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CENTER FOR MEDICARE

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To: All Medicare Advantage Organizations and Prescription Drug Plans

From: Gerard Mulcahy, Director
Medicare Parts C and D Oversight and Enforcement Group

Subject: Best Practices and Common Findings Memo #2 from 2012 Program Audits

In the course of conducting audits and best practices reviews, the Centers for Medicare & Medicaid Services (CMS), Medicare Parts C and D Oversight and Enforcement Group (MOEG), formerly the Program Compliance and Oversight Group (PCOG), has observed Medicare Advantage (MA) organizations and Part D Sponsors demonstrate excellence in operations and achieve strong results. CMS also identified program areas where numerous Sponsors are non-compliant with Medicare regulations and guidance. This memo seeks to share the best practices and common findings identified through the course of conducting audits and best practice reviews during 2012. In addition, this memo provides CMS' recommendations within each program area, as well as feedback and advice from previously audited Sponsors on how to best prepare for an audit.

On September 10, 2012, MOEG issued a Health Plan Management System (HPMS) memo entitled, 'Best Practices and Common Findings from 2012 Program Audits' that included the best practices and common findings identified as of the date of its release. This document supplements the earlier memo. The "*" (asterisk) next to a finding indicates that it is a new common finding **not** identified in our earlier memo. A finding is considered common when it occurs in at least 4 of the conducted audits.

Our audits in 2012 reviewed Part D formulary and benefits administration; Part D coverage determinations and appeals, and grievances; Part C organization determinations and appeals, and grievances; Part C access to care; Part C and D compliance program effectiveness; Part C and D agent and broker oversight; Part C and D enrollment and disenrollment; and Part D late enrollment penalty (LEP). Attachment A shares best practices and common findings for each of these areas. We hope that sharing this information will help all Sponsors focus their internal monitoring and auditing efforts to help ensure these deficiencies are prevented before they occur or corrected if they exist.

CMS expects all Sponsors to carefully and routinely assess risks to their organization and monitor and audit their operations to ensure compliance with CMS requirements. Sponsors should review this memo with their compliance staff, compliance committee, and other affected stakeholders and take appropriate action. Additionally, CMS Account Managers (AM) will be discussing this memo with their Sponsors shortly.

If you have any questions regarding the audit findings or best practices, please submit your inquiry to part_c_part_d_audit@cms.hhs.gov. CMS will also be available to address questions during the Part C and Part D User Call scheduled for September 11, 2013.

PRESCRIPTION DRUG FORMULARY ADMINISTRATION

Best Practices

1. **Pharmacy Messaging**
   Clear communication between the Part D sponsor and dispensing pharmacy is critical in ensuring beneficiary access to Part D-eligible prescribed medications. These processes allow the pharmacies to assist beneficiaries in resolving claim rejections, and can prevent delays in medication therapy. We observed the following:

   - Clear pharmacy messaging for step therapy rejections, which allows for more efficient processing of claims.
   - Utilization of detailed secondary reject messaging to provide dispensing pharmacies with detailed instructions on the steps required for resolving applicable claims rejections. For example, override codes are needed to process claims once the pharmacist verifies the submitted prescription.

2. **Cost Edits**
   CMS has noted that some sponsors set maximum cost edits that are based on usual and customary pricing for standard dosing regimens which results in beneficiaries receiving prescribed medications in a timelier manner. For example, drug X is normally dosed as one tablet daily and the usual and customary price for 30 tablets is $1500. The sponsor would set the maximum cost edit for drug X above $1500 to avoid claim rejections for a standard dose. As noted in the October 22, 2010 HPMS memo titled "CMS Part D Utilization Management Policies and Requirements" CMS expects that maximum cost edits can be overridden by the pharmacist once the correct quantity or dosage is confirmed with the prescriber and Part D sponsor.

