Medicare Part C: Organization Determinations, Appeals & Grievances (ODAG)

Best Practices for Initial Determinations, Appeals and Grievances

Kristi Sugarman Coats
Account Manager
Drug and Health Plan Operations
Centers for Medicare & Medicaid Services
December 9, 2019
ICE 2019 Annual Conference
San Francisco, CA

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Overview

- Important Policy Reminders
- Best Practices
- ODAG Resources

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Important Policy Reminders

- **Denial notice language is specific to the request***
  - Use approved notice language in a readable and understandable form that includes:
    - Specific reasons for the denial, the coverage rule or plan policy, and what is needed to approve the coverage.
    - The enrollee's right to appeal and appoint a representative.
    - A description of the appeals process including timeframes.
    - The enrollee's right to submit additional evidence.
    - An explanation of a provider's refusal to furnish an item or service (if applicable).

*42 CFR § 422.568

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Important Policy Reminders

- **Render appropriate organization determinations and appeal decisions***
  - Provide coverage or payment for all services covered by Medicare Parts A & B in the plan's service area.
  - Comply with CMS' national coverage determinations, general coverage guidelines (e.g. CMS manuals, EOC), and written local coverage policy determinations.

*42 CFR § 422.101

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Important Policy Reminders

- **Properly identify and respond to Quality of Care (QOC) issues***
  - Investigate and respond in writing within 30 days, plus 14-day extension if applicable (enrollee must be notified in writing of extension).
  - Include a description of the enrollee's right to file a grievance with the BFCC-QIO and contact information for the BFCC-QIO.
  - Plans must cooperate to resolve any complaints filed with the BFCC-QIO.

*42 CFR § 422.564

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Best Practices

- **Oversight of delegated entities***
  - The plan is ultimately responsible for ensuring delegated entities satisfy requirements.
  - Conduct routine monitoring and training of all delegated entities to oversee compliance.
  - Verify that policies and procedures, including mailroom policies, are up to date.
  - Audit delegated entities to validate readiness for a CMS audit. Include the process for preparing and submitting universe data and evaluate timeliness.

*42 CFR § 422.562

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Best Practices

- **Updates to policy or guidance**
  - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance released February 22, 2019.
  - When CMS issues new policy or guidance update:
    - Policies and procedures
    - Internal processes
    - Links to documents
    - Checklists, workflow documents, reference materials
    - Delegated entities processes and documents
  - Provide training to staff on all updates.

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Best Practices

- **Quality assurance and oversight of initial determinations, appeals and grievances**
  - Ensure consistency and catch errors.
  - Depending on need, monitor operational areas daily, weekly and/or monthly.
    - ✓ Customer service
    - ✓ Timeliness
    - ✓ Decision making
    - ✓ Notices
    - ✓ Classification of requests
    - ✓ Forwarding complaints / requests to correct department

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Part C Organization Determination and Appeals Process

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ODAG Resources

- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (released 2/22/2019)
- HPMS Memos
  - Change in QIO contractors for Medicare health plan enrollees – CORRECTION (6/7/2019)
  - 2018 Program Audit Enforcement Report (9/13/2019)
- MAXIMUS Reconsideration Process Manual
- 42 CFR Part 422, Subpart M
- NEW Part C Appeals & Grievances Mailbox Portal: https://appeals.lmi.org/

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Questions & Answers

Panel Discussion

Jullin Kwok, CMS SF
Kristi Sugarman Coats, CMS SF
Lucy Saldana, CMS SF
Robert Williams, Blue Shield of CA
Yolanda Morris, CHC, St. Joseph Heritage Healthcare

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Medicare Part D: Coverage Determinations, Appeals & Grievances (CDAG)

CDAG Common Issues, Best Practices and Chapter Guidance

Lucy Saldaña, Pharm.D.
Region IX Pharmacist Consultant
Drug and Health Plan Operations
Centers for Medicare & Medicaid Services
December 9, 2019
ICE 2019 Annual Conference
San Francisco, CA

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Overview

- Common Issues
- Best Practices
- New guidance based on regulatory changes (Appeals & Grievances Chapter)
- CDAG Resources

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Review of Common Issues

Denials letters not having adequate rationale*

Contributing factors :

- Use of Templates
- Lack of QA process
- Complex Drugs with Multiple FDA approved uses
- Multiple contracted Vendors

*42 CFR § 423.568

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Best Practice

- **Denial Notice Rationale**
- **Writing the Denial Rationale**
- **Final Hints**

