ODAG & CDAG WORKSHOP

The GHG Forum – Las Vegas

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April 26, 2018
INTRODUCTIONS

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TODAY’S SESSION OBJECTIVES

Provide our bird’s-eye view and first-hand accounts of the following:

- Common Missteps When Preparing for Program Audits
- Strategies for Improving:
  - Documentation
  - FDR Performance
  - Provider Engagement
- Data Validation Audit Preparation
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – RESOURCES

Preparing for, and enduring, a CMS program audit requires a small army of soldiers. Do not underestimate the need for resources:

- Scheduling
- Communication (internal/external)
- CMS Document Requests
- Quality Checks
- CMS Submissions
- Mock Scenarios (prep)
- Research
- Presenter
- Understudy/Backup
- System Driver
- Screenshots
- Documentation (case notes; daily summary)
- Technology
- External (consultants)

A successful audit experience relies on everyone taking the initiative and working to prepare. Compliance will also be audited, and like Operations, needs time to prepare.
Things to consider **before** the audit engagement letter arrives:

- Conduct mock audits at regular intervals
- Develop a playbook: determine the players and their assignments
- Engage leadership so they have an understanding of the process and resources required
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – UNIVERSES

- It is not uncommon for universes to require manual intervention
  - Each intervention brings additional risk (typos, versioning, etc.)
- Begin universe development immediately upon receipt of the audit engagement letter
- Ask clarifying questions of your CMS audit team in real time—better to ask questions than have a universe fail
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – **UNIVERSES** (CONTINUED)

- Have SMEs mine the universe data:
  - Are identified grievances, within the time frame dictated, found in the call log universe?
  - Are there blank universes? Is that accurate?
    - For example, if there are 5,000 denied NCP claims in ODAG Table 3 (Claims), why is Table 7 (PREC) blank?

- Universes will tell a story of compliance or non-compliance
  - Identify the issues before your auditor does
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – **UNIVERSES** (CONTINUED)

- Common ODAG Universe Issues:
  - Including only *successful* oral outreach attempts in a universe
  - Part D calls and/or grievances in the Part C universes
  - Effectuation date for denied requests
  - Effectuation date before decision date
  - Incorrect reimbursement date
  - “N/A” for AOR received date when a POA is on file
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – UNIVERSES (CONTINUED)

○ Common CDAG Universe Issues:
  o Many issues are the same as with ODAG
    ▪ Effectuation time/date, AOR, etc.
  o Medical necessity denials are not populated correctly (interpretation of medical necessity)
  o Exception approvals without a prescriber’s supporting statement
  o Exception effectuations not populated through end of plan year
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – **UNIVERSES** (CONTINUED)

Things to consider before the audit engagement letter arrives:

- Can we compile all universes?
- Have they been validated?
- If there are FDRs, can they compile the universes?
  - Have they been validated?
- Have FDRs had universe-related findings in other program audits?
  - If so, have they been remediated?
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – TIME FRAMES

- During the audit weeks, time frames for submission are short
- At the end of each audit day, you will receive a document request list (DRL), likely from each audit team
- Most often, documentation requested is due by 5 pm ET the following day
  - Why is this important? Remember, your teams are engaged in audit meetings all day. When do you find the time to pull together documentation?
    - This ties back to the need for resources
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – PRESENTATION

- Be prepared to show ALL documentation related to the case within your live system of record and any related hard copies:
  - Original claim/prior auth request/appeal/reimbursement, including date/time stamp
  - If an appeal, the original request; denial decision including rationale; and the denial letter
  - The POA/AOR on file, as applicable
  - Internal notes
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – PRESENTATION (CONTINUED)

When presenting cases, follow the chronology of the universe
• Present the case demonstrating the activities that occurred, in proper order

Ensure all appropriate players are in the room:
• Claims
• Grievances & Appeals
• Quality Management (call log and grievances)
• Utilization Management (UM)
• FDRs (for their cases)
• Medical Director for CDMs
COMMON MISSTEPS WHEN PREPARING FOR PROGRAM AUDITS – PRESENTATION (CONTINUED)

- Ensure the computer being used for case presentation has access to all required systems:
  - Call Track
  - Claims
  - Fulfillment Vendor
  - Grievances & Appeals
  - PBM
  - UM
STRATEGIES FOR IMPROVEMENT – DOCUMENTATION

