



Business Function Monitoring



Susan Herman, Branch Manager
Division of Medicare Health Plan Operations
San Francisco Regional Office

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Goals

- ◆ What is Business Function Monitoring?
- ◆ How were plans selected?
- ◆ Is this an audit?
- ◆ Areas reviewed
- ◆ Results/Trends
- ◆ CMS Recommendations



Business Function Monitoring

- ◆ Targeted review of operations
- ◆ Uses current information for selection
- ◆ Focus on areas of risk
- ◆ Monitoring activities are ongoing
- ◆ Corrective actions
- ◆ Compliance actions



Selection Process

- ◆ Data Review
- ◆ CMS reports
- ◆ Plan reported information
- ◆ Complaints
- ◆ Account Manager Feedback
- ◆ Escalated issues


Audit vs Monitoring

<p>Audit</p> <ul style="list-style-type: none"> ◆ Led by Baltimore ◆ Standard protocol for all audits ◆ Predominantly data driven selection process ◆ Use of contractor assistance ◆ On site review ◆ National in scope 	<p>Monitoring</p> <ul style="list-style-type: none"> ◆ Led by Regional Offices ◆ Areas of review may vary ◆ Data and RO information used for analysis ◆ Account Manager leads ◆ Regional staff conduct review ◆ Desk Review
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Review Process

- ◆ Timeframes are shorter
- ◆ Electronic submissions
- ◆ Reviews conducted by teams
- ◆ Discussions with pertinent staff
- ◆ Exit conference to share results
- ◆ Compliance actions




Areas of Review



- ◆ Enrollment/Disenrollment
- ◆ Appeals and Grievances – Part C
- ◆ Claims Part C
- ◆ Formulary Administration
- ◆ Coverage Determinations/Appeals/
Grievances – Part D
- ◆ Marketing and Surveillance
- ◆ Compliance

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Enrollment & Disenrollment



Julia Cohen
Account Manager

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**Enrollment and Disenrollment
Review Areas**

- ENR1 Completed Enrollment Requests
- ENR2 Incomplete Enrollment Requests
- ENR3 Denials of Enrollment Requests
- DNR1 Voluntary Disenrollment Requests
- DNR2 Denials of Disenrollment Requests
- DNR3 Involuntary Disenrollment Due to Move Out of
Service Area
- DNR4 Involuntary Disenrollment Due to Loss of Special
Needs Status
- DNR5 Involuntary Disenrollment Due to Failure to Pay
Plan Premium

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**Enrollment and Disenrollment
General Finding - Universe**

Finding

- Enrollment universes didn't include required data elements:
 - Receipt Date
 - Application Type
 - Agent/Broker Assisted

Recommendation

- Make sure your system can pull these data elements

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**Enrollment and Disenrollment
General Finding – Sample Cases**

Finding

- Non-compliant notices
 - Never Updated
 - Updated but system generated old notices
 - Updated but system plugged in incorrect information
- No proof of mailing date

Recommendation

- Perform a quality review of all notices
- Store mailing date in system or use date stamp
- Audit mailing vendor

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**Enrollment and Disenrollment
Completed Enrollment Requests**

Finding

- Lack of development when beneficiary is eligible for more than one election period

Recommendation

- Contact beneficiary to determine preferred effective date and document contact






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**Enrollment and Disenrollment
Incomplete Enrollment Requests**

Finding



- Universe problems – plan unclear as to what is considered incomplete
- Incorrect deadline in the Notice to Request Information
- Considered missing election period as incomplete

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**Enrollment and Disenrollment
Incomplete Enrollment Requests**

Recommendation

- Include all enrollment requests in the universe that were received without all of the required information and required contact with the beneficiary (either by phone or in writing)
- Call beneficiaries in addition to sending the Notice to Request Information
- Train staff so they understand the deadlines and modify systems if necessary

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**Enrollment and Disenrollment
Denial of Enrollment**

Finding

- Inadequate development for election period
- Sent denial notice too soon (for incomplete applications)

Recommendation

- Include Exhibit 1A with all enrollment mechanisms
- Don't send denial notice until after deadline
- Continually check MARx to see if Medicare A & B dates have been posted

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**Enrollment and Disenrollment
Voluntary Disenrollment**

Finding

- Failed to send proper notice to beneficiaries who requested disenrollment though plan
- Transmitted disenrollment transaction without correct disenrollment reason code

Recommendation

- Ensure that staff are aware of notice requirements
- Always submit disenrollment transactions with reason code

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**Enrollment and Disenrollment
Disenrollment Denials**

Finding

- Inadequate development for election period

Recommendation

- Include Exhibit 10A (Attestation of Eligibility for an Election Period) with disenrollment form.
- Call member!