Common Findings

In the area of Formulary Administration, Sponsors must ensure that beneficiaries receive the Part D drugs they are entitled to consistent with CMS guidance. Several Sponsors were unable to properly administer their CMS approved formulary and comply with transition requirements. CMS reminds Sponsors that it is their responsibility to understand CMS requirements, oversee the pharmacy benefit manager (PBM) and ensure that the PMB is operating consistent with CMS requirements. During the audits, CMS documented the following findings:

1. **Unapproved system edits.**
   Some Sponsors continue to fail to properly administer their CMS-approved formularies through the inappropriate use of unapproved edits. The specific edits that Sponsors must ensure are not in place include, but are not limited to:

- Unapproved quantity limits.
- Unapproved step therapy edits and/or criteria.*
- Inappropriate high cost edits that hinder beneficiary access.
- Improper effectuation of approved prior authorizations.
- Rejection of formulary medications as non-formulary.*

2. **Part B versus Part D coverage determinations**
   Failure to aggressively determine coverage under Part B versus Part D, causing an interruption in beneficiary access to medically necessary drugs, including drugs within the protected classes.*

3. **Part D Transition fills**
   Sponsors continue to inappropriately reject transition fills for non-formulary drugs, protected class drugs, and drugs subject to utilization management restrictions during beneficiaries' transition period for new and continuing enrollees. Sponsors must ensure beneficiaries have access to transition supplies. The following examples are errors in transition fill processing that were observed during the audits:

   - Failure to provide a required transition supply of medications that were removed from the formulary from one contract year to the next.*
   - Failure to provide a new beneficiary a transition supply of a medication with a CMS-approved prior authorization requirement.*
   - Failure to provide a new beneficiary a transition supply of a medication with a CMS-approved quantity limit.*
   - Failure to provide a new beneficiary a transition supply of a non-formulary medication.*
   - Failure to extend transition timelines for long term care beneficiaries.*

CMS Recommendations:

In addition to the above stated best practices, CMS recommends that Sponsors implement the following processes to ensure beneficiary access to care and compliance with CMS regulations:

- Ensure that the PBM does not administer the Part D benefit based on either Medicaid or commercial program requirements. CMS has observed that this practice leads to program non-compliance (e.g., inappropriate mandatory generic drug requirements).
- Perform regular review of rejected point of sale (POS) pharmacy claims. Reviewing a comprehensive set of claims on a daily basis is more likely to identify processing errors early and reduce beneficiary impact.
- Perform regular oversight of delegated PBM functions.
- Perform comprehensive testing of formulary file and system edits prior to going "live" in the adjudication system (e.g., compare the CMS approved formulary file to the adjudication file to ensure all drugs, tier information, and utilization management edits are consistent).

- Ensure that transition look-back logic accurately identifies transition beneficiaries and drugs that are eligible for transition fills.
- Disclose known issues to their CMS account manager in a timely manner.
- Provide outreach in a timely manner to all pharmacies experiencing rejections for non-matched National Provider Identifiers (NPIs).

PART D COVERAGE DETERMINATIONS, APPEALS, AND GRIEVANCES

Best Practices

1. **Ease of Beneficiary Access**
   Beneficiary access is easily impacted, in both positive and negative situations. CMS observed policies and systems that provide a sense of clarity, ease, and/or care to the beneficiaries at a level above the required or expected. In all instances, the beneficiary was able to continue care or drug use with little to no disruption. We observed the following:

   - A defined process for evaluation and effectuation of Part B versus Part D determinations allowed for seamless transitions for the beneficiary to receive necessary medications at point of sale with minimal disruptions.
   - Requests approved for 12 months, as CMS requirements permit, rather than through the end of the plan year even though it was not a requirement. This process helps beneficiaries avoid coverage determination requests during the busiest time of the plan year.
   - Prescriber confirmation on non-FDA approved dosages.
   - Referral to a social worker for beneficiaries experiencing financial hardship.

2. **Timeliness**
   Time stamping incoming faxes in the coverage determination system with the date and time received helps ensure that timeliness standards are tracked from the time the request was received rather than when entered into the system. The processing of all requests in a timely fashion allows for the highest level of beneficiary access.

3. **Effective Communication**
   Clear communication is critical to beneficiary access. CMS discovered that some Sponsors went above and beyond the expected level of communication to be sure that beneficiaries were well informed regarding all care concerns. We observed the following:

   - Providing oral notification, in addition to written notice, by calling all beneficiaries for all coverage determination approvals.
   - Member files are sent via Certified Mail requiring signature.
   - Expiration reminders on prior authorization forms.

