STATE OF COMPLIANCE
WHO IS GORMAN HEALTH GROUP?

*Gorman Health Group* is the leading solutions and consulting firm for government-sponsored health programs.

**Government Programs**
Leading enterprise of national consulting services and software solutions for payers and providers.

**Our Mission**
Our mission, as the industry’s most active professional services consultancy and provider of technology-based solutions, is to empower health plans and providers to deliver higher quality care to beneficiaries at lower costs, while serving as valued, trusted partners to government health agencies.

**Washington, DC**
Headquartered in Washington, DC with more than 200 staff and contractors nationwide with over 2,000 combined years of Government Programs experience.

**Leadership**
Deep payer and provider knowledge coupled with Centers for Medicare & Medicaid Services (CMS) regulatory expertise.

**Privately Owned**
Founded in 1996
BROAD SERVICES

Our clients have one-stop access to expert advice, guidance, and support, in every strategic and operational area for government-sponsored programs, across seven verticals.

CLINICAL
Changing how you approach Medical Management, Quality and Stars

PHARMACY
Leading experts in Part D, PBM, formulary and pharmacy programs

HEALTHCARE ANALYTICS & RISK ADJUSTMENT SOLUTIONS
Implementing cross-functional risk adjustment programs for medical trend management and quality improvement

PROVIDER INNOVATIONS
Supporting network design and medical cost control implementation

COMPLIANCE
Offering guidance and support in every strategic and operational area to ensure alignment with CMS

OPERATIONS
Bringing excellence to every aspect of your implementation from enrollment to claims payment

STRATEGY & GROWTH
Leading experts in Marketing, Sales and Strategy development that create short and long-term profitable growth
MEDICAID SERVICES

Dedicated to assisting Medicaid Managed Care Organizations achieve strategic, operational and quality goals across five verticals.

CLINICAL
Blending medical and pharmacy to improve care coordination, outreach and utilization management to meet the complex needs of your membership.

FINANCIAL ALIGNMENT
Providing health economic solutions for the needs of the Medicaid population including long-term care, behavioral health, and chronic condition management.

STRATEGIC POSITIONING
Analyzing and evaluating organizational adaptability, and readiness for change in new policy and population management environments.

QUALITY PROGRAM OVERSIGHT
Guidance and support to achieve the results your members and regulators expect while attaining compliance with State and Federal rules.

OPERATIONS
Creative solutions to maximize cost effectiveness, and deliver lasting results from eligibility to provider contract management, and claims.
TODAY’S AGENDA

• CMS Audit Scope: 2012 – Present
• Compliance and Operational Risks – CMS Compliance Findings
• 7-year Look-back: CMS Compliance Actions
• Star Ratings/Compliance Correlation
• Conclusions
EVOLUTION OF CMS AUDITS

Fundamental Shift Began in 2010

- Compliance environment utterly changed since 2010
- More outcome oriented
- Focused on specific areas of beneficiary impact
- Conducted at parent organization level
- Voluminous documentation requests
OUTCOME ORIENTED

- Civil Monetary Penalties (CMPs) and sanction trends have serious implications
- Issues with beneficiary impact are the clear focus
- Compliance issues are symptoms of operational disease
## 2012 Audit Scope

1. Part D Formulary Administration  
2. Coverage Determinations, Appeals and Grievances (CDAG)  
3. Organization Determinations, Appeals and Grievances (ODAG)  
4. Part C Access to Care  
5. Compliance Program  
6. Outbound Enrollment Verification (OEV)  
7. Part C and D Agent Broker Oversight  
8. Part C and D Enrollment/Disenrollment/Late Enrollment Penalty (LEP)
# EVOLUTION OF CMS AUDITS

<table>
<thead>
<tr>
<th>2013 Audit Scope</th>
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<tbody>
<tr>
<td>1. Part D Formulary Administration</td>
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<td>2. CDAG</td>
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<td>4. Compliance Program</td>
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<td>5. OEV</td>
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<td>6. Special Needs Plan – Model of Care (SNP-MOC), if applicable</td>
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## EVOLUTION OF CMS AUDITS

### 2014 Audit Scope

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<td>SNP-MOC, if applicable</td>
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## EVOLUTION OF CMS AUDITS

### 2015 Audit Scope

1. Part D Formulary Administration
2. CDAG
3. ODAG
4. Compliance Program
5. SNP-MOC, if applicable
6. **Medication Therapy Management (PILOT)**
7. **Provider Network Adequacy (PILOT)**
MOST PERVERSIVE COMPLIANCE AND OPERATIONAL RISKS

Review of All MA Sanction andCMP Letters, 2012-2015

- Documentation
- Timeliness
- Beneficiary Communications
- Notifications
- Misclassification of appeals and grievances
- Benefit Testing and Rejected claims review
- Clinical decision-making
- Model of Care
- FDR oversight
- Compliance risk management
LACK OF DOCUMENTATION

- Failure to *demonstrate* that compliance training is provided upon hire and annually thereafter to Board members, senior management, and employees.

- Failure to *demonstrate* the establishment and implementation of a system for monitoring and auditing Compliance Program effectiveness.
TIMELINESS

• Sponsor failed to forward untimely coverage determinations and redeterminations to the Independent Review Entity (IRE) within the required time frames.