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**Enrollment and Disenrollment
Involuntary Disenrollment - Move out of Service Area**

Finding

- Initiated disenrollment process for new members whose residence address was just confirmed
- Sent incorrect notice to members who confirmed move out of service area

Recommendation

- Ensure staff are aware of requirements
- Make system changes if necessary
- Send interim notices

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Enrollment and Disenrollment
 Involuntary Disenrollment - Loss of SNP Status

Finding

- Incorrect period of deemed continued eligibility
- Sent untimely disenrollment notices to beneficiaries
- Transmitted disenrollment transaction without reason code

Recommendation

- Don't rely on MARx data for Medicaid eligibility
- Ensure staff are aware of requirements
- Send interim notices to members

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Enrollment and Disenrollment
 Involuntary Disenrollment - Non-Payment of Premiums

Finding

- Not calculating grace period correctly
- Sent untimely disenrollment notices

Recommendation



- Ensure that staff understands requirements and make systems adjustments if necessary
- Extend grace period or eliminate it

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Part C Appeals & Grievance



Kristin Sugarman-Coats
 Plan Specialist

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**Part C Appeals and Grievances
Monitoring – Review Areas**



- **OP01** Standard Pre-Service Denials
- **OP02** Requests for Expedited Organization Determinations
- **RP02** Unfavorable Standard Pre-Service Reconsiderations
- **RP03** Requests for Expedited Reconsiderations
- **GV01** Formal Grievances
- **CSGV01** Customer Service Grievances

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**Part C Appeals and Grievances
Monitoring – OP01 & OP02**



- **Finding**
 - Using old or altered Notice of Denial of Medical Coverage (NDMC)
 - Denial reasons too technical
 - Unjustified extensions
 - Confusing Medicare and Medicaid rules
- **Recommendation**
 - Delegated entities must use current version of NDMC
 - Use ICE denial matrix for denial language
 - Member must always be notified

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**Part C Appeals and Grievances
Monitoring – RP02 & RP03**

- **Finding**
 - Approval notices not submitted to CMS
 - Failure to notify members of transfer from expedited to standard process
 - Provider initiated appeals - Enrollee not advised of appeal decision
- **Recommendation**
 - Plans and delegated entities must use approved letters
 - Notice requirement for case transfers
 - Implement verbal notice process for favorable determinations






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Part C Appeals and Grievances
Monitoring – GV01 & CSGV01/GV04 & CSGV04

◆ **Finding**

- Categorization - Part D grievances in Part C universe
- Categorization – Issues involving appeals were treated as grievances
- Appealable issues in grievance were not resolved
- Plan resolutions were often incomplete – verbal and written
- QIO complaint information omitted from quality of care closures






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Part C Appeals and Grievances
Monitoring – GV01 & CSGV01/GV04 & CSGV04

◆ **Recommendation**



- Must distinguish between appeals and grievances
- Proper categorization is critical to improvement
- Appealable issues must be addressed in closure
- Final resolution must address all issues in grievance

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Part C Appeals and Grievances
Monitoring – General Recommendations



- ◆ Notices must be current – check for models, standardized notices and CMS approval
- ◆ Delegated entity oversight
- ◆ Management review process
- ◆ Update policies and procedures
- ◆ Train staff

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Claims

Karen Ng
Account Manager

**Claims Monitoring
Review Areas**



- **OC01** Correct Claims Determination
- **OC03** Timely Payment of Non-Contracting provider Clean Claims
- **OC04** Interest on Clean Claims Paid Late
- **OC05** Timely Adjudication of Non-Clean
- **OC06** Claims Denials (Notice Content)

