Health Care Communiqué

Q4 2014

HEALTH PLAN IDENTIFIER (HPID)

The Affordable Care Act and HIPAA require that medical, stand-alone pharmacy, dental, vision and certain HRA plans obtain a unique 10-digit Health Plan Identifier (HPID) that will be used to identify the plan when performing certain electronic transactions.

While insurance carriers are responsible for obtaining HPIDs on behalf of fully-insured plans, self-insured plan sponsors must obtain HPIDs on their own behalf.

Self-insured plans with claims exceeding $5 million in the last full fiscal year are considered 'large' and must have obtained their HPID by November 5, 2014. Self-insured plans with claims under $5 million are considered 'small' and have until November 5, 2015 to obtain their HPID.

Large plans will have to certify compliance to the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) and the Department of Health and Human Services (HHS) by December 2015 and small plans by December 2016; however, details surrounding the certification processes have not been finalized.

CMS has released a Quick Reference Guide that walks through the multiple steps of the process and the two online portals (CMS Enterprise and HIOS) that will need to be accessed: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPIDQuickGuideSeptember2014.pdf.

(continued...)

HEALTH PLAN IDENTIFIER (HPID) *(Continued)*

Below are some additional considerations:

- The process is lengthy and can take several days to complete as access to online systems and the application process require review and approval.
- Multiple plans that are bundled together and reported as one plan for purposes of filing Form 5500 may be treated as a single Controlling Health Plan (CHP) and will likely need only one HPID number. Plans that are filed separately will need to obtain separate HPID numbers. Users have the ability to obtain more than one HPID.
- The following information will be needed:
  - Company Name
  - Tax ID
  - Address
  - Payer ID (self-funded employers who do not have these numbers may enter "not applicable" in this field on the application)
  - Plan Name/Description

The delay* stems from a recommendation made on Sept. 23, 2014, by the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS, which recommended that HHS rectify in rulemaking that all covered entities (health plans, health care providers, and clearinghouses and their business associates) not use the HPID in HIPAA transactions.

This enforcement discretion will allow HHS to review the NCVHS recommendation and consider appropriate next steps.

If a Controlling Health Plan had already obtained an HPID, they are in compliance and need not do anything.

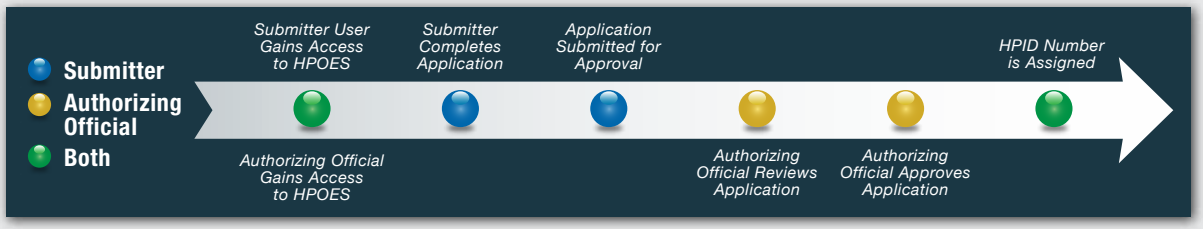
If a Controlling Health Plan has not obtained an HPID, they will not face penalties unless and until CMS makes a further announcement.

* On Friday, Oct. 31, 2014, the Centers for Medicare and Medicaid Services (CMS) announced a delay, until further notice, in enforcement of 45 CFR 162, Subpart E, the regulations pertaining to health plan enumeration and use of the Health Plan Identifier (HPID) in HIPAA transactions adopted in the HPID final rule (CMS-0040-F). This enforcement delay applies to all HIPAA-covered entities, including health care providers, health plans and health care clearinghouses.

Excerpt: A Quick Reference Guide to Obtaining a Controlling Health Plan HPID

Users that need to obtain a Controlling Health Plan (CHP) Health Plan Identifier (HPID) will go through the CMS Enterprise Portal, access the Health Insurance Oversight System (HIOS) and apply for an HPID from the Health Plan and Other Entity System (HPOES).

