TMG Health

The **Leader** *in Business Process Outsourcing*

for Medicare & Medicaid Health Plans

Compliance Webinar

Experience

Most Experienced Business Process Outsourcing Vendor Serving Medicare Advantage and Part D plans **– since 1998**

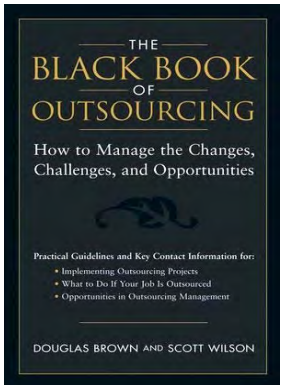
New Product Launches and Existing Plan Conversions including Medicare Advantage HMO, PPO, PFFS, SNP and PDP for 2.8 mil members

Client Experience – Over 30 clients serving members in all 50 states

- Local, Regional, Blues and Large National Plans
- More than 200 Employer Groups Implemented. 325,000+ members

Proven/Tested Technology and Systems

Dedicated Client-Centric Teams Using Medicare Focused Tools and Workflows



2008 #1 Ranked TPA & Medicare/Medicaid Management Services Organizations BPO

TMG Health Background

- Management: Health Plan Background
- Founded to Serve Managed Medicare Plans
- 1,200 + Employees
- Service Centers in Scranton and Dunmore, PA.
  - All Service Teams are US-based
  - Third Center Being Implemented in Amarillo
- Corporate Headquarters, King of Prussia, PA (Philadelphia)

2008 Gartner survey of 60 health insurer executives revealed approximately 40% expressed intent to invest in BPO services during 2009

TMG Scope of Services

- Medicare Configured Managed Care Information System and TMG Proprietary Applications
- Enrollment & Disenrollment Processing
- Eligibility Maintenance (System of Record)
- CMS Eligibility Reconciliation and Tracking
- Premium Billing and Cash Receipts Posting
- Claims Processing/Payment & RAPS Submission
- Member & Provider Call Services
- Surveys (HRA, MSP)
- Printing and Fulfillment Services
- MM, A&G Systems

TMG Health

Managing MA/MAPD With Increased CMS Monitoring- Keeping Ahead of CMS

Presented by

Olga Thornton- SVP Program Development & Chief Compliance Officer

They're coming in the windows, They're coming in the doors!

Presentation Overview

- Operational/Technology Challenges
- Compliance Risks
- Risk Based Auditing
  - 3 year audit cycle no longer in place
  - Beyond limits of monitoring guide
  - CMS Contact and/or CAP without actual audit (Chapter 99 Ad Hoc Compliance Events)
  - Findings are posted
- Financial Audit (1/3 audit)
- Fraud Waste and Abuse

Operational and Technology Challenges

Operational Challenges

- Over 1,100 HPMS directives and transmittals
  - Half (Transmittals) related to Claims Processing
    - ✓Due prior or same day as CMS Release: 4%
    - ✓Due between 1-20 days of CMS Release: 12%
    - ✓Due between 21-35 days of CMS Release: 29%
    - ✓Due between 36-90 days of CMS Release: 22%
    - ✓Due 90+ days of CMS Release: 33%
  - CMS Late notice - Plan retroactive or early delivery
  - Annual Call Letter and CMS rule changes
  - Increased Marketing Scrutiny

Operational Challenges (Cont.)

- CMS Timeframes are compressed
- Annualized Functions (e.g. ANOC mailings, COB Surveys, Annual Election) require flexible staffing
- Use of Brokers impacts timeframes
- Increased number of CMS standards and shortened timeframes to implement

Minimize Operational Challenges

- Establish an internal team to track and implement CMS Directives and Transmittals. Participate in all CMS calls and share information across the company.
- Assign a project manager to coordinate implementation of all CMS changes
- Increase number of part-time staff to allow flexibility
- Cross training and creative staffing models
- Increase level of automation to reduce reliance on staff

Technology

- CMS Systems Updates and requirements (MARx changes)
- CMS Data Record Layout Changes and new files and codes without adequate notice
- CMS Systems still generating errors on MMR and TRR
- CMS Transmittals often requiring claims configuration changes to meet new requirements. Over 400 issued annually
- Reacting to Fee schedule adjustments and retroactive changes.
- Changes and enhancements to HEDIS reporting
- CMS required Part C&D reporting/required audits of reported data
- Internal resources competition with commercial business