• Sponsor did not mail written confirmation of determinations within 3 calendar days after first providing oral notification of expedited coverage determinations or redeterminations.

• Sponsor failed to notify enrollees of the resolution of grievances within CMS-required timeframes.
BENEFICIARY COMMUNICATIONS

• Grievance resolution letters failed to provide enrollees with written notice of their right to file with, and the contact information for, the Quality Improvement Organization (QIO).
• Denial letters did not include a denial rationale written in a manner that was clearly understandable by beneficiaries.
• Sponsor provided inaccurate or incomplete information in grievance resolution letters.
NOTIFICATION

• Sponsor did not notify beneficiaries or their prescribers of its decisions within 7 days of receipt of standard redetermination requests.

• Sponsor did not notify beneficiaries or their prescribers of its decisions within 72 hours of receipt of expedited redetermination requests.

APPROVED
MISCLASSIFICATION

- Sponsor misclassified organization determination or reconsideration requests as grievances.
- Sponsor misclassified coverage determination or redetermination requests as grievances.
BENEFIT TESTING AND REJECTED CLAIMS REVIEW

- Failure to properly administer the CMS transition policy.
- Failure to properly administer its CMS-approved formulary (i.e., by applying unapproved utilization management (UM) practices, prior authorizations (PAs), or quantity limits (QLs), or rejecting formulary medications as non-formulary).

TRUST but verify
—Ronald Reagan
• Sponsor did not demonstrate sufficient outreach to prescribers or beneficiaries to obtain additional information necessary to make appropriate clinical decisions.

• Sponsor’s Medical Director failed to oversee Part D coverage determinations and appeals effectively.

• Medical Director did not ensure the clinical accuracy of coverage determinations and redeterminations involving medical necessity.
MODEL OF CARE (MOC)

• Failure to verify the beneficiary’s dual eligibility prior to enrollment in the Dual Eligible Special Needs Plan (D-SNP).
• Failure to maintain records that the sponsor sent a seamless conversion notice to D-SNP beneficiaries.
• Failure to administer the initial health risk assessment (HRA) to beneficiaries within 90 days of their enrollment.
FDR OVERSIGHT

• Failure to establish and implement a system for routine monitoring of FDRs to ensure compliance with CMS regulations.

• Failure to establish and implement a system for auditing of FDRs to ensure compliance with CMS regulations.
COMPLIANCE RISK MANAGEMENT

- Lack of sufficient Compliance oversight of day-to-day operations.
- Lack of Board of Directors (BOD) reporting related to compliance risk.
- Lack of resources and attention provided by the BOD and CEO to address and remediate non-compliance.
Q1 What do you consider to be your Organization’s “top” Compliance Program risk?

- Documentation
- Sufficient Auditing & Monitoring
- FDR Oversight
- High-Level Oversight
Q2. What do you consider to be your Organization’s “top” Operational Compliance risk?

- Appeals & Grievances (Part C)
- Appeals & Grievances (Part D)
- Rejected Claims
- Misclassification of Initial Determinations and Redeterminations
- Clinical Decision-Making
Q3 What do you consider to be the biggest contributing factor to your Organization’s compliance risks?

Lack of Subject Matter Expertise
Lack of Compliance Oversight
Lack of Resources
Lack of High-Level Oversight
STAR RATINGS IMPACT

• Contracts under an enrollment sanction are automatically assigned 2.5 stars for their highest rating. If a contract under sanction already has 2.5 stars or below for their highest rating, it will receive a 1-star reduction. Contracts under sanction will be evaluated and adjusted at two periods each year.

Source: Medicare 2015 Part C & D Star Rating Technical Notes
# 7-YEAR LOOK-BACK

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PLEASE NOTE: THIS DATA IS BASED ON WHEN THE ACTION WAS IMPOSED AND NOT THE PROGRAM AUDIT YEAR

Source: CMS.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Part-C-and-Part-D-Enforcement-Actions-.html
*April 2015
CONCLUSIONS

• Compliance environment has evolved dramatically in last 5 years.
• Compliance violations have correlation to and enormous impact on Star Ratings.
• Most common violations are in consumer protection and delegate performance.
• Sound operations means few/no compliance issues. Treat the disease, not the symptoms.
Gorman Health Group, LLC (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Exchange opportunities. For nearly 20 years, our unparalleled teams of subject-matter experts, former health plan executives and seasoned health care regulators have been providing strategic, operational, financial, and clinical services to the industry, across a full spectrum of business needs. Further, our software solutions have continued to place efficient and compliant operations within our client’s reach.

GHG offers software to solve problems not addressed by enterprise systems. Our Valencia™ software reconciles the capitation payment of more than six million Medicare beneficiaries and continues to support customers participating in the Health Insurance Exchanges. Nearly 3,000 compliance professionals use the Online Monitoring Tool™ (OMT), our complete Medicare Advantage and Part D compliance toolkit, while more than 45,000 brokers and sales agents are certified and credentialed using Sales Sentinel™. In addition, hundreds of health care professionals are trained each year using Gorman University™ training courses.

We are your partner in government-sponsored health programs