In order to submit the application and obtain an HPID for a Controlling Health Plan, both the Submitter and Authorizing Official users must have approved access to HPOES for their respective organization. The steps below outline the process for each user to complete to obtain an HPID for a Controlling Health Plan:



Source: CGI, A Quick Reference Guide to Obtaining a Controlling Health Plan HPID, September, 2014.

MEDICARE PART D CALL LETTER – CHANGES IN 2015

CMS issued the final 2015 Call Letter on April 7, 2014. The Call Letter is used to improve the overall management of the Medicare Advantage and Prescription Drug programs. CMS developed the Call Letter so that there are better outcomes in the programs. CMS wants to ensure that the programs have:

- Vibrancy and stability
- Value for beneficiaries and taxpayers
- Quality improvement
- Compliance improvement

In this article, we've provided a brief summary of some of the changes that will be implemented for 2015, based on the Call Letter.

Star Ratings:

2015 Star Ratings were released in the fall of 2014 and will be used for 2016 Quality Bonus Payments. Some of the measures will be revised, including high-risk medication and medication adherence for diabetes medications. In addition, medication adherence measures will be adjusted in 2015 to account for beneficiaries with hospice or skilled nursing facility status.

The 2015 Call Letter included information on a new Star measure. The Special Needs Plan (SNP) Care Management (Part C SNPs) measure will be added to the 2015 Star Ratings. This particular measure will be assigned a weight of "1" since it will be newly added for 2015.

CMS also reiterated the potential for termination of contracts that have less than a 3-Star Rating for three consecutive periods beginning in 2012. Contracts at risk should review to see if plans with low ratings can be moved into other plans in the organization with at least a 3-Star Rating.

New Display Measures:

CMS is considering adding new Display Measures in 2015. Based on their analyses and the quality of data that CMS receives, CMS will potentially display these new measures:

- CAHPS measures pertaining to surrounding contact from providers, plans and pharmacies as well as feedback on electronic health records from patients
- Transition Monitoring for Part D
- Plan Finder accuracy
- Disenrollment reasons

MEDICARE PART D CALL LETTER – CHANGES IN 2015 *(Continued)*

Medication Therapy Management (MTM):

CMS has been monitoring MTM program requirements. Based on the monitoring that was conducted, CMS included information on how they will develop new audit performance elements for MTM programs in the future. CMS may begin to pilot MTM program audits as early as the 2014 or 2015 audit season. The results from the proposed audits will not impact Part D Star Ratings for the first year that the protocol is piloted. CMS will be publishing audit protocols in the near future and will be requesting feedback from organizations.

CMS is also requiring changes to the text of standardized formatting of Comprehensive Medication Reviews (CMR). This change was implemented as part of the Paperwork Reduction Act. The final changes will be effective January 1, 2015.

Enhancements and Clarifications on Improving Utilization Review Controls:

CMS is requiring that organizations begin submitting their internally-identified potential overutilization issues to the Overutilization Monitoring System (OMS) quarterly along with the response code indicating the status of each beneficiary case, no later than January 1, 2015. The overutilization issues submitted with response codes that are known exceptions may be excluded from future OMS reports.

CMS included criteria in the final Call Letter for when plans should implement point of sale edits for prior authorization for drugs and/or drug classes that pose a greater risk of non-Part D uses. The criteria include:

- High likelihood that coverage is available under Parts A or B (versus D) for the drug as prescribed and dispensed or administered,
- High likelihood that the drug is excluded from Part D coverage (e.g., a drug or drug class or its medical use that is excluded from coverage or otherwise restricted under Part D as defined in section 1927(d)(2) of the Act), or
- High likelihood of use for non-medically accepted indications as defined in section 1860D-2(e)(4) of the Act.

The 2015 Call Letter contained valuable information on both the Part C and D programs. The information should be used to prepare bids for the upcoming year as well as improve overall management by the organizations who administer Medicare Advantage and Prescription Drug programs. In addition to including changes for 2015, the Call Letter contained reminders to the plans of CMS' expectations, and also included changes for 2016. CMS' ultimate goal with releasing the final 2015 Call Letter is to strengthen the Medicare Part C and D programs. All organizations should conduct an in-depth review to ensure that they are in compliance with all CMS regulations that are contained within the document.