- Documentation is critical to a successful audit
- Always document all activities as if they were under an auditor’s scrutiny:
  - Receipt date/time
  - Mail dates
  - Outreach attempts (oral, fax, mail, email, etc.)
  - Decisions and criteria
  - Internal notes (e.g., forwarding a grievance to Quality for review)
  - Requests for supporting documentation and/or AOR
STRATEGIES FOR IMPROVEMENT – FDR PERFORMANCE

Ensure FDRs are included in audit activities outside of the program audit

- How do they present cases?
- Can the presenter speak to processes?
- Can the presenter speak to downstream entity processes?
  - For example, fulfillment vendor
- Do they have the ability to provide scanned, original documentation?
- Do they speak “CMS’ language”?
Some FDRs offer mock audit services.
• While this offering adds to audit universe and webinar preparedness, be mindful of any self-policing.
• Sponsors should conduct mock audits outside of FDR-driven activities to identify compliance issues.

Sponsor diligence in oversight activities is a key component of preparedness.

Remember: their success is your success, and their struggles are your struggles.
STRATEGIES FOR IMPROVEMENT – PROVIDER ENGAGEMENT

- Engage network providers in order to reduce potential audit findings. For example, continuing education of the following:
  - Prior authorization process
  - Supporting documentation necessity
  - Expedited request criteria
  - Provider portal availability
  - Appeals process

- Include decision-making clinicians in mock audit activities.

- Do you have a web-based provider portal? This can be an effective tool in having providers attest to and update directory information.
DATA VALIDATION AUDIT PREPARATION –
THE FOCUS

Unlike program audits, data validation audits are highly technical in nature.

There are two guiding principles to the data validation audit:

• Adequacy of processes in place
• Integrity of reported data from source systems

What types of things are reviewed:

• Programming code
• Saved data queries
• Documented macros
• Version control
• Security
• Workflows
DATA VALIDATION AUDIT PREPARATION – HOW TO BE BEST PREPARED

- As with program audits, conduct a mock data validation audit
  - IT personnel are not accustomed to speaking with auditors
  - Ensure they have an understanding of the interview process and can speak to system workflows
- Documentation (evidence) is critical to success
  - P&Ps, workflows, business requirements documents (BRDs) will help best demonstrate system processes
- Ensure there is some oversight by IT
  - Test the processes and have evidence of testing
ODAG:

- Star Measures
  - Scaled reductions to star measure ratings for appeal IRE data completeness

- Validation Audits
  - CMS is excluding CPE conditions in its threshold for determining whether or not a sponsoring organization will be required to hire an independent validation auditor as a result of program audits conducted in 2019
  - CMS is moving forward with enhancements to its guidance related to independent auditor conflicts and a template validation audit work plan
CDAG: Part B versus Part D

- Confirms the use of best available information
  - Immunosuppressants for transplant rejection
    - MARx or Additional Beneficiary Information Initiatives (ABII) are the source of truth
    - If there is no information from CMS (MARx or ABII), the plan should default to covering the immunosuppressants
  - Inhalation Durable Medical Equipment (DME) drugs
    - The DME benefit is not available to beneficiaries residing in long-term care (LTC)
    - Plan sponsors are required to report residence codes on prescription drug events (PDEs)
      - Patient residence code of 3 or 9 used for LTC
CDAG (continued):

- **Part D Tiering Exceptions**
  - Elimination of provision to exclude generic tier from the tiering exceptions process
  - Establish framework based on the type of drug (brand, generic, biologic) and cost-sharing of applicable alternative drugs
  - Clarified that cost-sharing for approved requests is the lowest applicable tier when alternatives on multiple lower tiers
  - Authorized generics are treated as generics for the purpose of tiering exceptions

- **Part D Redeterminations and IRE Reconsiderations**
  - Lengthened existing timeframes for adjudicating enrollee payment appeals requests at the redetermination and IRE reconsideration levels from 7 to 14 calendar days.
CDAG (continued): Opioid Management