Minimize Technology Challenges

- Place an Emphasis on MA/MAPD equal to the Commercial products with IT staff dedicated to MA/MAPD to address dynamic changes
- Move away from home grown applications
- Select systems and partners dedicated to addressing MA changes expeditiously
- Outsource Systems to a partner that will provide focus on MA needs

Financial Risks

Financial Risks

- CMS Reimbursements
  - Decrease for 2010
- Risk Adjustment Premium Data Reporting
- PDE Data Reporting - $$$
- Member Premiums
- Provider Network Contracting
- BID Submission Accuracy
- Administrative Economies of Scale
  - $38 PMPM to $71 PMPM(9% to 12%)
  - SNP $109 PMPM
- Medicare Medical Loss Ratios
  - 85% to 100+%

Minimize Financial Risks

- Institute a compliance-driven approach to correct coding of claims including a quality-clinical based approach to stimulate a reward for correct coding
- Profile Providers to identify “lazy coder” by comparison to peers and statistical norms
- Implement a developed, focused & robust Medicare medical management and care coordination programs
- Measure financial performance over multiple years to account for shifts in reimbursements
- Consider lowering administrative costs by outsourcing functions to obtain savings through volumes and expertise

Compliance Risks and Challenges

Compliance Risks

- Increased CMS operational oversight & monitoring including but not limited to:
  - Appeals and Grievances
  - Marketing Issues
  - Formulary and P&T Requirements
  - Claims Denial language
  - "Secret Shopper" program
  - Auditing Changes
  - CTM Complaints
- Increased congressional oversight & pressure on CMS
- Increased Public/Press Scrutiny

Compliance Risks

- DOI Wants More Oversight
- Fraud Waste and Abuse Prevention Measures
- HIPAA/HITECH Security Requirements
  - Requirement to report to CMS
- Whistle Blower Qui Tam Actions
- Increased CMS Service Level Standards
  - Transmission of enrollments or disenrollments to CMS
  - RFI deadlines
  - Customer Service call statistics and hours of operation
  - Secret shopper and data to monitor Customer Service
- OIG 2010 Work Plan

Paradigm Shift in CMS Auditing

- CMS will no longer audit on a 3 year cycle
- Risk identification drives compliance oversight
- May be either desk or onsite audit
- Intent to audit to include the largest volume of members during a plan year
- CMS committee meets during third quarter to plan subsequent year audits
- CMS will also identify compliance concerns and issue and publish an Ad HOC Compliance Event

CMS – Power of Analytics
Nine Performance Dimensions

Tracked by CMS to determine the plan risk for non-compliance

- Compliance Letters (letter of non-compliance or warning letter)
- Performance Metrics (Star Ratings)
- Part C Routine Audit CAPS
- Multiple Ad Hoc CAPS
- Beneficiary Impact of Problems
- Financial Instability
- Disruptive Mutual Terminations
- Enforcement Actions
- Open, Significant Problems

Reorganization Creates New Oversight Group

- Program Compliance and Oversight Group
  - Advises that there will be increased scrutiny
  - Monitoring any data “they can get their hands on”
- Action based on data to which CMS has visibility
  - Intent is that action taken when risk is minimal
- No longer providing auditing tools
- Audits will go beyond any available auditing guide

Ad Hoc Compliance Findings

Letter from CMS based on ad hoc finding

Within 30 days of the date of this letter, you must submit a corrective action plan (CAP) that
(1)fully describes the actions you will take to correct each deficiency,
(2)include the date by which you expect the deficiency to be corrected,
(3)describe how you will conduct ongoing compliance monitoring, and
(4)include your revised polices and procedures

Example: Jan 2007-June 2008 Data and Ad Hoc CAPs and Warning Letters*

Basis for Action	CAP	Warning Letter
Data-Driven	0	377
Ad Hoc	72	26
Combined	72	405

* Slide from 2009 CMS Enrollment and Payment Conference, Medicare and Part D Compliance Oversight and Monitoring Overview

