



Medicare Managed Care: Compliance in the Post-Health Care Reform Era

HCCA Managed Care Compliance Conference
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(Superbowl-Friendly) Agenda

- The year in review
- Mandatory compliance plans, CMS Audits, RACs and ZPICs
- Practical implications for Plan Sponsors
 - Medicare Advantage star quality ratings
 - Past performance review
 - Part D issues identified in CMS audits
 - Data validation audits

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The Year In Review

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What We've Seen

- Two pieces of legislation
 - Patient Protection and Affordable Care Act
 - Health Care and Education Reconciliation Act of 2010
- Rulemaking
 - 2 final rules
 - 1 proposed rule
- Sub-regulatory guidance
 - Numerous notices, requests for information, information collection activities
 - Approximately 300 HPMS issuances
 - Includes 7 manual issuances

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What We've Seen (cont.)

- Launch of the Coverage Gap Discount Program
- Announcement of the MA Quality Bonus Payment Demonstration
- CMS Part D audits
- CMS levying intermediate sanctions (including contract termination and suspensions) on several Plan Sponsors

What We Expect to See in 2011

- Preparation for launch of the MA Quality Bonus Payment Demonstration
- Preparation for change in MA Plan payment methodology
 - Finalization of November 2010 proposed rule
 - Implementation of data validation audits
 - Discussion on role of RACs for MA and Part D Programs
- More CMS audits
 - MA? Part D?
 - RADV?

What Are The Take-Aways?

- Understanding Programs' changes and developments
- Learning from prior years' activities
- Anticipating and preparing for challenges and "hot spots"
- "SWAT" team and other fast response capabilities

Mandatory Compliance Plans, CMS Audits, RACs and ZPICs

Mandatory Compliance Plans

- Non regulatory provisions
 - Published April 15, 2010, found at 75 Fed. Reg. 19678
 - 42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)
 - Effective June 7, 2010
- Compliance Program changes effective 2011 plan year (or as of about 5 weeks ago)

Mandatory Compliance Plans (cont.)

- Most of the information codified in regulation were contained in existing subregulatory guidance – namely Chapter 9 of the Medicare Drug Plan Manual
- The regulations specifically reference the requirement for an 'effective' compliance plan
- What do we think that means?

Mandatory Compliance Plans (cont.)

- More detailed requirements now codified in regulation for each of the 7 compliance program elements
- The seven habits of highly effective compliance programs
 - Standards and procedures
 - Oversight
 - Education and training
 - Monitoring and auditing
 - Reporting
 - Enforcement, discipline and incentives
 - Response and prevention

Mandatory Compliance Plans (cont.)

- Element One:
 - Written policies, procedures and standards of conduct
 - Commitment to comply with applicable federal and state standards
 - Description of compliance expectations – standards of conduct
 - Compliance operations
 - Guidance to employees when dealing with compliance issues
 - How to communicate issues to compliance personnel
 - Description of how matters are investigated
 - Policy re: non-intimidation and non-retaliation

Medicare Managed Care Compliance Plans (cont.)

- Element Two: Designation of a compliance officer and compliance committee
 - Must report directly to and be accountable to organization's chief executive or other senior management
 - Must be employee of the entity, parent or corporate affiliate
 - Cannot be employee of first tier or downstream entity
 - Must periodically report to board of organization re. activities and status of the program
 - Board must be knowledgeable about content and operation of compliance program as well as exercise oversight for implementation and effectiveness of program

Mandatory Compliance Plans (cont.)

- Element Three: Plan sponsors must establish, implement and provide effective training between the compliance officer and employees including, 'chief executive or other senior administrator' (new), managers and 'governing body members' (also new) and the organizations first tier, downstream and related entities
 - Must be at least annual, and made part of orientation for a new employee, a new first tier or downstream entity or a new chief executive, manager or governing body member

Mandatory Compliance Plans (cont.)

- Element Three (continued):
 - First tier, downstream and/or related entities that currently possess a Medicare provider, supplier or DMEPOS supplier number are DEEMED to have met the FWA training and education requirements
 - Think through what this last item means, both good and bureaucratic

Mandatory Compliance Plans (cont.)

- Element Four: Establishment of effective lines of communication, 'ensuring confidentiality' (new) between the compliance officer, members of the compliance committee, employees, managers and 'governing body' (also new), and first tier, downstream and related entities
 - Lines of communication accessible to all
 - Anonymous, confidential good faith reporting

Mandatory Compliance Plans (cont.)

- Element Five: Well publicized disciplinary standards 'through the implementation procedures which encourage good faith participation in the compliance program by all affected individuals' (new)
 - Policies that:
 - Spell out expectations for reporting and assisting in resolution of compliance issues
 - Identify non-compliant or unethical behavior
 - Timely, consistent, effective enforcement standards

Mandatory Compliance Plans (cont.)