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Review of Common Issues

Misclassified Coverage Determination or Redetermination as Grievance*

*42 CFR § 423.560

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Best Practices

Quality assurance and oversight of initial determinations, appeals and grievances

- Ensure consistency
- Regular monitoring of operational areas

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New Guidance
Appeals & Grievances Chapter

- 10.6- Outreach for Additional Information to Support Coverage Decisions
- 30- Grievances
- 80.1- Guidelines for a Reopening

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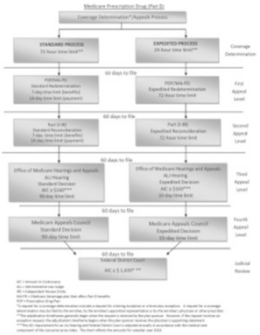
Part D Coverage Determination and Appeals Process



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CDAG Resources

- Medicare Prescription Drug Appeals & Grievances: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Released February 2019)
  https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf
- CMS.gov Appeals & Grievance flowchart
  https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Downloads/Flowchart-Medicare-Part-D.pdf
- MAXIMUS Reconsideration Process Manual
  http://www.medicareappeals.com/Portals/3/PDF/Recon%20Manual%2012-19-12.pdf
- 42 CFR Part 423, Subpart M
- New Part D Appeals & Grievances Mailbox:
  https://appeals.lmi.org/

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HEALTH PLAN AND PROVIDER ORGANIZATION'S PERSPECTIVE ON CMS PROGRAM AUDITS

ICE A&G Improvement Team Co-Leads
Yolanda Morris, CHC
Robert Williams

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OBJECTIVES

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- Focus on Lessons Learned during CMS Program Audits conducted in 2019.
- Best Practice Reminders from a Plan and Provider Organization's perspective.

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BEST PRACTICES FOR ODAG DATA VALIDATIONS

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- Recommend for Health Plans to conduct ODAG Data Validations with Provider Organization periodically
- Recommend for Health Plan and Provider Organizations to conduct monthly data validation to ensure data is accurately reported

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BEST PRACTICES PREPARING FOR CMS PROGRAM AUDIT

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- Recommend for Health Plans to communicate possible CMS Program Audit dates to delegates shortly after Health Plans are informed.
- Recommend for Health Plans to update Provider Organization Contact Information regularly for quick response during CMS Program Audits.
- Recommend conducting periodic mock audits with delegates for CMS Program Audit Readiness

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BEST PRACTICES DURING A CMS PROGRAM AUDIT

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- Recommend to carefully review your file selection prior to presenting to CMS.
- Designate a speaker and driver who is knowledgeable of the organization's process and systems.
- Designate back up speaker(s) and driver(s)
- Recommend to press "mute" for internal discussion to be able to provide clear answers to CMS Auditors.

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BEST PRACTICES DURING A CMS PROGRAM AUDIT

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- Recommend including a key player from each impacted area (i.e. UM, Medical Director, Claims, Customer Service, Pharmacy Services, Appeals, Grievance, Compliance and Enrollment)
- Flexible Schedule to reply promptly to CMS requests for additional information.
- Mail Policy - develop and maintain working knowledge of your organization's mail policy
  - *Knowledge of vendor's mailing process if utilizing vendors for mailing*
  - *Ensure reporting accurately reflects your mailing policy*

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INTERNAL ON-GOING MONITORING AND OVERSIGHT

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- Continue to monitor timeliness and conduct root cause analysis if deficiencies are identified to remediate issues promptly
- Provider Organizations: Monitor Integrated Denial Notices
  - Mail Member Denial Notifications in current IDN templates
  - Include all applicable letter inserts with all member notifications
- Send Member Notifications in Preferred Written Language (disclaimer: save copies of English and Preferred Written Language if threshold language applicable for specific plan)

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INTERNAL ON-GOING MONITORING AND OVERSIGHT

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- Documentation: clear and concise documentation
  - Build awareness on clear and concise documentation *(if it's not documented it did not occur)*
  - Part of clear and concise documentation includes all actions taken (e.g., parties spoken with) and resolution documented for future reference.
- Ensure OIG Exclusion Checks are conducted for non-par providers prior to pre-service approvals.
  - Review Policy to ensure it reflects your process
  - Document in the system of OIG Exclusion Checks for non-par provider referrals

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INTERNAL ON-GOING MONITORING AND OVERSIGHT

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- Review Denial Rationale to ensure clear and concise explanation to the member
  - Cite criteria used for clinical decision making
  - 8th grade reading level for member notifications.

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