Madena, Ltd.

THE BRIDGE

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From the Desk of ...

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Readiness Checklist – Annual Task to Complete or a Valuable Profitability Tool?

CMS provides a comprehensive Readiness Checklist in October to be used as a self-assessment of your health plan's ability to meet CMS requirements for the upcoming plan year. The Readiness Checklist includes many of the same critical requirements every year, but also includes new items based on concerns identified by CMS audits and new or revised regulations.

The CMS Readiness Checklist is not intended to be an exhaustive list of all of your requirements under the Medicare regulations. Why not take the time between the bid submission and AEP start to complete an internal readiness review and include last year's CMS readiness checklist? An organization should prioritize operational areas before they dive head-first into AEP readiness activities.

Going through this activity now has major benefits:

1. To be successful, health plans must establish a process to complete the Readiness Checklist that includes business owner attestation with supporting documentation. The next step is an independent validation of the responses by the Compliance department or a third party to validate the completeness of the supporting documentation.
2. Because the CMS readiness checklist does not change dramatically from year to year, you will likely have 90% or more of the readiness validated. This will allow you to focus only on the additions to the newly released checklist and free up staff to focus on AEP activities.
3. The independent validation can also feed into your annual Compliance Risk Assessment as long as it examines the risk associated with the people, process, and technology that

supports the requirement, and assigns a risk score. Additional best practice includes summary reporting to create a roadmap for process improvement opportunities. All risks associated with a health plan's ability to be 'ready' are required to be reported to the CMS Account Manager, which will most likely result in a request for a corrective action plan.

CMS requirements are in place to protect Medicare members. Health plans have an opportunity to
use this 'readiness' exercise to create visibility and transparency, identify risk, and craft remediation plans well in advance of the annual attestation. Health plans will increase profitability and STAR ratings when they implement efficient and effective processes geared toward a positive member experience.

Madena is available to provide support with development of the Readiness Checklist process, validation of business owners' responses, and to assist with resolution of identified risks.

Understanding Premium Billing Reconciliation

A member's perception on whether a health plan 'can get their billing right' weighs heavily in their decision to stay a member of your plan. Incorrect or confusing invoices will be a primary driver of spikes into your call center. The two fundamental pieces to successful premium billing processes are: detailed invoicing and shortened timeframe from data pull to mailing. And, of course, you should never skip Reconciliation!

A clear invoice helps the member understand their current billing. Detail out LIS and LEP adjustments so that the member knows what the base premium is (that matches to the plan they enrolled in), and the adjustments impacting what they owe. Ensure that you have no more than four business days from the time the invoice file is generated to the time they are printed to help minimize a spike in call volume.

What should you be doing in those four business days? **Premium Billing Validation and Reconciliation.**

1. Before premium billing is run, make sure all payment files have been loaded and unidentified cash has been fully worked. Ensure all LIS and LEP adjustment transactions from CMS have been processed and applied to the premium billing.
2. Quality check the invoice pull by reviewing a subset for accuracy. Look for anomalies (large differences in invoice counts compared to last month, large balance due amounts) that could indicate a systematic or processing error.
3. Reconcile the invoice pull to the CMS LEP and LIS data files. There will be some timing differences, but catching your discrepancies before a member calls and files a grievance, or worse, a CTM, is value added to any billing cycle. Pull and adjust incorrect invoices as needed to minimize member abrasion.
4. Reconcile the invoice pull to the CMS MPWR data file. Again, you will have some timing differences, but ensuring you are not double billing a member because their premium is being withheld by SSA and you are mailing an invoice is important.

Lastly, don't underestimate the value of feedback. Look at your Call Center call logs, grievances, and CTMs to identify member concerns and use that for premium billing improvements to drive higher member satisfaction.

Don't have the tools or staffing for premium billing reconciliation? Madena has modular and highly affordable options to assist with your monthly premium billing reconciliation. Contact us to see how we can help.

CMS Program Audit Protocol Updates

Interim Compliance Officer & Senior Consultant Sue Dahlkamp Summarizes the Updates

On June 19th, CMS announced that the final audit protocols for the Medicare Parts C and D Program Audit and Timeliness Monitoring Data Requests were available on the CMS website. They can be downloaded here.

While the changes are not extensive, plans should review them and make the necessary system updates to ensure compliance. Also make sure to pay close attention to Field Name and Length in all Record Layouts. Even though CMS announced in March they were reprioritizing Program Audits this year, they will be considering options for modifying the timing and scope of the 2020 program audits in order to complete them later this year.

As your plan is making the necessary updates to the Program Audit Record Layout, remember to add any necessary validation and timeliness checks to your file exports. This will ensure compliance and provide the necessary internal monitoring and auditing also required by CMS. If you have any questions, or need guidance on these activities, please contact us.

Below is a summary of the pertinent updates:

- CDAG – for the Standard and Expedited Redeterminations layouts CMS added clarifying language to the NDC field for at-risk redeterminations and added the Exception Type of "safety edit exception." Removed Tables 9 & 10 (Standard & Expedited IRE Auto-forwarded Coverage Determinations & Redeterminations).

- ODAG – for the Payment Reconsideration layout CMS added denied request clarification to paid date, for the Direct Member Reimbursements Requests layout they add clarification for reconsideration requests, and for the majority of tables they removed the requirement to include ICD-10 code for drug when providing an NDC in the diagnosis field. Removed Level of Service from all applicable tables.

- SNP-MOC – CMS removed several questions from the Questionnaire and revised the question on HRA administration.

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Industry News

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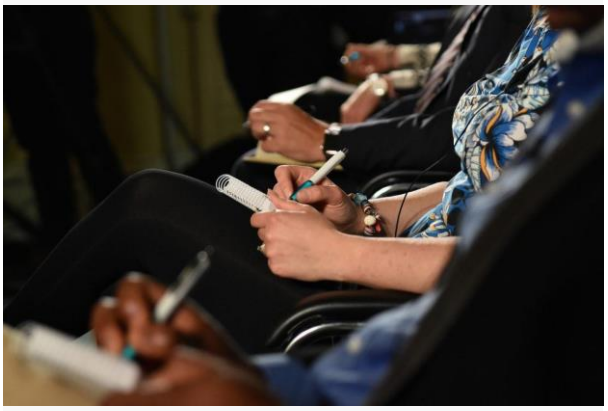
MedPAC's Quality Bonus Program | Report to Congress

Loneliness: America's Other Epidemic

Medicare Part D 'Donut Hole' Struggle

Madena's Synchronicity™ Reconciliation Tools



Upcoming Conferences

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

Enhancing Appeals & Grievances and Improving ODAG & CDAG Readiness
August 25-27, 2020 |**Now a virtual conference**--more information coming soon.

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

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