Madena, Ltd.

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From the Desk of . . .

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What to Do With Your COB Full File

On 4/14/2020, CMS announced the annual full replacement files were delivered to clients between 4/27/2020 and 4/30/2020. This memo generally provides confusion to clients, and understandably so!

The most common question that I receive is: Do I have to send out the annual survey when we receive this annual full replacement file? The answer is: **No.**

The CMS Prescription Drug Benefit Manual (PDBM) Chapter 14 section 50.2 reads: "*Each Part D plan is required to reach out to their beneficiaries for whom OHI was received to confirm COB information. Beneficiaries who have received the New Enrollee Letter specified above need not receive an annual letter for the same benefit year. Plans **may choose** to use information on the annual full replacement file to trigger the annual mailing. The letters should be done; 1) early enough in the year to maximize use of the information obtained and 2) well in advance of open enrollment to minimize member confusion.*"

With so many organizations being impacted by work-from-home orders, plans must take into consideration the impact to business operations of mailing out notices, receiving return phone calls or notices, and whether they can be compliant with CMS regulations on submitting any updates to ECRS within 30 days of a return phone call or written return notice.

Organizations should have processes in place to identify when an individual has already received a COB notice in 2020 and not mail subsequent COB notices within the same benefit year (always a

calendar year unless the plan is an EGWP with a non-calendar year effective date). Be sure to plan how notices will be mailed out. We are fans of "wave mailing," which establishes a maximum amount of COB notices that can go out per week so that the volume of any responses can be managed by the health plan Call Center and Operations teams. Make sure any COB notice details the other coverage information on file and requests that the member only respond if updates are needed (consistent with Chapter 14 section 50.2 guidance). This will greatly reduce the amount of non-actionable responses.

The other update that CMS announced is that, similar to the TRR process when there are no records to report on a particular day, they will be sending a file confirming that there are no COB records to report. Previously, the COB file was an "up to Daily" (Monday - Saturday) file sent by CMS when there were any changes or updates to any field of any COB record. That change or update would trigger the record to appear on the COB file. This is also why plans receive the same COB record 4+ times per year. The new MARx COB-OHI No Report File provides an audit trail to confirm that CMS did not have any changes or updates to send to you that day. For smaller organizations that may receive a COB file a few times per month, this will be helpful to make sure that all files (actionable or not) are received, accounted for, and processed.

CARES Act: Impact to Claims Payment Handling

Senior Consultant Mae Regaldo Outlines Important CARES Act Provisions

The Corona Aid, Relief and Economic Security Act (CARES Act) was recently passed on March 27th. Outlined below are some select CARES Act provisions that will impact various reimbursement components of the handling of Medicare claims payment and processing:

Temporary Suspension of Medicare Sequestration:

- Medicare sequester currently reduces claim payments made to health care providers. The temporary suspension will increase the payments to health care providers and decrease premium payments made to Medicare Advantage Organizations (MAOs) under Parts C and D by the same amount.
- The suspension of the sequester will increase payments to health care providers and hospitals, as well increase premium payments to MAOs through the remainder of the year, and is intended to provide some relief during the COVID-19 pandemic.

20% Medicare Add-on Payment for Inpatient Treatment of COVID-19:

- HHS is increasing reimbursement by 20% for Medicare patients diagnosed with COVID-19 who are discharged during the declared emergency period.
- CMS and MAOs will identify eligible discharges through the use of diagnosis and/or condition codes.
- The adjustment is a 20% increase to the weighting factor that would otherwise apply to the diagnosis-related group (DRG) for discharge.
- To implement this temporary add-on, MA's claims processing systems are required to apply an adjustment factor to increase the MS-DRG relative weight that would otherwise be applied by 20% when determining inpatient prospective payment systems (IPPS) operating payments for discharges.