Common Findings

In the area of Part D Coverage Determinations, Appeals, and Grievances, several Sponsors lacked adequate systems and processes for timely and accurate communication with beneficiaries about coverage determinations, appeals, and grievances. Several Sponsors also lacked adequate processes for effective and accurate classification of coverage determinations, appeals, and grievances. Sponsors must ensure coverage determinations, appeals, and grievances are handled in a meaningful and timely manner. During the audits, CMS documented the following findings:

1. **Noncompliance with Adjudication Timeframes and Processing**
   Sponsors continue to be untimely in effectuating determinations. Timeliness is imperative in ensuring beneficiaries receive access to necessary medications. We observed the following:

   - Failure to effectuate determinations within 24 hours of receipt of the expedited coverage determination requests.
   - Failure to effectuate determinations within 72 hours of receipt of the standard coverage determination requests.
   - Failure to effectuate determinations within 72 hours of receipt of the expedited redetermination request.
   - Failure to effectuate exception approvals through the end of the Sponsor year.*

2. **Noncompliance with Notification Requirements**
   Sponsors continue to inadequately communicate with beneficiaries. Beneficiaries must receive clear communications from Sponsors. We observed the following:

   - Failure to notify the beneficiaries or their prescribers of their decisions within 24 hours of receipt of an expedited coverage determination request.
   - Failure to notify the beneficiaries or their prescriber of their decisions within 72 hours of receipt of a standard coverage determination request.
   - Failure to notify the beneficiaries of their decisions within 7 days of receipt of a standard determination request.
   - Failure to effectuate its determination within 7 days of receipt of the standard redetermination request.
   - Denial letters did not include adequate rationale or contained incorrect information regarding the denial.

3. **Improper Classification and Processing of Requests**
   Sponsors continue to misclassify coverage determinations and redeterminations. Sponsors must appropriately classify and take appropriate action when processing requests. CMS observed the following findings:

   - Redeterminations were inappropriately classified as coverage determinations and vice versa.

- Insufficient outreach to the prescriber or beneficiary to obtain additional information necessary to make an appropriate clinical decision.
- Insufficient research to make an appropriate determination of coverage under Part B versus Part D.*
- Failure to appropriately auto-forward coverage determinations exceeding the CMS required timeframe to the IRE for review and disposition.
- Failure to adhere to HPMS approved utilization management criteria in its coverage determination.*
- Failure to honor the request for an expedited review or the requirements for notifying the beneficiary of their decision.
- Requests for coverage determinations were inappropriately denied.*

5. Grievances

Sponsors continue to be noncompliant in their handling of Part D grievances. Sponsors must thoroughly process grievances to ensure resolution of all issues. The findings observed included:

- Complaints were improperly classified as grievances when they should have been processed as coverage determinations or redeterminations and vice versa.
- Failure to fully investigate or appropriately address all issues raised in the grievances.
- Inaccurate or incomplete information provided in the grievance resolution letters.
- Failure to resolve and notify the beneficiaries of the resolution of the grievances within CMS required timeframes or as expeditiously as the enrollees' cases required.

CMS Recommendations:

In addition to the above stated best practices, CMS recommends that Sponsors implement the items below to ensure beneficiary access to care and compliance with CMS regulations:

- Having an automated system to track requests to ensure decision-making, notification and effectuation timeliness.
- Having processes in place to ensure that approved exceptions requests are properly entered into your claims processing system (i.e., through the end of the plan year or for a period of 12 months).
- Having fully trained staff that understand the difference between an inquiry, grievance, coverage determination, redetermination, reconsideration and are able to classify them appropriately, as well as processes in place to review a certain number of cases daily to ensure compliance.
- Having processes in place to review decision letters/notices to ensure that decision rationale is clear and detailed and that appropriate appeal rights are included.
- Ensuring review staff understand their responsibility to conduct appropriate outreach to providers to obtain needed information to process a request (e.g., at a

minimum 2 attempts to contact a provider's office during the provider's business hours on 2 different days and at different times of the day).

- Having systems in place to identify cases that are not decided timely, so they are auto-forwarded to the Independent Review Entity (IRE).
- Having processes in place to review grievances and ensure issues identified reached a proper resolution and were communicated accurately.

PART C ORGANIZATION DETERMINATIONS, APPEALS, AND GRIEVANCES

Best Practices

1. **Beneficiary Satisfaction**
   Continued beneficiary care and assurance of beneficiary satisfaction was found in several audits. We observed the following:

   - Following up with beneficiaries to confirm their issue was resolved and they were satisfied with the outcome.
   - Offering a second level grievance if the beneficiary is not satisfied with the outcome of the original grievance. Clear and specific instructions are provided on how to file the second level grievance.