CY2014 PART D FORMULARY AND ADMINISTRATION ANALYSIS (FAA)

On October 17, 2014 HPMS released a memo entitled, "Contract Year 2014 Part D Formulary and Administration Analysis (FAA)." CMS' expectation of the memo is that Part D Sponsors make every effort to ensure prescription drug claims are adjudicated in compliance with the Part D Sponsor's Contract Year (CY) CMS-approved formulary.

Last year, CMS assessed selected CY2013 Part D Sponsors' formularies by reviewing selected sample rejected claims from April 2013, and provided Part D Sponsors the chance to review and comment on the selected samples. From their analysis of the selected 88 contracted Part D Sponsors, CMS concluded that 9 contracts failed due to more than 20% of their selected rejected claims being incorrect. Therefore, CMS has apprehension and has begun this oversight again on Part D Sponsors' not properly adjudicating claims correctly with their CY2014 approved formulary.

All Part D Sponsors, Employer Group Waiver Plans (EGWPs) and Care for the Elderly (PACE) organizations are included in the CY2014 FAA, except those meeting the exclusion criteria below:

- Selected to participate in a Program Audit in 2013 and also participated in a Medicare part D Formulary and Benefits Administration (FA) Validation Audit in 2014.
- Selected to participate in a 2014 Program Audit.

CMS began to notify Part D Sponsors' Medicare Compliance Officers selected for this analysis on or about October 10, 2014. The notice provided detailed instructions on the submission requirements, which included the file layouts and instructions for accessing and uploading to the Acumen secure website. Part D Sponsors selected for this analysis were instructed to begin uploading the required Rejected Claims Files on or about October 16, 2014 through October 22, 2014 (5:00 PM EDT).

CMS will not start to review Part D Sponsors' CY2014 rejected claims until mid-January 2015.

2013 PART C AND PART D ANNUAL AUDIT AND ENFORCEMENT REPORT

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) is one of the groups within Medicare which is responsible for the program's integrity, which it maintains by conducting Part C and Part D program audits. Audits evaluate sponsors' compliance with a number of core program requirements, with a focus on the sponsors' ability to provide beneficiaries with access to medically necessary services and prescription drugs. This is the second annual report released by MOEG.

In conducting audits, CMS can be reasonably assured that sponsors are delivering benefits in accordance with the terms of their contract and plan benefit package. Audits are designed to detect instances where beneficiaries are denied services and therefore sponsors are required to correct any identified deficiencies and conduct outreach to adversely affected beneficiaries.

Program audits are conducted at the parent organization level. Therefore, all contracts owned and operated by the sponsor are included in the audit scope. Audits are conducted for compliance in the following areas:

- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals and Grievances (CDAG)
- Part D Organization Determinations, Appeals and Grievances (ODAG)
- Compliance Program Effectiveness (CPE)
- Part C and Part D Outbound Enrollment Verifications (OEV)
- Special Needs Plans Model of Care (SNP MOC) (Pilot Year)

MOEG works collaboratively with the CMS Regional Offices (RO) to develop and execute the program audits. Resources are utilized both internally from MOEG as well as from the RO. MOEG also oversees and manages two audit support contracts to execute program audits and validations each year. Generally, the team consists of a MOEG Audit Lead and a Team Lead (generally either RO or contractor staff) for each audit area and Staff. Staff are basically additional team members who help perform and complete the audit. In 2013, the Audit Lead and the Compliance Effectiveness team traveled onsite to assess compliance, while the remainder of the audit was accomplished via webinar technology.

MOEG utilized a data-driven risk assessment to generate a risk score and ranking for all sponsors (at the parent organization level) as the primary means for audit selection. Risk assessment was compiled from various performance data collection from March 2012 through October 2012 and a sponsor's overall parent organization risk score was calculated by weighing each contract by its enrollment. The lower the risk score, the higher the risk. Plans were placed in order of risk and were then selected for an audit based on one of 4 risk classifications:

- **High Risk** – sponsors in the highest risk quartile of the Risk Assessment.
- **High Star** – a limited number of sponsors with 2013 Star Ratings greater than or equal to 4.5 stars.
- **Low Performing Icons (LPI)** – all sponsors with Part C or Part D summary star ratings of less than 3 stars for at least 3 consecutive years.
- Sponsors not audited in the past 3 years.