**Claims Monitoring
OC 01**

◆ **Finding**



- Inappropriate denial of Emergency and OOA Urgent Care Services
- Lack of development of Ancillary Services
 - ▶ Link claims within an approved episode of care
 - ▶ Avoid unnecessary denials
- Claim from Non-Contracted Provider
 - ▶ Check for authorization/referral
 - ▶ SNPs – benefits covered by Medicaid

**Claims Monitoring
OC 01 (continued)**

◆ **Recommendation**



- Identify and develop claims
- Identify all claims for episode of care
- Identify situations where contracted providers referred members to non-contracted providers for medical services and ensure the claims are paid appropriately

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**Claims Monitoring
OC03**

◆ **Finding**



- Claim receipt date
 - ▶ Illegible receipt dates on original claim
 - ▶ Incorrect receipt date recorded in claim system
- Paid date
 - ▶ Incorrect paid date
- Lack of monitoring for MAO and for delegated providers

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**Claims Monitoring
OC03 (continued)**



◆ **Recommendation**

- Claim receipt date must be legible
- Paid date must be check mail date
- Implement claim timeliness monitoring process

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**Claims Monitoring
OC04**

- ◆ **Finding**
 - Interest on late claims
 - ▶ Not paid
 - ▶ Incorrect calculation - rate and payment formula
- ◆ **Recommendation**
 - Develop process to identify and pay interest
 - Interest rate changes Jan and July each year
 - ▶ http://www.treasurydirect.gov/govt/rates/tcjr/tcjr_opdprmt2.htm

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**Claims Monitoring
OC 05**

- ◆ **Finding**
 - Lack of claim development evidence for non-clean paid claim classification
 - Claim pending but not paid or denied within 60 days.
- ◆ **Recommendation**
 - Document request for information in claims system
 - Implement system to monitor timeliness

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**Claims Monitoring
OC06**

- ◆ **Finding**
 - Outdated Notice of Payment Denial (NDP)
 - Unclear Medical Service Description
 - Unclear Claim Denial Reason
 - Provider RA Claim Dispute/Appeals-- State/Federal

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**Claims Monitoring
OC06 (continued)**



- ◆ **Recommendation**
 - Use revised NDP to members
 - Provide complete and clear medical service description, and denial reason to members

Formulary Administration



Lucy Saldaña, Pharm.D

Regional Pharmacist



**Formulary Administration
Review Areas**

- ◆ **PCM101** – Protected Class Drugs
- ◆ **FRM101** – Formulary Administration – Formulary Tier
- ◆ **FRM102** – Formulary Administration – Step Therapy and Prior Authorization
- ◆ **FRM201** – Formulary Administration – Any Applicable Quantity Limit Restrictions, Prior Authorization Criteria and Step Therapy Criteria on the Plan Website

Pharmacy Administration



- Areas of Review:
 - Transition
 - ▶ Plans definition of new member
 - Protected Drugs
 - Prior Authorization, Step therapy, and Quantity limits

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Pharmacy Administration Lessons Learned



- ◆ Prior Authorization
 - Entry at drug name level for protected drug class
- ◆ Automated Transition process at Point of Sale
 - Minimum need to contact help desk
- ◆ Pharmacy messaging
 - Clear and directive

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Pharmacy Administration Lessons Learned *cont'd*



- ◆ Routine review of rejected claims
 - Detect patterns of rejections that may alert you to problem areas early on.
- ◆ Other

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Part D – Coverage Determination Appeals & Grievance

Nicole Edwards
Account Manager



Part D A&G Monitoring -Review Areas

- ◆ **CDD101** Timely processing coverage determination requests
- ◆ **CDD102** Properly effectuating approved coverage determinations
- ◆ **CDD103** Timely notifying the enrollee of the coverage determination decision
- ◆ **CDD104** Timely providing written notification for denied requests

Part D A&G Monitoring - Review Areas

- ◆ **ARD101** Timely processing redetermination requests
- ◆ **ARD102** Properly effectuating approved redeterminations
- ◆ **ARD103** Timely notifying the enrollee of the redetermination decision
- ◆ **ARD104** Providing the appropriate notification of the redetermination decision

