

# CMS Auditing Part C & D

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# Session Overview

- Changes to the Audit Guides
- Problem Areas in Preparing for Audit and Remedies
- Problem Audit Areas for Part C and D
- Responding to the CAR
- Best Practices

# Changes to the MA Guide

## MA Audit Guide

- Chapter 2 - Enrollment & Disenrollment
  - ER18 – Appropriate and Timely Action
  - ER802 – Group Enrollment into Employer/union Sponsored Plan
  - ER803 – Requirement to Set EGHP Enrollment “Flag” for all EGHP Enrollment

# Changes to the MA Guide

## MA Audit Guide

- Chapter 3 – Marketing
  - All Marketing elements updated to reflect new legislation
- Chapter 9 – Employer Group Health Plan Premiums
  - SU801 – Uniform Premium Requirement for Employer/Union Sponsored Plans

# Changes to the MA Guide

## MA Audit Guide

### Elements Deleted

- Chapter 13 – Organization Determination
  - OP10 – Termination of Provider Service: Notice (Timeliness)
  - OP11 – Termination of Provider Service: Notice (Notice Content)

# Changes to the PFFS Guide

## PFFS Audit Guide

- Chapter 2 - Enrollment & Disenrollment
  - ER18, ER802, and ER803
- Chapter 3 – Marketing
  - MR201 - PFFS plans must prominently display the required PFFS disclaimer in all materials.
- Chapter 6 – Provider Relations
  - PR207 - PFFS plans must conduct effective outreach to providers to help them understand how PFFS plans work.

# Changes to the PFFS Guide

## PFFS Audit Guide

- Chapter 9 – Employer Group Health Plan Premiums
  - SU801 – Uniform Premium Requirement for Employer/Union Sponsored Plans
- Chapter 11 – Contracts
  - LS801 - Financial Solvency Standards for Employer/Union Direct Contract Plans

# Heads Up/Tips

- Policy & Procedures Listing
- Narrative
- Universe Attestations
- Timeframes for Implementing a CAP
- Once CMS Accepts a CAP

# Problem Areas in Preparing for the Audit

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

# Misclassification Problems

- Separate Part C Claim Universes:
  - Contracted vs. Non-Contracted
  - Clean vs. Non-Clean for Interest Calculation
  - Paid vs. Denied vs. Pre-Service Denials

# Misclassification Problems

- Separate Grievance/Appeal Universes:
  - Part C vs. Part D
  - Grievances vs. Appeals
  - Part C Organization Determinations vs. Part D Coverage Determinations
  - Part C Reconsiderations vs. Part D Redeterminations

# No Universe? Are You Sure?

- Plan shows no unfavorable Part C Appeals, but Maximus reports shows some do exist.
- No Favorable Part C Appeals, but large universe of pre-service and claims denials
- No Part D Redetermination requests, but plan does have unfavorable Part D Coverage Determinations.

# Universe Problems

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

# What Can Plans Do to Avoid Universe Problems?

- Program systems to track and capture the Universes in Enclosure IV
- All Plans are **REQUIRED** to perform ongoing Internal Audits
- Call your CMS Account Manager with Universe questions

# The Common Problem Audit Areas for Part C

Chapter 2: Enrollment & Disenrollment

Chapter 6: Provider Relations

Chapter 11: Contracts

Chapter 13: Organizational Determinations,  
Grievances and Appeals

# Chapter 2: Enrollment & Disenrollment

- ER05 - Enrollment Acknowledgment (Timeliness)
- DN05 - Involuntary Disenrollment (Nonpayment)
- DN06 - Involuntary Disenrollment (Move)

# Chapter 6: Provider Relations

## PR03 – Credentialing

Focus on:

- Reviews for Medicare opt-out
  - Palmetto website
    - [www.palmettoga.com/palmetto/j1.nsf/docsCat/home](http://www.palmettoga.com/palmetto/j1.nsf/docsCat/home)
- Timely re-credentialing
- Oversight of credentialing

# Chapter 11: Contracts

## CN04 – Required Contract Provisions

Focus on:

- Ensuring downstream contracts include Medicare contract language
  - agree to audits and inspections by CMS
  - cooperate, assist and provide information
  - maintain records a minimum of 10 years

# Chapter 13

## Organizational Determination – Claims

OC05 – Timely Adjudication of Non-Clean Claims

OC06 – Claims Denial (Notice Content)

# Chapter 13

## Organizational Determinations - Pre Service

**OP02 – Adverse Standard Pre-Service (Notice Content)**

**OP04 – Requests for Expedited (Timeliness)**

**OP05 – Adverse Expedited (Notice Content)**

**OP15 – Detailed Notice of Discharge of Inpatient Hospital  
Care**

# Chapter 13

## Reconsiderations – Pre-Service

### RP06 – Decisions Not to Expedite Reconsideration (Notice Content)

## Grievances

### GV04: Grievance Decision Notification (Notice Content)

# Chapter 13

Focus on:

- Timeliness of
  - processing claims
  - request for expedited organizational determination or reconsideration
- Use of approved notices
- Revising policy and procedures

# MCO Internal Audit Focus Areas for Part C

Chapter 6 – Credentialing of providers

Chapter 11 – Contract provisions

Chapter 13 – Notices and timeliness

# Problem Audit Areas for Part D

- **Chapters 2**, Provider Communication
- **Chapters 7**, Formulary, Transition Process and P&T Committee
- **Chapters 15**, Policies and Procedures

# Problem Audit Areas for Part D

- **Focus on:**
  - Policy and Procedures
  - Examples
- Chapter 6 Manual –*revised version*
  - *Part D Drugs and Formulary Requirements*

# Acceptable CAP

- Address Deficiency Cited
- Provide Timetable for Correction
- Establish Process for Validating Correction
- Develop System for Ongoing Monitoring
- Send Progress Reports to CMS RO
- Involve RO Account Manager Before Submitting Through HPMS.

# Acceptable CAP

MCO Submitted CAP:

***Action Health Plan will revise the Policy and Procedures per CMS request.***

***Action Health Plan will provide training on this Policy and Procedures once we create it.***

*Do you think this is an acceptable CAP?*

# Acceptable CAP

MCO Revised Submitted CAP to meet CMS Requirements:

1. Action Health Plan revised the Policy and Procedure per CMS request (MCO submitted the P&P for CMS approval)
2. Action Health Plan submitted Training documentation for CMS approval.

# Timeframes for Implementing a CAP

- MCO/Sponsor has 45 days to submit an acceptable CAP. CMS has 30 days to determine whether the CAP is acceptable.
- If not acceptable the MCO/Sponsor has an additional 30 days to revise the CAP.
- If the MCO/Sponsor cannot submit acceptable CAP, CMS must consider taking additional enforcement actions against the organization.

# Once CMS Accepts a CAP

- The MA, MA-PD or PDP Sponsor has 90 days to attain full compliance for all deficiencies resulting in a CAP.

# References

- Universe Descriptions (handout)
- Minimum Documentation Required for each selected sample (handout)
- MA & Cost Plan Enrollment & Disenrollment Guidance  
[www.cms.hhs.gov/MedicareMangCareEligEnrol/](http://www.cms.hhs.gov/MedicareMangCareEligEnrol/)
- PDP Enrollment & Disenrollment Guidance  
[www.cms.hhs.gov/MedicarePresDrugEligEnrol/](http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/)
- Palmetto website:  
[www.palmettoga.com/palmetto/j1.nsf/docsCat/home](http://www.palmettoga.com/palmetto/j1.nsf/docsCat/home)

# Best Practices from Medicare Organizations

- Blue Shield of California
  - Michael Osorio, Manager Medicare Compliance
- Kaiser Foundation Health Plan, Inc.
  - Michael Fletcher, Director, California Medicare Compliance
- Intervalley Health Plan
  - Susan Tenorio, Vice President Health Services
- Consultant
  - Donovan Ayers, VP of Regulatory Compliance for Clear Vision Information Systems

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QUESTIONS?