- New tools available to fight overutilization and abuse
- Part D Sponsors must implement a hard safety edit to limit opioid prescriptions for acute pain to no more than a 7-day supply
  - Required to notify its network pharmacy to distribute a written copy of the Medicare Prescription Drug Coverage and Your Rights notice
  - Right to request a coverage determination from the plan for a drug or drugs subject to the days’ supply limit
  - Part D Sponsors are expected to implement:
    - Real-time safety edits to engage members and prescribers about overdose risk and prevention;
    - An opioid care coordination edit at 90 morphine milligram equivalents per day; and
    - Additional “soft” safety edits to alert pharmacies about duplicative opioid therapy and concurrent use of opioids and benzodiazepines.
QUESTIONS?
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
## 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 eight verticals

<table>
<thead>
<tr>
<th>Vertical</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>CLINICAL</strong></td>
<td>Pairing clinical teams with innovation to provide patient-centered care</td>
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<tr>
<td><strong>PHARMACY</strong></td>
<td>Leading experts in Part D, Pharmacy Benefit Manager, formulary, and pharmacy programs</td>
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<tr>
<td><strong>HEALTHCARE ANALYTICS &amp; RISK ADJUSTMENT SOLUTIONS</strong></td>
<td>Implementing cross-functional risk adjustment programs for medical trend management and quality improvement</td>
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<td><strong>PROVIDER STRATEGIES</strong></td>
<td>Supporting network design and medical cost control implementation</td>
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<td><strong>COMPLIANCE</strong></td>
<td>Offering guidance and support in every strategic and operational area to ensure alignment with CMS</td>
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<tr>
<td><strong>OPERATIONS</strong></td>
<td>Bringing excellence to every aspect of your implementation — from enrollment to claims payment</td>
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<tr>
<td><strong>STAR RATINGS &amp; QUALITY INNOVATIONS</strong></td>
<td>Strategic innovations to drive quality and improve performance</td>
</tr>
<tr>
<td><strong>SALES, MARKETING &amp; STRATEGY</strong></td>
<td>Driving profitable growth and member retention through strategic marketing, sales, and product development</td>
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Software solutions to stay compliant, maximize revenues, and manage complex processes

**Sentinel Elite™**

Sentinel Elite™ is a module-based software solution designed to assist government managed care organizations onboard agents, provide training, manage ongoing oversight activities, and pay commissions effectively and compliantly.

**Valencia™**

Valencia™ provides rigorous, compliant, and transparent workflow controls that ensure your operational processes — and the resulting payment — are as accurate as possible.

**OMT™**

OMT™ is a complete compliance toolkit that supports the complete organization by bringing a new level of transparency to performance monitoring, including the required oversight of delegated entities.

**CaseIQ™**

CaseIQ™ not only captures all of the data points needed to categorize, work, and report MA and Part D appeals and grievances, it also guides case processors through each case to minimize the risk of non-compliance due to user error.

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Gorman University™ provides training sessions on a variety of industry topics, each designed to meet the unique needs of your organization.

**The Insider**

The Insider provides in-depth analysis and expert summaries of the most critical legislative and political activities impacting and shaping your organization and the future of Medicare, Medicaid, and the Health Insurance Marketplace.
Gorman Health Group (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Exchange opportunities. Since 1996, our unparalleled teams of subject matter experts, former health plan executives, and seasoned healthcare regulators have been providing strategic, operational, financial, and clinical services to the industry across a full spectrum of business needs. Our mission is to empower health plans and providers, through a compliant, member-centric focus, to deliver higher quality care to members at lower costs while serving as valued, trusted partners.

Further, our software solutions have continued to place efficient and compliant operations within our clients’ reach. Our Valencia™ software provides rigorous, compliant, and transparent workflow controls that ensure your operational processes – and the resulting payment – are as accurate as possible. Sentinel Elite™ is our module-based software solution designed to assist government managed care organizations onboard agents, provide training, manage ongoing oversight activities, and pay commissions effectively and compliantly. Our Online Monitoring Tool™ (OMT) is the complete Medicare Advantage and Part D compliance toolkit, designed to perform ongoing monitoring and auditing, manage regulatory notices, document corrective actions, and streamline member material review. CaseIQ™ brings clarity to appeals and grievances and offers a new way to ensure your cases come to a compliant resolution. We also offer training courses on a variety of industry topics designed to meet the unique needs of your organization through Gorman University™, and our exclusive daily digest, The Insider, provides in-depth analysis and expert summaries of the most critical legislative and political activities impacting and shaping your organization.

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We are your partner in government-sponsored health programs.

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