NAVIGANT

2016: A YEAR IN THE TRENCHES – LESSONS LEARNED, BEST PRACTICES, AND KEY TAKE-A-WAYS FOR 2017

2016 proved to be another big year for the Centers for Medicare and Medicaid Services (CMS) audit and enforcement activity. Key developments included the full roll-out of the Independent Validation Audit process and some of the most wide-sweeping enforcement actions cutting across all key risk areas.

Navigant has been a trusted advisor to plans in performing "mock" CMS Audits, Independent Validation Audits and ongoing remediation efforts. It is out of those efforts that we offer key lessons learned, best practices, and key take-a-ways as health plans and their FDRs gear up for another strong year of CMS audit and enforcement activity.

PROGRAM AREA	LESSONS LEARNED IN 2016	BEST PRACTICES	KEY TAKE-A-WAYS FOR 2017
Compliance Program Effectiveness (CPE)	Routine Monitoring and Auditing are key to a best-in-class compliance program.	• The implementation of the 3 lines of defense approach by establishing business, compliance, and Internal Audit level monitoring and auditing. • The development and maintenance of a monitoring and auditing work plan that addresses risks associated with the Medicare Parts C and D benefits. • The Compliance Officer has regular meetings with Senior Leadership and a standing session as well as an executive private session with the Board of Directors Audit Committee.	• Be prepared to exhibit your routine monitoring activities, as well as your more formal auditing practices, to CMS. • Be able to demonstrate your communications of Compliance issues from the informal to the Audit Committee level. • Be able to defend the lens by which you evaluate and report issues to the Compliance Committee and Board of Directors.
First Tier, Downstream, & Related Entities (FDRs)	Plans need robust ongoing FDR monitoring and auditing.	• The Sponsor established an account management structure to closely work with FDRs and be a single point of contact within the organization. • The development of a program to show evidence of on-going monitoring and auditing of FDR's. • The Sponsor co-sources FDR audits to reach all high-risk FDRs.	• FDRs will increasingly be a noticeable focus of CMS scrutiny. • Larger plans can have 200 or more FDRs and plans are required to audit them on a risk-ranked basis. • Identify any FDR Universe issues and mitigate risks. • Be prepared to deal with inconsistencies between interpretations of CMS guidance as many national FDRs contract with multiple plans. • Carefully develop your risk assessment to include FDRs and make sure that you can demonstrate communications of issues through your Corrective Action Plan process.

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HPMS Memos	Every HPMS memo is important. Memos include new audit protocols, monitoring requirements, job aids, and other important topics. Few plans have devised methods to efficiently and effectively communicate the large number of memos distributed each year.	• The Compliance team reviews HPMS memos and, in many cases, the Legal team. • All HPMS memos are evaluated for business impact. • Targeted training is performed for the appropriate impacted business areas. • Establishing business owners and recording actions taken to ensure key attributes from the memos are addressed.	• Each year CMS distributes approximately 400 memos. You should expect at least 400 more in 2017. It is time to figure out how to effectively communicate the memos to the impacted areas of your plan.
IVAs	Validation audits are different from regular CMS audits. Experience matters when considering an independent validator.	• The Sponsor worked with the validator to develop a CMS-compliant work plan that included validation timelines and completion dates within the CMS established timeframe. • The validator worked collaboratively with CMS and the Plan Sponsor to develop a flexible yet targeted approach to validating that program audit conditions were corrected.	• CMS will require your plan to hire an independent auditor to validate any corrective actions required as the result of an audit. • Share CAPs and CMS reports with the validator early. CMS wants work plans approved, applicable universes identified, and no-audit zones established before the validation begins. • Chose a validator that has experience with the process.
Part D Coverage Determinations, Appeals, and Grievances (CDAG)	Maximus reported an overwhelming increase in IRE auto-forwards in 2016.	• Leadership recognized that IRE auto-forwards are the result of deficiencies in staffing and inefficient processes that are causing cases to fall untimely. • The Sponsor developed and implemented processes that foster timely decisions and avoid high levels of cases that need to be auto-forwarded to the IRE.	• In 2017, CMS will begin effectuating the compliance-to-enforcement escalation process to Sponsors that have ten or more IRE cases/appeals, ten or more auto-forwarded cases, and an auto-forward rate of 10 per 10,000 members during any quarter in 2016.
	Member impact is CMS' number one concern.	• The Sponsor implemented a training program designed to highlight the importance of denial rationale and denial language. The training included understanding the member's request and need and understanding the member impact of the plan's action or inaction. • The Sponsor developed a member-centric culture and re-organized the Compliance Department to more closely align with beneficiary touch points.	• CMS continues to judge beneficiary impact more harshly because of the health risk to the member. • Access to care and timeliness will be under even more scrutiny in 2017. • Monitor CTMs for trends in beneficiary impacts.
	Staffing the right people with the right knowledge in the right place is vital to the efficiency and effectiveness of your Part C and D businesses.	• Managers routinely trained and tested staff for adequate knowledge and performance.	• CMS will inquire about your staffing model if you exhibit you are falling behind on determinations and increasing your IRE auto-forwards.