Star Ratings/CMS Published Plan Comparisons

CMS Star Ratings: Customer Services

Category	Data Source
Drug Plan Customer Service	This category shows how Medicare and members rate the drug Plan and how well a drug Plan provides Customer Service.
Time on Hold When Customer Calls Drug Plan	The drug Plan's "Customer Service for Current Members – Part D" phone number was monitored.
Calls Disconnected When Customer Calls Drug Plan	The drug Plan's "Customer Service for Current Members – Part D" phone number was monitored. T
Time on Hold When Pharmacist Calls Drug Plan	The drug Plan's "Pharmacy Technical Help Desk" phone number was monitored.
Calls Disconnected When Pharmacist Calls Drug Plan	The drug Plan's "Pharmacy Technical Help Desk" phone number was monitored.
Complaints about the Drug Plan	Data comes from Medicare's Complaints Tracking Module (CTM). These rates represent the number of complaints received for every 1,000 people enrolled in the drug Plan (based on Medicare enrollment records), pro-rated to a 30-day basis.
How Helpful Is Your Plan When You Need Information	Data comes from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
Rating of Drug Plan	Data comes from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

CMS Star Ratings: Using your plan to get prescriptions filled

Category	Data Source
Using Your Plan To Get Your Prescriptions Filled	This category shows how well drug Plans make prescription drugs available to their members.
Getting Prescriptions Easily	Data comes from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey information was collected between April 1, 2007 and June 30, 2007.
Pharmacists Have Up-to-date Plan Enrollment Information	The percentage includes the total number of enrollees who have complete records provided by the drug Plan out of all drug Plan enrollees in Medicare's enrollment records. Data comes directly from Medicare's Management Information Integrated Repository (MIIR) database.
Pharmacists Have Up-to-date Information on Plan Members Who Need Extra Help	The percentage includes the total number of LIS enrollees who have complete records provided by the drug plan out of all drug plan LIS enrollees. The data used for this measure come directly from Medicare enrollment records.
Complaints about the Plan's Benefits and Access to Prescription Drugs	Data comes from Medicare's Complaints Tracking Module (CTM). These rates represent the number of complaints received for every 1,000 people enrolled in the drug Plan (based on Medicare enrollment records), pro-rated to a 30-day basis.
Complaints about Joining and Leaving the Plan	Data comes from Medicare's Complaints Tracking Module (CTM). These rates represent the number of complaints received for every 1,000 people enrolled in the drug Plan (based on Medicare enrollment records), pro-rated to a 30-day basis.
Delays in Appeals Decisions	The data comes from a third party reviewer (also known as the Independent Review Entity or IRE). The IRE evaluates Part D appeals after the drug Plan's review. A rate of IRE cases reviewed, because the drug Plans did not make a timely decision, is calculated per 10,000 people enrolled in the drug plan (based on Medicare enrollment records).
Reviewing Appeals Decisions	A percentage of cases in which the IRE agreed with the drug Plans' decision are displayed. "No Appeals Required Review" means that the appeals for these drug plans did not reach the IRE for review.

CMS Star Ratings: Other

Category	Data Source
Drug Pricing Information	This category shows how well drug Plans are doing with pricing prescriptions and providing information on the Medicare website.
Availability of Drug Coverage and Cost Information	The data used for this measure come from price files that drug Plans submit for display on Medicare's website (also known as Medicare's Prescription Drug Plan Finder).
How Often the Plan's Drug Prices Change	The data used for this measure come from price files that drug Plans submit for display on Medicare's website (also known as Medicare's Prescription Drug Plan Finder).
Complaints about the Plan's Drug Pricing and Out-of-pocket Costs	Data comes from Medicare's Complaints Tracking Module (CTM). These rates represent the number of complaints received for every 1,000 people enrolled in the drug Plan (based on Medicare enrollment records), pro-rated to a 30-day basis.
Helping You Stay Healthy	Survey of Medicare health plan enrollees in 2007 + clincial quality data collected from MC health plans in 2006.
Getting Care from Your Doctors and Specialists	Survey of Medicare health plan enrollees in 2007 + clincial quality data collected from MC health plans in 2006.
Managing Chronic (Long-Lasting) Conditions	Clinical quality data collected in 2006 from Medicare health plans. The results have been independently validated.
Getting Timely Information and Care from Your Health Plan	Survey of Medicare health plan enrollees in 2007 + clincial quality data collected from MC health plans in 2006.
Your Rights to Appeal	Independent Review Entity (IRE)