Part D A&G Monitoring - Review Areas

- ◆ **GVD101** Correctly Categorization
- ◆ **GVD102** Timely providing notification to the enrollee
- ◆ **GVD103** Appropriate Grievance Resolution



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Part D A&G Monitoring

- ◆ Review period January 1, 2011 to May 31, 2011
- ◆ Documents Reviewed
 - Internal Audit Reports and Sampling Methodology
 - Organizational Charts
 - Flow Charts



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Part D A&G Monitoring – CDD103

- ◆ **Finding**
 - Members were not notified if their request was approved
- ◆ **Recommendation**
 - Notice to both the member and provider are required
 - A verbal approval process may save time



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Part D A&G Monitoring – CDD104

◆ **Finding**

- Part C Notice of Denial used for Part D determinations
- Incorrect appeal rights provided
- Incorrect instructions

◆ **Recommendation**

- Routinely review notices for accuracy

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Part D A&G Monitoring ARD101 and ARD102

◆ **Finding**

- Part C notices and timelines were used
- Expedited requests were not documented sufficiently
 - ▶ Transfer to standard process missing

◆ **Recommendation**

- Review notices
- Document decision making process
- Notify member of transfer to the standard process and provide expedited appeal rights

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Part D A&G Monitoring – ARD103

◆ **Finding**

- Members were not notified of redetermination overturns
 - ▶ Provider notice only
 - ▶ No verbal notice process

◆ **Recommendation**

- Provider and member must be advised of redetermination decisions

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Part D A&G Monitoring – GVD102/GVD103

◆ Finding

- Grievance resolutions were incomplete
- Complaints were not resolved timely

◆ Recommendation

- Need a standard process to track grievances through resolution for timeliness and completeness



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Best Practices

- ◆ Review policies and procedures
- ◆ Compare policies with Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals
- ◆ Conduct internal monitoring
- ◆ Reach out to your AM's



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Marketing & Surveillance



Juliana Payiatas
Account Manager



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**Marketing & Surveillance
Review Areas**

- **MR05** Marketing Materials: Enrollment and Understanding of Plan Rules
- **MR07** Outbound Enrollment Verification (OEV) Process
- **MR08** Sales Agent/Broker Activity
- **MR19** Part D Explanation of Benefits (EOB)



Marketing & Surveillance– MR05

- ◆ **Finding**
 - Untimely mailing or missing documentation to prove mailing
 - Poor oversight of mailing vendor
- ◆ **Recommendation**
 - Track the mail date
 - Improve documentation retention

Marketing & Surveillance– MR07



- ◆ **Finding**
 - Script and letter didn't follow the model
 - Calls didn't follow the script, untimely, not documented, or weren't completed
 - Letters weren't sent timely or at all
 - Used incorrect cancellation date

Marketing & Surveillance– MR07
(cont.)

• **Recommendation**

- Record and monitor OEV calls
- Track the call date(s) and time(s) and the mail date of the letter
- Use the CMS model
- Take appropriate action to either cancel a beneficiary’s enrollment request and/or investigate a sales/broker allegation






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Marketing & Surveillance Monitoring
– MR08

• **Finding**

- Inadequate documentation of training and testing
- Poor implementation of testing
- Improper handling of marketing misrepresentation complaints
- Improper marketing at educational events






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Marketing & Surveillance Monitoring
– MR08 (cont.)

• **Recommendation**



- Improve documentation retention
- Develop a more robust training and testing program
- Develop a process for or improve upon sales allegation investigations, include complaints in subcategory “Marketing Misrepresentation – RO Action Needed”
- Perform internal audits of sales agents/brokers to ensure compliance with the marketing guidelines

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Marketing & Surveillance Monitoring
- MR19



- ◆ **Finding**
 - No documentation of mailing
 - EOB doesn't follow the model
 - Incorrect beneficiary address
- ◆ **Recommendation**
 - Develop a process to track the mail date
 - Ensure that instructions provided to plans in the CMS model are followed
 - Verify the beneficiary's address in the plan's system with the one in MARx at least quarterly

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Marketing & Surveillance
Best Practices



- ◆ Take this opportunity to monitor your own plan
- ◆ Sample cases need to be well-organized and labeled
- ◆ Update notices and internal procedures
- ◆ Pay attention to the material ID format and submission
- ◆ Follow the CMS model