- Element Six: Establish and implement 'effective system for routine monitoring and identification of compliance risks' (new)
 - Routine additional monitoring of compliance risk areas by business units (which ones?)
 - Periodic internal audits
 - External audits as appropriate (includes first-tier monitoring)
 - Evaluation of overall effectiveness of the program

Mandatory Compliance Plans (cont.)

- Element Seven: Establish procedures for prompt response to compliance issues as they are reported – investigation of problems identified from self-evaluations and audits, correction of such problems promptly and thoroughly to 'reduce the potential for recurrence and ensure ongoing compliance with CMS requirements' (new)
 - Timely, reasonable inquiries into reported incidents and conduct
 - Corrective actions
 - Self-reporting procedures for discovered fraud and misconduct related to CMS

Mandatory Compliance Plans (cont.)

- Government's focus: deficiencies in compliance plan requirements
 - One immediate contract termination
 - Numerous marketing and enrollment sanctions
 - See:
<http://cms.hhs.gov/MCRAAdvPartDEnrolData/EA/list.asp>

CMS Audits

- Plan Sponsors targeted based on risk analysis results
- Plan Sponsors selected just for a compliance plan effectiveness audit
- What does this mean?
 - Not a paper exercise
 - On-site investigation
 - CMS seeks data, personnel and documentation

CMS Audits (cont.)

- The audit report - examples
 - Element 1: Standards of conduct are not being made available to delegated entities
 - Element 1: 'C' level management not knowledgeable about compliance and FWA issues
 - Element 3: Training/education not extending down to contracted entities
 - Element 6: Risk assessments not being conducted

CMS Audits (cont.)

- The audit process
 - Evaluation of effectiveness
 - Can you show the auditors you have a system in place that proactively finds and fixes non-compliance with FWA issues?
 - Things like?
 - Monitoring programs
 - Personnel processing and interpreting that data
 - Internal audits
 - Secret shoppers

RACs and ZPICs

- Recovery Audit Contractors (RACs)
 - Health Care Reform expanded RAC Audits to Medicare Parts C and D
 - December 31, 2010 deadline
 - Also the date by which states were required to contract with RACs for Medicaid provider audits

RACs and ZPICs (cont.)

- RACs (cont.)
 - Expect significant increase in RAC activity coming to a theater near you
 - RAC standards may reveal errors
 - Even when you believe you're billing/coding correctly
 - Even when you are dealing with a provider who is billing/coding correctly
 - Medical Necessity Reviews are a targeted area for RACs
 - In RAC demonstration project, 50% of identified overpayments related to medical necessity

RACs and ZPICs (cont.)

- RAC results and potential False Claims Act liability
 - Health Care Reform amended federal law to require an entity that has received an overpayment to (i) return it, and (ii) notify the appropriate entity
 - The entity has no more than 60 days from 'date on which the overpayment was identified' or 'the date any corresponding cost report is due, if applicable' (31 U.S.C. § 3729)
 - Penalties
 - \$10,000 per claim
 - Treble damages for each claim
 - Possible exclusion from federal healthcare programs and state healthcare programs

RACs and ZPICs (cont.)

- Does denial of an appeal create an overpayment?
- What are the responsibilities of a provider or payor who realizes during an audit that there was an overpayment?
- What is the potential liability if the provider cannot afford to repay the overpayment?

RACs and ZPICs (cont.)

- RAC Request for Information
 - Published December 27, 2010 (75 Fed. Reg. 81278)
 - Comments due to CMS by 5 PM on Friday, February 25, 2011
 - Comments sought on proposed approach to how RACs are to be used with Medicare C and D
 - CMS acknowledges in the RFI that until now RACs have been used solely in FFS arena
 - Fundamental differences between FFS and Medicare Parts C and D

RACs and ZPICs (cont.)

- Comments sought by CMS on:
 - Methods for RACs to identify payment discrepancies
 - Utilizing a phased-in approach
 - Appropriate criteria and/or qualifications of RACs
 - Conflict of interest rules
 - Establishing an oversight entity – CMS references a possible review board
 - How to resolve underpayments
 - How Part C and D entities can use RACs internally to identify issues

RACs and ZPICs (cont.)

- Comments sought by CMS (cont.):
 - Approaches to implementing special rules from the Affordable Care Act, including:
 - Verifying plans have anti-fraud plans in place
 - Utilization of RACs to examine claims for reinsurance
 - Having plans report direct and indirect remuneration (DIR)
 - Review estimates submitted by Part D plans regarding enrollment of high cost beneficiaries

RACs and ZPICs (cont.)

- CMS RFI on RACs
 - Confidentiality
 - Provider contracts
 - Accessible to RAC auditor?
 - Oversight?
 - Other issues?

RACs and ZPICs (cont.)

