insurance (DOI) Liaisons and SHIPs.
- Open lines of communication for receipt of agent/broker complaints, as well as cooperation in taking action against non-compliant agents/brokers.
 - E.g. cooling off period enforced by State DOIs during investigations.

Surveillance



Horizontal Surveillance Strategy

- Casts a strategically targeted net to capture information from
 - All MA and PDP Organizations; and
 - All States and territories.
- Utilizing disproportionate sampling for high-risk beneficiaries and high-risk geographic regions.



Horizontal Surveillance Activities

- Secret shopping of marketing events
- Secret shopping of call centers
- Clipping Service
- Data Analysis
 - Complaints Tracking Module
 - Rapid disenrollment
- Readiness Online Assessment Tool

Vertical Surveillance Strategy

- Contracted auditors and CMS staff conduct *targeted* surveillance activities.
- Fewer activities, but more in-depth analyses.
- Surveillance of high-risk MA and PDPs identified as outliers through horizontal surveillance activities.



Vertical Surveillance Activities

- Secret shopping of marketing events
- Outbound calling to Medicare beneficiaries
- Review of recorded enrollment calls

Compliance and Enforcement



Compliance and Enforcement Strategy

- Ensures that the information collected through surveillance activities leads to timely and effective compliance and enforcement actions.
- Strong partnership and information sharing between various CMS components and contractors.
 - *Timely* escalation of serious deficiencies from surveillance activities for immediate follow-up.
 - May include additional surveillance or result in immediate compliance action.

Compliance and Enforcement Activities

- Surveillance data are aggregated and analyzed for outliers.
- Focused audits are conducted.
- CMS expects organizations to take immediate and proactive steps to ensure compliance with all new marketing provisions.
- Outliers and organizations demonstrating non-compliance are subject to any available compliance and enforcement actions.

Impact on Beneficiaries

- Protection from deceptive or high-pressure marketing tactics to make plan choices for reasons other than those that best meet their health care needs by entities offering Medicare private plans and their sales agents
- Enhanced ability to report allegations of abusive marketing tactics to oversight agencies for investigation.

Impact on Organizations



- Surveillance data strengthens the assessment of an organization's performance across operational areas.
- CMS uses objective performance results to assess compliance.
- Organizations found to be outliers are subject to direct compliance and enforcement actions, including but not limited to
 - Civil monetary penalties;
 - Limitations on provision of services; and
 - Corrective action plans.

Conclusion

- CMS 2008 AEP marketing surveillance strategy is the most comprehensive set of marketplace surveillance activities CMS has implemented yet.
 - Committed to transparency and beneficiary protection.
- Expected outcomes of 2008AEP marketing surveillance activities are:
 - Real time snap shot of marketplace;
 - Reliable information to enable CMS to correct abuses committed by outlier organizations and agents; and
 - Refinement of program guidance.

Questions?