MOEG also conducts ad hoc audits and audits based on referrals from the CMS Central Office and ROs. These audits are separate from the risk assessment audits.

An audit starts upon an audit notice being issued to the sponsor and concludes upon receipt of the sponsor's audit closeout letter. Efforts have been made to improve the efficiency of the audit lifecycle. Below are several improvements which were implemented in 2013:

- Agent Broker program was limited to Outbound Enrollment Verification
- Auditing of Special Needs Plans Model of Care (SNP MOC) was piloted
- CMS began to post the previous year's audit scores and status on the Compliance and Audits webpage
- CMS incorporated the audit scoring methodology into the Part C and Part D Star Ratings and Past Performance Assessment
- MOEG implemented a 2-week audit review period to conduct all webinars and the compliance program review
- MOEG implemented the first phase of its HPMS audit module with the goal to automate the entire audit process

2013 PART C AND PART D ANNUAL AUDIT AND ENFORCEMENT REPORT *(Continued)*

MOEG began its program audits in 2010, with the goal to audit every sponsor in a reasonable period. By the end of 2014, sponsors that account for 96% of the total Medicare Advantage, other Medicare managed care health plans and Prescription Drug Programs' enrollment will have been audited.

In 2013, CMS utilized a scoring system that generates an audit score for every sponsor based on the number and severity of non-compliance conditions detected. A lower score represents better performance. Since the audit score is based on a number of non-compliant conditions, the maximum audit score is unlimited. Additionally, the scoring system is weighted to ensure that conditions that have potential impact to beneficiary access to care have a greater impact on the overall score. The audit score is calculated by assigning 0 points to observations, 1 point for each CAR and 2 points for each ICAR, and then dividing the sum of these points by the number of audit elements tested.

- **Observation** – an instance of non-compliance detected during the audit that appears to be limited to a single case or is clearly not systemic in nature. An observation does not require the development and submission of a corrective action plan, but is discussed with the sponsor in an effort to prevent compliance problems in the future.
- **Corrective Action Required (CAR)** – an instance of non-compliance that demands that the sponsor correct the detected condition. The sponsor is given 7 days from the date of the issuance of the final report to provide a corrective action plan (CAP). Once CMS accepts the CAP, the sponsor is given 90 days to implement the plan to correct the non-compliant condition.
- **Immediate Corrective Action Required (ICAR)** – an instance of non-compliance that demands that the sponsor correct the detected condition immediately. This occurs when the condition causes significant beneficiary harm, which is defined as policies, procedures, systems and/or operations that may result in beneficiaries not receiving medical services or prescription drugs. The sponsor has 3 days from the issuance of the ICAR notice to remediate the condition and provide proof of correction. ICARs are issued in the following program areas: FA, CDAG, ODAG and CPE.

In 2013, each program area received an audit score as well as an overall audit score. Audit results and reports can be found online at: http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Program-Audits.html.

2015 DISPLAY MEASURES

Part C and Part D sponsors can preview their Display Measure data in HPMS prior to posting on the CMS website. Plan preview was held from October 22 – November 5, 2014. CMS has also included a separate data page containing HEDIS 2014 data submitted by contracts that had less than 1,000 enrollees as of July 2013. In late November, the 2015 Display Measures will be available to the general public at http://www.cms.gov under "Medicare," "Prescription Drug Coverage-General Information," and "Part D and D Performance Data." For 2015, there are 22 Part C Display Measures and 14 for Part D. Display Measures have no Star Ratings assignment. Typically, during the release of the annual Call Letter, CMS moves Display Measures to actual Star Ratings.

2015 Star Ratings are available on the Medicare Plan Finder tool at www.medicare.gov.

About our Authors

About SBG

Solid Benefit Guidance, LLC (SBG) is one of the nation's leading consulting firms and thought leaders in the PBM industry. With more than 130 years of collective experience in this highly complex industry, SBG provides plan sponsors and health plans an unparalleled evaluation of their compliance, pharmacy costs, performance and trends. Some of the services they offer include:

- PBM Procurement & Vendor Oversight
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SBG experts serve as UL EduNeering's Health Care Library Course authors, and also contribute articles to the Health Care Communiqué.

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