Financial Audit

CMS Financial Audit: Goals and Objectives

- **Solvency**
  - To evaluate the MAOs and PDPs ability to bear the risk of potential financial losses. This section will include a review of organizations' current financial information for indicators of insolvency.
- **Risk Scores Review**
  - To verify the accuracy of a MAOs self-reported diagnosis data submitted for risk adjustment and used to determine CMS payment amounts. This section will include a review of a sample of medical records to verify whether the ICD-9 diagnosis codes submitted to CMS are supported by documentation in enrollee medical records..

CMS Financial Audit: Goals and Objectives

- **Related Party Transactions**
  - To identify and ensure that MAOs and PDPs significant related party transactions included in the bid are properly reported. This section will include a verification that claimed costs associated with related organizations (parties) i) do not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere and ii) are allocated on an equitable basis.
- **Direct Medical and Administrative Costs**
  - To verify that i) historical expenses reported on the bid are valid, proper, and correct and ii) allocated on an equitable basis.
- **Regional Preferred Provider Organizations (RPPOs)**
  - To ensure that the elements of actual allowed medical expenses, allowed medical revenue, and supporting data included in the risk-sharing reconciliation i) are properly classified; ii) represent activities significantly related to the provision of medical services; iii) are allocated on an equitable basis ; and iv) are correct with respect to risk-sharing computations.

CMS Financial Audit: Goals and Objectives

- **Part D Costs and Payments**
  - To determine whether Part D benefits are properly administered and reported costs are adequately supported. This section will include obtaining the PDE data and reviewing the MAOs or PDPs supporting documentation.
- **Direct/Indirect Remuneration (DIR)**
  - To ensure that DIR reported to CMS is correct and properly allocated This section will include a review of MAOs and PDPs DIR supporting documentation.
- **True Out of Pocket Costs (TrOOP)**
  - To verify that TrOOP costs are properly calculated. This section will include a verification of TrOOP cost calculations for a sample of beneficiaries transferred in and out of plans as well as beneficiaries under the catastrophic coverage.

Fraud Waste and Abuse

Fraud Waste and Abuse

- Training
  - Upon Hire and Annual
  - Specialized and Generalized
- Conflict of Interest
- Confidentiality
- Code of Conduct
- Program to identify Potential Fraud
- Exclusion Checks
  - OIG/GSA
- First Tier and Downstream Entity Oversight

2010 OIG Workplan

2010 OIG Workplan

- Includes 10 Part C and 28 Part D elements
  - Appears to shift the audit from a direct audit of CMS oversight to direct OIG audit of the plan
  - Descriptions high level difficult to tell what will be audited
  - No indication of timelines

Minimize Compliance Risks

- Create a Culture of Compliance
- Reward Compliance – performance evaluations
- Establish Operational Compliance Teams
- Continuous Training and Education
- Monitor Customer Contacts and CTM
- Publish Key Compliance Statistics Daily, Weekly and Monthly to staff
- Document all internal CAP to address any deficiencies
- Closely Monitor CMS Actions
  - CMS Web Site
  - Audits of Other Plans/Published CAP
- Understand Qui Tam actions and what to do if you are visited by federal investigators

Steps to take

- Monitor findings on CAP reports
  - http://www.cms.hhs.gov/MCRAdvPartDEnrolData/CAP/
- Make a comprehensive list of everything CMS is looking at
- Perform an internal risk assessment of every element that CMS is monitoring
- Prioritize and take action

Summary – Anticipate and Plan for Risks to Survive

- Medicare Health Plans need Agility, Innovation and Flexibility to Survive in Today's Market
  - Information systems need to be adaptable, flexible and responsive to new demands
  - Operational processes need to be flexible to accommodate new requirements
  - Flexible staffing models are needed to accommodate fluctuations in seasonal, open enrollment and one-time demands
  - Data analysis to monitor, assess and report the effectiveness and efficiency of operations are critical to survival
  - Monitor what CMS is monitoring. Get ahead of the problems that could trigger audit.

Putting It All Together

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