Expansion of the Medicare Hospital Accelerated Payment Program:

- Under the CARES Act, CMS has expanded the *Accelerated and Advance Payment Program* to a broader group of Medicare Part A and Part B suppliers in order to increase cash flow to providers of services and suppliers impacted by COVID19 pandemic.
- An accelerated/advance payment means a payment intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. Specifically, under the CARES Act, hospitals participating in the program may request that the Secretary of HHS do the following:
    - Make accelerated payments on a periodic or lump sum basis.
    - Increase the amount of payment that would otherwise be made to hospitals under the program up to 100% (or, in the case of critical access hospitals, up to 125%).
    - Extend the period that accelerated payments cover to up to a six-month period.
    - Provide up to 120 days before claims are offset to recoup the accelerated payment.
    - Allow not less than 12 months from the date of the first accelerated payment before requiring that the outstanding balance be paid in full.

Increased Access to Telehealth in Medicare:

- The CARES Act includes at least one provision to expand access to telehealth services during this emergency.

Things are changing quickly as this pandemic evolves. If you have questions or concerns about your implementation/system set-up, **let us help!** Contact us at 720.428.2650 or via our website.

A Clear Guide to Network Adequacy

Questions about Network Accuracy?
Interim Compliance Officer & Senior Consultant Sue Dahlkamp has got you covered.

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage plans maintain a network of appropriate providers that is sufficient to offer adequate access to covered services to meet the needs of the population they serve. CMS expects that plans continuously monitor their contracted networks throughout the contract year to ensure compliance with the current network adequacy criteria.

Network Adequacy Requirements:
Each year, CMS assesses health care industry trends and enrollee health care needs to establish network adequacy criteria, and on April 22nd they updated the 2020 reference file. The reference file includes provider and facility specialty types that must be available, consistent with CMS number, time, and distance standards.

Triennial Network Adequacy Review:
CMS monitors network compliance by reviewing plans' full network on a triennial basis. Plans that are due for their triennial review will receive at least 60 days' notice before the deadline to submit their networks.

Prior to the formal network review, CMS provides all plans the opportunity to upload their networks in the HPMS Network Management Module for an **informal** review. This is a great opportunity for plans to see if they are meeting requirements. The informal review returns the Automated Criteria Check (ACC) extracts to provide guidance on closing gaps.

Triggering Events:
In addition to the triennial network adequacy review, CMS may perform a network review after specific triggering events. Triggering events include:

- Initial application – full network review
- Service area expansion (SAE) application – partial network review
- Significant Provider/facility contract termination – based on the event
- Change of ownership transaction – based on the event
- Network access complaint – based on the event
- Organization-disclosed network gap – based on the event

If an organization experiences a triggering event requiring a full network review, then the timing of that organization's subsequent triennial review may be reset.

Timing of Network Adequacy Reviews:
- All organizations submit their bids by the first Monday in June, reflecting their assumed service area for the upcoming coverage year.
- Initial and SAE applicants and organizations due for their triennial review must upload their health service delivery (HSD) tables into the NMM in mid-June for CMS review.
- Initial and SAE applicants must upload their tables for the upcoming contract year, while organizations due for their triennial review must upload their tables for the current contract year.

Compliance/Enforcement Actions:

Organizations that fail to meet network adequacy requirements during their triennial review may be subject to compliance or enforcement actions.

Initial applicants that fail to meet network adequacy requirements may be suppressed from the Medicare Plan Finder for the upcoming Annual Election Period until the initial applicant is determined to have an adequate network in place and is prepared to provide access to services under that network in the new contract.

Both initial and SAE applicants that fail to meet the network adequacy requirements by January 1 (when services must be provided under the new contract or service area) may also be subject to compliance or enforcement actions.

How can Madena help:
We offer a range of support services to help plans meet network adequacy requirements, including:

- Current network assessment and gaps identification.
- HSD Table review.
- Network outreach package support.
- Contract development assistance.
- Assistance in reviewing local patterns of care and writing exception requests for gaps that cannot be closed.

Visit Our Website

Upcoming Conferences

Please check event websites for ongoing updates to dates and times.

Medicare Advantage Member Accounting & Reconciliation Summit
June 15-16, 2020 | Join us in participating in this virtual event.

Enhancing Appeals & Grievances and Improving ODAG & CDAG Readiness
August 25-27, 2020 | AC Hotel Downtown, Nashville, TN

Medicare Advantage End-to-End Operations: Enrollment to Reconciliation
April 22-23, 2021 | The Harvard Club, Boston, MA

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