2. **Communication**
   Clear communication is critical to beneficiary access. CMS discovered that some Sponsors were going above and beyond the expected level of communication to be sure that beneficiaries were well informed regarding all care concerns. Included in the observations were acknowledgement letters sent to the beneficiaries for every beneficiary appeal received.

3. **Processing Accuracy**
   Development and implementation of a tracking system for Waiver of Liability forms from providers allows for a more thorough level of accuracy in processing of requests and claims.

Common Findings

In the area of Part C Organization Determinations, Appeals, and Grievances, organizations often continue to be noncompliant, predominantly in the areas of clinical decision making, timely processing and notification of decisions, and in classification and processing of grievances. Organizations must ensure coverage decisions, appeals, and grievances are handled appropriately in order to avoid beneficiary harm due to delayed or incorrectly denied access to services. During the audits, CMS documented the following findings:

1. **Making Clinical Decisions**
   Sponsors continue to be inaccurate and unclear in the communication of their coverage decisions. It is critical that Sponsors clearly and accurately communicate their decisions. We observed the following:

- Upon receiving a request for reconsideration of a denied claim from a non-contract provider without the waiver of liability (WoL), there was a failure to make, and document, reasonable efforts to secure the necessary form.
- When Sponsors denied services or payments, in whole or in part, or discontinued/reduced a previously authorized ongoing course of treatment, it did not give the enrollee a written notice of its determination using the approved notice language.*
- Sponsors failed to gather all necessary information before reaching a coverage decision (i.e., failed to conduct appropriate outreach to obtain needed medical documentation).

2. **Noncompliance with Adjudication Timeframes and Processing**
   Sponsors continue to be untimely and/or improperly processing organization determinations, reconsiderations, and payments. Timeliness is imperative in ensuring beneficiaries receive access to care. We observed the following:

   - Sponsors did not notify the enrollee of its determination within 14 calendar days after the date the organization received the request for a standard organization determination.*
   - When Sponsors received a request for an expedited organization determination, they did not make the determination and notify the enrollee (and the physician involved, as appropriate) within 72 hours after receiving the request.*
   - When Sponsors received a request for an expedited reconsideration, it did not complete the expedited reconsideration and give the enrollee notice (and the physician involved, as appropriate) of its decision within 72 hours after receiving the request.*
   - Sponsors did not prepare a written explanation and send the case file to the IRE in a timely manner upon affirming its adverse organization determination.*
   - Sponsors did not process a payment organization determination in a timely manner.
   - Sponsors did not issue a decision for a standard payment reconsideration request timely.
   - Sponsors did not issue a decision for a standard pre-service reconsideration request timely.

3. **Denials**
   Sponsors inappropriately denied services to beneficiaries, including:

   - Sponsors denied payment for services that were either ordered or provided by their contract providers.*
   - Sponsors did not provide enough information for the enrollee to understand the reason their request was denied; the denial rationale was not specific to the individual's case and was not written in a manner that an enrollee could understand.*
   - Sponsors denied a request for payment from a non-contracted provider. The notice did not contain the required information, including provider appeal rights.*

4. **Grievances and Dismissals**
   Sponsors continue to misclassify organization determinations, appeals, and grievances. Proper classification is imperative in ensuring issues are appropriately addressed. We observed the following:

   - Sponsors did not take prompt, appropriate action, including a full investigation, in response to grievances.*
   - Sponsors' quality of care grievance resolution letters failed to provide the beneficiary with written notice of their right to file with, and the contact information for, the QIO.
   - Sponsors failed to correctly determine whether the issues in the enrollee's complaint met the definition of a grievance, an appeal, or both and, therefore, did not resolve the complaints or disputes through the appropriate procedure.
   - Sponsors failed to process and respond to grievances within 30 days of receiving the oral or written request.*
   - Sponsors submitted dismissal cases to the IRE prior to the conclusion of the appeal time frame.*

CMS Recommendations:

In addition to the above stated best practices, CMS recommends that Sponsors implement the items below to ensure beneficiary access to care and compliance with CMS regulations:

- Having an automated system to track incoming requests to ensure decision-making, notification and effectuation timeliness.
- Having fully trained staff that understands the difference between an inquiry, grievance, organization determination, or request for appeal and can classify them appropriately; and, processes in place to review a certain number of cases daily to ensure compliance.
- Having processes in place to review decision letters/notices to ensure that decision rationale is clear and detailed and that appropriate appeal rights are included.
- Ensuring review staff understand their responsibility to conduct appropriate outreach to providers to obtain needed information to process a request (e.g., at a minimum 2 attempts to contact a provider's office during the provider's business hours on 2 different days and at different times of the day).
- Having systems in place to ensure auto-forwarding of adverse plan reconsiderations to the Independent Review Entity (IRE).
- Having processes in place to review grievances and ensure issues identified reached a proper resolution and were communicated accurately.
- Ensuring that your claims processing systems and any automated enrollee notices that are issued as a result of claims determinations accurately reflect enrollee liability (e.g., no enrollee liability if a claim is denied but was provided, ordered or referred by a network provider).

