

# Medicare Part D Compliance & Oversight Overview

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## Session Overview

- New CMS Compliance/Oversight Structure
- Oversight Strategy
- Oversight Activities
- Alignment of Audit Approach
- Statutory & Regulatory Updates
- What's on the Horizon?



## New CMS Compliance and Oversight Structure

### June 2008 Reorganization - Key Changes

- New name - “Center for Drug and Health Plan Choice” (“CPC”) (formerly “Center for Beneficiary Choices”)
- New - Program Compliance and Oversight Group - exclusively devoted to developing and implementing a more effective, comprehensive compliance and oversight program
- Medicare Drug Benefit and C & D Data Group – consolidated C & D data collection, measurement development and performance analysis



3

## New CMS Compliance and Oversight Structure

### June 2008 Reorganization - Key Changes (cont'd)

- Medicare Drug & Health Plan Contract Administration Group – consolidated C & D marketing policy and financial solvency reviews
- Regional Consortium for Medicare Health Plans Operations - consolidated C & D account management



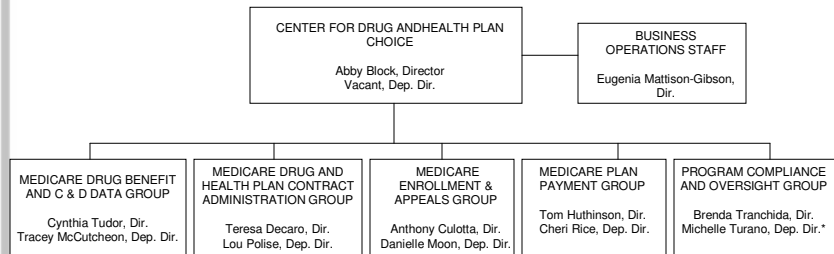
4

# New CMS Compliance and Oversight Structure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED  
LEADERSHIP

As of  
November 5, 2008  
\*Acting



5

# New CMS Compliance and Oversight Structure

## June 2008 Reorganization - Key Goals

- Enhance focus on:
  - Compliance/oversight activities
  - Data collection and tools to analyze data
  - Communication and coordination
  - Consistency
- Coordinated allocation of oversight tools and resources to address highest program risks
- Integrate C & D compliance and oversight activities (e.g., day-to-day account monitoring, data collection and performance assessment, compliance/enforcement actions)



6

## New CMS Compliance and Oversight Structure

### June 2008 Reorganization - Key Goals (cont'd)

- Facilitate risk-based, data-driven approach to monitoring and oversight
- Promote organizational ability to be more proactive to prevent potential problems, detect non-compliance at lowest level possible and respond in a timely, effective manner when detected



7

## New CMS Compliance and Oversight Structure

### June 2008 Reorganization - Key Goals (cont'd)

- Streamline organizational structure to improve collaboration and communication (internal and external)
- Increase transparency (internal and external stakeholders)
- Consolidate certain operational activities to reduce duplication of efforts/use resources more efficiently



8

## Oversight Strategy

- Paramount goals = Protecting beneficiaries and promoting efficiency and sustainability of Medicare program
- Strategies/resources based on assessment of risks and are targeted to proactively address these risks
- Foundation = data-driven monitoring and quantifiable performance measures (e.g., “star” ratings/plan report cards)
- Promotes early alerts and consistent, prompt corrective responses at lowest level possible using a progressive compliance model

## Oversight Strategy

- Supports sustainable compliance and/or enforcement actions (intermediate sanctions, civil monetary penalties, terminations) that have positive effect on future performance and behaviors of plan sponsors
- Integrates with agency-wide oversight strategies and supports role as federal regulator (protection of beneficiaries, Medicare trust fund, prevention of fraud, waste and abuse, etc.)
- Flexibility to be responsive to new challenges/risks

## Oversight Strategy

- Ensures stakeholders (plan sponsors, States, SHIPs, beneficiary advocates, program integrity, law enforcement, etc.) provide needed “front line” feedback and are appropriately informed
- Transparency of compliance organizational structure, plan performance data and compliance/enforcement actions

## Oversight Activities

- Day-to-day account management and monitoring
- Comprehensive data collection, measurement development and plan sponsor performance assessment
- Audit/review activities (bid reviews, risk adjustment validation reviews, financial and accounting reviews, program audits, Part D LIS readiness audits, compliance plan audits, etc.)