- Zone Program Integrity Contractors (ZPICs)
 - Nearly 3 years ago, CMS began to consolidate Program Safeguard Contractors (PSCs) and Medicare Prescription Drug Integrity Contractors (MEDICs) into ZPICs
 - All Claim types reviewed: Parts A through D, home health, hospice, DMEPOS
 - Cost report and reimbursement audits as well

RACs and ZPICs (cont.)

- ZPICs: What's your zone?
 - Zone 1 - California, Nevada, American Samoa, Guam, Hawaii, and the Northern Mariana Islands
 - Zone 2 - Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa and Missouri
 - Zone 3 - Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky
 - Zone 4 - Colorado, New Mexico, Oklahoma, and Texas
 - Zone 5 - Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and West Virginia
 - Zone 6 - Pennsylvania, New York, Maryland, Washington D.C., Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, and Vermont
 - Zone 7 - Florida, Puerto Rico and Virgin Islands

RACs and ZPICs (cont.)

- ZPICs
 - Renewed focus by the government through PPACA and other legislation
 - Number of ZPIC audits to increase in 2011
 - Government reliance on data mining will continue to grow
 - Will see ALJ hearings where auditor is 'participant'
 - Will likely aggressively oppose arguments in support of payment



Practical Implications for Plan Sponsors



MA Star Quality Rating System

- Health Care Reform attempts to align payment and quality for the MA Program
- Quality bonuses for high-ranking MA Plans
 - Ranking based on CMS five-star quality rating system
 - Double bonuses (up to 10 percent) for “qualifying plans in qualifying counties”
 - Bonuses available for new and low-enrollment MA Plans

MA Star Quality Rating System (cont.)

- Reduction in MA “rebates”
 - CY 2012-2014 phase-down of MA rebates to 50 percent
 - High ranking quality MA Plans eligible for 65 - 70 percent rebate retention
 - Certain new and low-enrollment MA Plans may be eligible for 65 - 70 percent rebate retention
 - Legislation does not dictate priority of rebate spending

MA Star Quality Rating System (cont.)

- 4 sources of data feeding the quality star rating system
 - CMS administrative data
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Health Outcomes Survey (HOS)
- Payments based on quality data originating from several years earlier
- Appeal opportunities

Past Performance Reviews

- CMS has the regulatory authority to deny new plan and service area expansion applications based on failure to comply with Program requirements
 - Agency analyzes performance in the 14 months prior to the application deadline
 - *E.g.*, January 1, 2010-February 28, 2011 for CY 2012 application cycle
 - Includes issues that occur or are identified during the 14-month review period

Past Performance Reviews (cont.)

- Scoring system evaluates issues in eleven performance categories:
 - Compliance letters (notices of non-compliance, warning letters, corrective action plans)
 - Performance metrics (*i.e.*, star ratings)
 - Multiple ad hoc CAPs
 - Ad hoc CAPs with beneficiary impact
 - Financial watch list
 - Financial audits

Past Performance Reviews (cont.)

- Performance audits
- Exclusions (*e.g.*, from auto-assignment of LIS individuals)
- Enforcement actions
- Termination
- Outstanding compliance concerns not otherwise captured
- Plan Sponsors with high performance scores notified in fall if submitted Notice of Intent to Apply
- Opportunity to withdraw applications prior to issuance of Notice of Intent to Deny

Past Performance Reviews (cont.)

- CMS's policy exemplifies the importance of compliance in a Plan Sponsor's long-term strategy
- How can Plan Sponsors capitalize on this approach?
 - CMS notes Plan Sponsors have access to the same performance information upon which these performance analyses are based
 - Tracking and improving performance through the year

Part D Issues Identified in CMS Audits

- In addition to compliance plan effectiveness, CMS also evaluated:
 - Formulary development and administration
 - Transition policies
 - Grievances, coverage determinations and appeals
 - Among other issues
- Beneficiary access (“touch points”) is the common theme

Part D Issues Identified in CMS Audits

- Looking forward to CY 2011 audits...
 - Will CMS re-evaluate past performance issues?
 - What will be the recurring areas reviewed? New areas?
 - What are your operational issues?
 - Evaluating internal priorities
 - Preparing rapid response team

Data Validation Audits

- New data validation audit requirements effective in CY 2011 for data submitted to CMS in CY 2010
 - Audit must occur in March and April 2011
 - 11 Part C and Part D data elements
 - Contract level analysis
- Expansion in CY 2012
 - 17 Part C and Part D data elements
 - Includes both CY 2010 and CY 2011 data

Data Validation Audits (cont.)

- Self-evaluation of CY 2010 data analysis
- Anticipating results of CY 2011 data analyses
 - Mock audits
 - Identifying areas for improved performance
 - "What if..."

Questions and Comments (go Steelers!)

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