- Having processes in place to review requests for urgently needed care, to ensure that they are being processed in accordance with 42 CFR, §422.113(b)(iii).
- Ensuring that if an EOB is used in place of a standardized denial notice, that all of the language from the denial notice is placed, verbatim and in its entirety, in the EOB document.

COMPLIANCE PROGRAM EFFECTIVENESS

Best Practices

1. **Communication**
   Clear communication is critical to ensure that all individuals associated with the Sponsor are exposed to and well informed of the compliance expectations. We observed the following:

   - CMS-required compliance provisions were added to all first-tier, downstream, and related entity (FDR) contracts.
   - The Compliance Department created a series of communication vehicles including posters, newsletters, intranet links, videos, quizzes, contests, town hall meetings and employee essays. These methods work cohesively to serve as reminders to employees that a compliant culture is of utmost importance at the Sponsor.

2. **Monitoring and Auditing**
   Sponsors are required by CMS to appropriately monitor and assess all dealings of the company. CMS discovered that Sponsors did in fact have procedures in place to ensure that the CMS requirements were met and often exceeded. We observed the following:

   - Compliance committee activities and corrective actions independently monitored by the parent company.
   - Rationale behind prescriptions being denied or unfilled is investigated.
   - 100% prepayment review of home infusion therapy claims to ensure that the Sponsor is correctly billed, and therefore correctly paying, all claims.
   - Sponsors' Internal Audit and Corporate Compliance Divisions that are staffed with a highly-qualified, professional auditing staff including Certified Public Accountants, Certified Internal Auditors, and employees highly skilled in the operational requirements for Medicare Parts C and D program.
   - Quarterly risk assessment analyses to address changes in law, regulations, CMS requirements and operational matters

3. **Fraud, Waste, and Abuse (FWA)**
   The avoidance of FWA events greatly enhances a Sponsor's ability to provide quality care to all beneficiaries. We observed the following:

   - Comprehensive monitoring of claims for identification of potential FWA.

- OIG/GSA exclusions checked prior to every payment.

4. **Governing Body**
   CMS requires that a Sponsor's governing body exercise reasonable oversight with respect to the implementation and effectiveness of said Sponsor's compliance program. We observed the following:

   - The Board of Directors is the only entity that can terminate the Director of Internal Audit and Chief Compliance Officer.
   - The Sponsor's Board of Directors held executive sessions with the Compliance Officer to discuss the effectiveness of the Sponsor's compliance program and measures taken to resolve operational non-compliance and timely reporting to CMS.
   - The Board of Directors includes board member(s) with healthcare, audit, and compliance backgrounds. This expertise on the Board can sensitize and assist governing body members with understanding the severe impact of regulatory noncompliance or fraudulent activities facing the organization.

Common Findings

In the area of Part C and D compliance program effectiveness, CMS identified areas of concern with respect to some of the Sponsors' compliance programs. During the audits, CMS documented the following findings:

1. **Compliance Officer, Compliance Committee, and High Level Oversight**
   Sponsors did not provide evidence that the Board had knowledge about the content and operation of the compliance program and exercises reasonable oversight with respect to the implementation and effectiveness of the compliance program.*

2. **Training and Education**
   Sponsors continue to fail to meet the requirements for training and education, including:

   - Sponsors did not provide training and education addressing compliance, to the organizations' employees, the organizations' chief executive or other senior administrators, managers, and governing body members, upon hire and annually thereafter.
   - Sponsors did not provide training and education addressing FWA, to the organizations' employees, the organizations' chief executive or other senior administrators, managers, and governing body members, upon hire and annually thereafter.

3. **Routine Monitoring, Auditing, and Identification of Compliance Risks**
   Sponsors continue to have ineffective systems for monitoring, auditing and identifying compliance risks, including:

- Sponsors have not established and implemented a system for monitoring and auditing compliance program effectiveness.*
- Sponsors have not established and implemented an effective system for the identification of compliance risks within the organization.