## Oversight Activities

- Surveillance activities (e.g., secret shopping, call center monitoring, review enrollment calls, clipper service, etc.)
- Complaint/information exchanges with State Departments of Insurance (DOIs) and participation in NAIC workgroups
- Compliance/enforcement actions (address individual sponsor and programmatic issues)
- Feedback from plan sponsors (e.g., self-disclosures based on internal monitoring, self-audits, or compliance assessment activities)

## Alignment of Audit Approach

- Shift from routine audits to more targeted data-driven/risk-based audits (beginning in 2009)
- More real-time and focused on risks or known concerns
- Targeted towards plan sponsors that demonstrate problematic performance and/or high risk areas that have the greatest potential for beneficiary harm (e.g., enrollment operations, appeals & grievances, etc.)
- Will include some degree of random selection

## Alignment of Audit Approach

- Will include gap analysis of available data/information to determine items that cannot be evaluated other than through audit process
- Earliest possible detection and correction of issues before they become full-blown problems
- Quantifiable, meaningful results for CMS and plan sponsors upon which to make corrections and improvements and facilitate decision-making
- Focused on improving performance and overall quality improvement

## Alignment of Audit Approach

- Use of audit support staff for assistance in focused compliance reviews/audits (e.g., MEDICS)
- Audit findings will be integrated in comprehensive, real-time management reports and performance data on plan sponsor (“dashboard”)

## Statutory & Regulatory Updates

### **Final Compliance Regulation (CMS 4124-FC) 72 Fed Reg 68700 (published 12/7/07)**

- Title: Medicare Program; Revisions to the Medicare Advantage and Part D Prescription Drug Contract Determinations, Appeals, and Intermediate Sanctions Processes
- Certain Provisions Effective 1/4/08 & 1/1/09



17

## Statutory & Regulatory Updates

### **Final Compliance Regulation (CMS 4124-FC) 72 Fed Reg 68700 (published 12/7/07)**

- Effective 1/4/08: Provisions concerning intermediate sanctions, non-renewals, terminations and civil money penalties
  - Simplified and made consistent appeal procedures for all contract determinations (including intermediate sanctions, terminations, and non-renewals)
  - Removed reconsideration process for contract determinations
  - Provide regulatory appeal procedures in 422 and 423 for civil money penalties



18

## Statutory & Regulatory Updates

### Final Compliance Regulation (CMS 4124-FC) 72 Fed Reg 68700 (published 12/7/07)

- Effective 1/1/09: Compliance plan changes and contract provisions:
  - Clarified access to facilities and records of first tier, downstream and related entities
  - Clarified compliance plan application to first tier, downstream, and related entities



19

## Statutory & Regulatory Updates

### Medicare Improvements for Patients and Providers Act (MIPPA) (Enacted July 15, 2008)

- Section 103: Marketing Provisions Specifically Prohibit:
  - Providing meals as part of marketing activities
  - Telemarketing, door-to-door solicitation & other sales contacts without beneficiary's express invitation
  - Cross-selling of non-health care related products during any sales or marketing presentation for and MA or PDP plan
  - Conducting sales presentations or distributing and accepting applications in provider offices or other places where health care is delivered
  - Conducting sales activities, distributing or collecting applications at education events.



20

## Statutory & Regulatory Updates

### Medicare Improvements for Patients and Providers Act (MIPPA) (Enacted July 15, 2008)

- Section 103: Marketing Provisions Specifically Apply To:
  - Private insurance companies (MAO and PDPs);
  - Agents and brokers; and
  - Any contractors or downstream entities (i.e., field marketing organizations).



21

## Statutory & Regulatory Updates

### Recent Final Regulations Affecting Marketing

- **Effective September 18, 2008:**
  - CMS 4138-IFC: Revisions to the Medicare Advantage and Prescription Drug Benefit Programs (73 Fed Reg 54226)
  - CMS 4131-F: Medicare Advantage and Prescription Drug Benefit Programs: Final Marketing Provisions (73 Fed Reg 54208)
- Regulatory Guidance Re:
  - Meals at promotional and sales events;
  - Unsolicited contact by sponsors/organizations and their agents (including telemarketing, downstream (i.e. FMOS));
  - Cross-selling of non-health care related products; and,
  - Sales presentations and distribution of enrollment applications at educational sessions
  - Scope of Appointments
  - Plan Reporting of Terminated Agents



22

## Statutory & Regulatory Updates

### Recent Final Regulations Affecting Marketing

- **Effective November 10, 2008**
- CMS 4138-IFC2: Revisions to the Medicare Advantage and Prescription Drug Benefit Programs: Clarification of Agent/Broker Compensation Plans (73 Fed Reg 67406)
- Modified CMS 4138-IFC released on 9/18/08



23

## What's On the Horizon?

- “Dashboard” implementation – vehicle for consolidation of data for management oversight and decision-making about a plan sponsor, a product type, analysis of emerging compliance trends, etc.
- Stay tuned for:
  - future changes in audit approach and processes
  - Industry compliance training and educational initiatives



24

## What's On the Horizon?

- Improved coordination and exchange of information with the States to better support our respective oversight and enforcement roles
- Expectation for plan sponsors to provide ongoing feedback and information from front lines (internal monitoring, auditing and self-disclosure of issues)
- Note: OIG work plan – appeals and grievances will be focus in 2009 (expect similar heightened focus from CMS)

## CMS Auditing & Monitoring Part C & D

QUESTIONS?

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