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Part C Organization Determinations, Appeals, and Grievances (ODAG)	Plans must implement the CMS required Integrated Denial Notice (IDN) with no modifications to the OMB form.	• The development of denial codes that align with CMS requirements. • The use of denial rational language that is easily understood by the member.	• Include member notices in your on-going monitoring of both internal and FDR operational areas. • Denial Rationale should strike a balance between ease of understanding, specificity to what was denied and cultural competence. • Consider purchasing member friendly CPT and ICD-10 descriptions for use in denial rationale.
Special Needs Plan Model of Care (SNP-MOC)	Implementing a successful process for enrollment verification of SNP members is challenging.	• Consistently verifying dual eligibility in accordance with CMS guidance and accessed State Medicaid Eligibility systems within the enrollment area.	• For current enrollees, the SNP must verify continuing eligibility at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility.
	HCA timeliness is impacted by SNP eligibility.	• The development of an ICP for new members who did not complete the HRA within 90 days of enrollment. • The use of various venues to develop an Interdisciplinary Care Plan for all members of the SNP plan. • The use of the member's initial RAF score to develop the ICP and then outreach to the member to confirm all diagnosis and prior health issues.	• Ensure that you develop and implement a comprehensive individualized plan of care through an interdisciplinary care team in consultation with the beneficiary. • Identify goals and objectives including measurable outcomes as well as specific services and benefits to be provided. • Complete ICPs for members who have opted out of the Care Plan program.
Data Analytics	Data analytics makes your business better and your jobs easier.	• The development and use of data analytics for all areas of MA-PD and PDP compliance monitoring.	• CMS is using data analytics to select plans for audit and monitor their performance. • Plans should seek to mirror these capabilities.
Data and Systems	The number one issue Navigant encountered, and that had the most negative impact on our clients in 2016, was their inability to consistently produce valid universes. Many plans are still unprepared in their IT departments to consistently and accurately produce these new universes.	• Routinely practiced producing universes to ensure universes consistently pass validation. • Developed weekly universe pulls on an automated basis. • Developed "on-demand" universe capabilities so that business owners can gauge their performance.	• Invalid Data Submissions (IDS) affect your audit score. • Know your weaknesses before CMS does. • Use your universe data as part your ongoing monitoring program.
Data and Systems	Disparate systems can cause electronic breakdowns in communication. System integration improves communication, speeds up processes, and reduces manual errors.	• Plans moved toward having single systems for Claims Adjudication and Coverage Determinations/Appeals.	• Simplification of Universe creation increases efficiency. • Decrease the maintenance and human resource requirements of data management of multiple platforms and data mapping of these sources.

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