4. **Prompt Response to Compliance Issues**
   Sponsors failed to meet the requirements for promptly responding to, investigating, and correcting issues of non-compliance and/or FWA. Observed deficiencies included:

   - Sponsors have not established and implemented a system for responding to, investigating, and correcting potential and identified compliance issues.
   - Sponsors have not established and implemented a system for responding to, investigating, and correcting potential FWA issues.

5. **Effectiveness Measure**
   Sample cases reviewed during the audits did not provide support that Sponsors have effective compliance programs.*

6. **Sponsor Accountability and Oversight of FDRs**
   Sponsors failed to appropriately monitor and manage their FDRs. Observed deficiencies included:

   - Sponsors did not establish and implement effective systems for monitoring and auditing their FDRs' performance and compliance with CMS requirements.
   - Sponsors did not provide accessible lines of communication to their FDRs to allow compliance and potential FWA issues to be reported to Sponsors' compliance officer/departments, including a method for anonymous and confidential good faith reporting of such issues.*
   - Sponsors continue to not ensure that FDRs received and completed FWA training at orientation and annually thereafter.

CMS Recommendations:

In addition to the above stated best practices, CMS recommends that Sponsors implement the items below to ensure beneficiary access to care and compliance with CMS regulations:

- Sponsor conducts monthly checks of the OIG and GSA exclusion lists to ensure all levels of employees, board members and FDRs are not excluded from participating in federal programs.
- Thoroughly review the Annual Call Letter (risks and changes to the MA and Part D programs), CMS Readiness Checklist (summarizes key operational requirements), enforcement and compliance actions and other CMS advisory materials to assist with creating the formal risk assessment.
- Establish a centralized unit dedicated exclusively to delegated entity (FDR) oversight.
- Develop a comprehensive monitoring and auditing system to frequently validate the performance of FDRs' compliance with CMS operational requirements and detect

unusual trends (e.g. formulary administration, Parts C and D determinations, appeals and grievances, Part C access to care, compliance program, etc.).

- Compliance of operational areas should be regularly tracked by management and any issues of noncompliance or FWA shared with staff and reported to senior management.
- Take timely and appropriate actions based on CMS fraud alerts distributed via HPMS memos.
- Ensure significant operational compliance challenges are reported to the CEO and governing body and are addressed in the compliance committee. Meeting minutes or other documentation should reflect organizational oversight of the Medicare operations,
- Ensure that the compliance department, as well as impacted business/operations managers, are aware of any operational areas with significant noncompliance, and ensure corrective action is implemented and effective.
- Implement a continuous process improvement program. Use current or past operational issues, track your responses and corrective actions to identified or reported issues, and trace all activities through each of the seven elements of an effective compliance program. This process will test internal and external controls with detecting and correcting program noncompliance and FWA.

AGENT/BROKER OVERSIGHT

Best Practices

1. **Plan Effectiveness and Evaluation**
   It was observed that some Sponsors were meticulous in their marketing oversight procedures and effectiveness. Through diligent monitoring and reaction, Sponsors were able to ensure the highest quality of service was provided to beneficiaries. We observed the following:

   - Regularly performing secret shopper audits and open audits during which all agents are fully aware that management is performing audits for agents who have multiple complaints.
   - Routinely hiring new and bilingual Secret Shoppers to secret shop its agents. The Secret Shoppers are rotated regularly to avoid the possibility of an agent recognizing an individual from a prior event.
   - Management conducts sales complaint counseling with agent/brokers who have allegations brought against them. Each complaint against an agent had documented support of a sales complaint counseling session.

2. **Communication**
   CMS discovered that some Sponsors maintained above average procedures to ensure the clearest communication with beneficiaries. We observed the following:

   - System generated outbound enrollment verification (OEV) letters.
   - Implementing new email and task procedures to ensure adequate communication with beneficiaries during enrollment.

- Implementing a new phone system to leave a message on unanswered OEV calls and receive a call back from the beneficiary.