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Compliance Review

Ayanna Busby-Jackson
 Region 9

Compliance Review



- Review period July 2010 to June 2011
- Documents Reviewed
 - Policies and Procedures
 - Compliance Plan
 - Compliance Committee Minutes
 - Code of Conduct
 - Organizational Chart
 - Samples Reviewed
 - ▶ WSCPT1 – Training Events
 - ▶ WSCPT2 – Compliance Logs
 - ▶ WSCP1E – Internal and External Audits
 - ▶ WSCP1A1 – Corrective Actions

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Compliance Review Elements



- CP01 - Written Policies, Procedures and Standards of Conduct
- CP02 - Compliance Officer and Compliance Committee
- CP03 - Effective Training and Education
- CP04 - Effective Lines of Communication
- CP05 - Enforcement of Standards
- CP06 - Effective Internal Monitoring and Auditing
- CP07 - Prompt Response to Detected Offenses

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Compliance Review– CP01

- Finding
 - Missing Policy and Procedures
 - ▶ Oversight of Agent Investigations
 - Structure for training programs
- Recommendation
 - Develop and implement policies and procedures stated in Manual Chapter 9 section 50.2.1.2 and 2011 regulations 42 CFR § 423.504(b)(4)(vi)(A)

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Compliance Review– CP01

◆ **Finding**

- Policies and procedures were not updated timely

◆ **Recommendation**

- Develop internal controls that provide for periodic review and update to policies and procedures

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Compliance Review– CP03

◆ **Finding**

- No process in place to track attendance at trainings

◆ **Recommendation**

- Must document attendees at required trainings
- Develop tracking mechanisms to ensure that appropriate staff attend trainings

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Compliance Review– CP04

◆ **Finding**

- Compliance logs failed to document the complaint
- Progress reports to document ongoing corrective actions were not found

◆ **Recommendation**

- Implement a tracking system to measure the timeliness of investigation of complaints received by PO
- Develop progress reports to track follow up and closure

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Compliance Review– CP06

◆ Finding

- Failed to perform internal audits of Medicare Part C & D Operational areas
- Did not fully document the audits' objectives, scope and methodology, findings and recommendation

◆ Recommendation

- Develop a structure and processes to perform internal audits
- Implement a report process to document internal audit outcomes

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Compliance Review– CP07

◆ Finding

- Failed to document the development and implementation of corrective actions

◆ Recommendation



- Develop procedures for ensuring prompt responses to detected offenses and the implementation of corrective action
- Create a tracking system to manage the range of corrective actions taken by the PO and to document the progress made towards compliance

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Compliance Review– General Findings



◆ Organization Charts - Structure

- ◆ Medicare Compliance Officer must have at least a dotted line reporting relationship to the Board or Board Audit Committee.

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**2011 Compliance Monitoring
PO Best Practices**



- Have compliance expertise on the Board of Directors
- Board of Directors Agenda includes compliance as standing agenda item
- Board minutes reflect the detail of any discussion and resolution of compliance issues
- Regular education is provided to Board members on compliance program/ risks in order to properly exercise independent judgment and oversight
- Business leaders are held accountable for compliance results (performance evaluations, incentives, etc)

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**2011 Compliance Monitoring
PO Best Practices**



- Perform internal audits of Medicare Part C & D operational areas
- Implement corrective actions designed to correct the underlying problem that result in program violations and prevent future misconduct
- Have developed a process for tracking training
- Disclose non-compliance issues to the Account Manager in a timely manner

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Contact Information

- Julia Cohen - Julia.Cohen@cms.hhs.gov
- Kristin Sugarman-Coats - Kristin.Sugarman-Coats@cms.hhs.gov
- Karen Ng - Karen.Ng@cms.hhs.gov
- Lucy Saldana - Lucy.Saldana@cms.hhs.gov
- Nicole Edwards - Nicole.Edwards@cms.hhs.gov
- Juliana Payiatas - Juliana.Payiatas@cms.hhs.gov
- Ayanna Busby-Jackson - Ayanna.Busby-Jackson@cms.hhs.gov

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