Common Findings

In the area of Part C and D agent/broker oversight, the most common areas of deficiency include the appointment and training of agents, the requirements for outbound enrollment verification (OEV) calls, and the complaints process. During the audits, CMS documented the following findings:

1. **Appointment and Training***
   Sponsors failed to meet the requirements for agent appointment and training, including:
   - Agents sold a Sponsor's product to beneficiaries prior to appointment in the state.
   - Agents did not complete CMS required annual training specific to the Sponsor products they intend to sell.
   - Sponsors did not provide the appropriate Medicare or plan specific training to its agent/brokers prior to selling Medicare Advantage and Part D Sponsor products.

2. **OEV Calls**
   Sponsors continue to fail to meet the requirements for OEV calls. It is critical that Sponsors ensure beneficiaries receive the appropriate communication following enrollment. We observed the following:

   - Sponsors could not produce evidence that at least three OEV calls were made and/or that a follow-up enrollment verification letter was sent to the beneficiary.
   - Sponsors did not comply with CMS regulations for completing OEV calls and supplying its beneficiaries with accurate information during the calls.
   - Sponsors did not provide the beneficiary with the correct cancellation date either verbally during the phone call or in the OEV letter.

3. **Complaints**
   Sponsors continue to conduct incomplete investigations of beneficiary complaints, as not all allegations against the agent/broker were reviewed and followed up on by the Sponsor. Sponsors must conduct thorough investigations and take appropriate action against agent brokers who fail to follow procedures.

CMS Recommendations:

In addition to the above stated best practices, CMS recommends that Sponsors implement the items below to ensure beneficiary access to care and compliance with CMS regulations:

- Sponsors should implement standardized procedures to ensure that new agents are properly appointed and licensed prior to selling products if required by the State. Additionally, Sponsors should enact a system or process which periodically checks agents to ensure they are licensed and appointed.

- Sponsors should enhance internal controls over agent/broker training verification to ensure their agents/brokers are properly trained and tested on all updates pertaining to Medicare Parts A, B, C, and D. Sponsors should also ensure that the training and testing aligns with the annual CMS agent/broker Training Guidelines. Additionally, Sponsors must maintain evidence supporting completion of required training.
- Sponsors should establish an effective process and internal controls to ensure that all OEV staff members are trained properly on the OEV call process and plan benefits and services offered. Additionally, Sponsors should conduct internal monitoring to ensure all OEV staff are following requirements.
- Sponsors should have effective processes and internal controls in place to ensure accurate and timely OEV calls and verification letters are conducted in accordance with CMS requirements.
- Sponsors should implement procedures to ensure they follow CMS guidance regarding cancellation dates and must conduct quality assurance reviews to ensure that all beneficiaries are informed of the correct cancellation period.
- Sponsors should develop and implement internal controls and procedures to ensure that all beneficiaries' complaints are fully investigated and followed up on in a timely manner. Additionally, Sponsors must ensure that the staff is appropriately trained on how to conduct an investigation on a beneficiary's complaint.
- Sponsors must take action against agent/brokers who receive substantiated complaints against them.

PART C AND PART D ENROLLMENT AND DISENROLLMENT

Best Practices

Beneficiary communication

Clear communication is critical to ensure beneficiaries are aware of all details regarding their enrollment and disenrollment. CMS discovered that some Sponsors were going above and beyond the expected level of communication to be sure that beneficiaries were well informed. We observed the following:

- Sponsors send multiple delinquency notices for non-payment of premiums, to provide several opportunities to inform the beneficiary of the repercussions of non-payment of premiums.
- For all cases that require member outreach, such as incomplete enrollment requests, there are three attempts to contact the beneficiary via telephone, in addition to sending a written notice.
- Following the receipt of an incomplete enrollment request, the Sponsor follows up with the beneficiary, as well as the agent/broker, in order to ensure the required additional information is received timely.

Common Findings

In the area of Part C and D enrollment and disenrollment, a significant number of Sponsors continue to be noncompliant with CMS requirements for processing enrollments and disenrollments. Sponsors must ensure enrollments and disenrollments are processed timely, thoroughly and in accordance with requirements. During the audits, CMS documented the following findings:

1. **Processing of enrollment or disenrollment requests**
   Sponsors incorrectly processed enrollment/disenrollment requests and denials, as follows:

   - Sponsors failed to send the beneficiaries complete and accurate acknowledgement notices for enrollments and/or voluntary disenrollments.
   - Sponsors did not determine and submit the correct enrollment or disenrollment effective dates.*
   - Sponsors inappropriately denied enrollment and/or disenrollment requests.
   - Special Needs Plans incorrectly determined the start and/or end dates of the period of deemed continued eligibility.*
   - Sponsors failed to send the beneficiary a complete and accurate notice of loss of special needs status.*

2. **Processing of incomplete requests**
   Sponsors incorrectly processed incomplete enrollment requests, as follows:

   - Sponsors inappropriately determined enrollment requests incomplete for various reasons; including, when the missing item was the Sponsor's determination of a valid election period or by simply overlooking provided information.
   - Sponsors failed to send the beneficiaries complete, accurate, and timely requests for additional information.*
   - Sponsors did not provide the full required timeframe to the beneficiaries to supply missing information before enrollment or disenrollment denials.*

3. **Timely Processing**
   Sponsors were not timely in the processing of enrollment and disenrollment requests, as follows:

   - Sponsors failed to process enrollment and voluntary disenrollment transactions timely.
   - Sponsors failed to send the beneficiaries acknowledgement and /or denial notices in a timely manner.*

4. **Non-Payment of Premium**
   Sponsors failed to apply their grace period for payment of premiums correctly and consistently to all beneficiaries.*

CMS Recommendations:

In addition to the above stated best practices, CMS recommends that Sponsors implement the items below to ensure beneficiary access to care and compliance with CMS regulations:

- Conduct root cause analysis to identify aspects of current enrollment and disenrollment processes that contribute to unnecessary delays.
- Maximize the use of telephonic outreach for resolving incomplete enrollment and disenrollment requests.
- Utilize telephonic outreach for determining if the individual has a valid election period in which to request enrollment or disenrollment.
- Identify the elements most frequently missing from enrollment and disenrollment requests and enhance instructions in enrollment kits accordingly.
- Ensure adequate training regarding the relationship between enrollment and disenrollment request receipt dates, election periods and enrollment and disenrollment effective dates.

PART D LATE ENROLLMENT PENALTY

Best Practices

No new Best Practices were identified related to this area.

Common Findings

In the area of Part D Late Enrollment Penalty (LEP), a significant number of Sponsors continue to be noncompliant with regard to complete and effective communication with beneficiaries and CMS about Late Enrollment Penalty concerns. During the audits, CMS documented the following findings:

- Sponsors failed to send beneficiaries the initial attestation documents and notices of LEP timely.*
- Sponsors failed to send beneficiaries complete and accurate notice of LEP.
- Sponsors did not abide by CMS stipulated guidance when calculating beneficiaries' numbers of uncovered months.*
- Sponsors failed to update CMS' enrollment systems with the beneficiaries' Number of Uncovered Months (NUNCMO) timely.*
- Sponsors failed to effectuate the IRE's decision in their internal system timely.*

CMS Recommendations:

CMS recommends that Sponsors implement the items below to ensure beneficiary access to care and compliance with CMS regulations:

- Ensure that staff understand and are providing the appropriate communication to beneficiaries regarding the LEP initial attestation documentation and timeframes for

notification of the Part D LEP. This is critical to ensuring that the beneficiary can respond timely to the attestation of creditable coverage and, if necessary, file for a reconsideration of the penalty.

- Utilize the NUNCMO Tool to test accuracy in calculating the Number of Uncovered Months.
- Train staff regarding timeframes for updating the CMS systems with the NUNCMO.
- Train staff regarding timeliness in effectuating the IRE's decisions.
- Establish internal processes for effectuating IRE decisions within 2 months of receipt.

SPONSOR RECOMMENDATIONS

CMS conducted several listening sessions with previously audited sponsors to obtain their feedback on the audit process and their recommendations to fellow sponsors on how best to prepare for an audit. Below is a listing of their recommendations:

- Ensure your organization is audit ready.
    - Assemble your audit team, so individuals who will be responsible for various portions of the audit are aware of their responsibilities and familiarize themselves with the protocols.
    - Prepare your IT staff and talk with them about Webex technology and impacts to IT resources.
    - Practice using Webex technology (sharing screens, pulling up systems).
    - Practice compiling universe requests.
    - Ensure your delegated entities are audit ready.
    - Utilize the protocols to conduct practice audits.
    - Don't wait until receipt of the audit start notice to ask CMS your audit related questions.
- Review your outbound communications to ensure they are written in a manner that can be understood by the member and/or provider.
- Ensure all of your internal processes and meeting minutes are well documented.
- During the audit, keep executive leadership well informed of the progress of the audit.
- During the audit, keep audit teams in close proximity for improved oversight.